Changing Trends in Physician Preference Items

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• Supplies represent 30% of the total cost of hospital care.

• PPIs account for approximately 60% of this spend.

• Supply intensive admissions are associated with surgical procedures—a single item or construct (mix) may dominate the cost.

• Volume of these admissions (total hip, total knee, spine surgery, cardiac procedures) is increasing due to: 1) Expanded indications, and 2) population demographics.

• Hospitals accustomed to giving surgeons whatever they ask for are struggling to hold down costs.
Supplies are the second largest cost to a hospital (31%), second only to labor costs. Physician preference items comprise 60% of this cost.
Challenge in controlling PHIs

• History

• Strong relationships between physicians and industry.

• Physician autonomy & separation from hospital control. They are interdependent, yet distinct.

• Resource dependency-power depends upon the relative resources a party controls.
Trends

Consolidation of hospitals
Consolidation of physicians
Reimbursement changes
Move towards evidence based medicine
Changes in physician attitude, in addition to reduced power and influence
Hospital Mergers and Acquisitions

Physician Consolidation

• Estimates are that 90% of MDs will be aligned with a primary health delivery system within the next 5 years.

• Multispecialty clinics, consolidated specialty practices, PHOs, Faculty practice plans, etc.

Hunter, Himmelstein; Navigant Healthcare Pulse 2013
Physician Autonomy

Institute of Medicine Report (2000)

Practice variation = unnecessary introduction of error

Eliminate variation by enforcing standards, guidelines and protocols

Autonomy now means ceding control to other physicians, and gaining autonomy as a profession
Physician autonomy in the age of accountability

• Followed on the heels of “To Err is Human,” the report on medical error from the Institute of Medicine, published in 2000.


• A change in physician’s compact with society
  • Review of care plans by insurers.
  • Calls for public reporting of errors and quality indicators.
  • Increasing level of administrative oversight of billing, documentation, etc.

• Where do we go from here?
Balance between autonomy and regulation

• Physicians will regain clinical autonomy by policing their own profession.
• Physicians will regain autonomy by practicing consistent science.
• Adoption and adherence to jointly developed clinical guidelines will translate knowledge into a superior system of care.
• Autonomy will be best achieved by practicing as a team of professionals.
Arguments made against evidence based guidelines and protocols

• “We can’t all agree on the science.”
• “Specialties will make self-serving judgments on the science.”
• “Protocols stifle innovation.”
• “Guidelines expose us to legal risk.”
• “It’s cookbook medicine.”
• “Guidelines are unprofessional.”

James Reinertsen, MD published these in 2004, yet the same arguments are still put forward today, albeit less successfully.
The physicians of tomorrow

• Medical schools are recruiting students who are more altruistic, and who demonstrate characteristics of team players.

• Students are entering medical schools, and residents are completing residencies, with a new understanding of autonomy—one that involves applying scientific medicine as a team, yet practicing the art of medicine as an individual.
Factors changing traditional selection of physician preference items

- Increased margin pressure on hospitals
- New payment models aligning hospital and physician payment
- Increasing number of physicians employed by hospitals or affiliates
- New physician attitudes towards autonomy, & reduced physician leverage
Pharmacy and therapeutics committees (P&T)

Have existed for many years

Comprised of physicians, pharmacists and organizational representatives

Collaborative committees that are strongly influenced by evidence bases medicine.
A formulary approach to management of medical devices...Why not?

• Few correlates with traditional P & T committees.
• Fewer clinical trial data are available.
• New devices brought to market much more rapidly (510K). Difficult for hospitals to stay current.
• Product equivalencies are difficult to establish.
• Lack of price transparency makes cost comparisons and effectiveness evaluations difficult.
• Surgeons often need to customize selection based upon patients needs (e.g. anatomy), or their personal training and competence.
AMA will assign a CPT code only after studies have been published, and use of the procedure is widespread. Time?
Successful strategies for reducing the cost of PPIs

• Standardization: make genuine efforts to overcome distrust-recruit physicians to participate in standardization efforts.

• Limiting manufacturers from which physicians may choose.

• Retain an employee dedicated to working collaboratively with surgeons, industry representatives and hospital management.

• Supply pertinent information to surgeons (reverse detailing). Information is key.

• Form Value Analysis Teams (VATs) to use available information to choose appropriate technologies (75% of hospitals have such committees, but only 50% of them include physicians.)

• Gain sharing programs with physicians, or physician groups.
Successful strategies for reducing the cost of PPIs

- Communication and transparency regarding pricing.
- If necessary use outside purchasing agencies.
- When asking physicians to make changes, be willing to give something back (better OR efficiency, reduced turnover times, etc).
- Encourage proactive discussions of new technologies in hospital section meetings.
Device company rep perspective

- Major shift in stakeholder alignment, shifting clinicians from first to last in terms of influence.
- Vendors scrambling to structure strategic approaches to administration.
- Costs are dominating over features, benefits & outcomes.
- Over past 5 years, prices moving toward commoditization
- Decrease in innovation.
- Device companies are cutting sales force—not even calling on smaller hospitals
- No fun anymore.
Marketing devices to hospitals and physicians

• Understand the decision making process for the institution, and be smart about working within it.

• Direct marketing efforts to both providers and the institution, providing both cost and outcomes information.

• Support independent quality evaluation of your product.

• Seek long-term relationships, not short-term wins.
Physician attitudes: Miscellaneous trends

• 59% would not recommend a young person not become a physician.

• 42% of physicians are dissatisfied with their occupation, an 17% are very dissatisfied.

• Satisfied physicians tend to be greater than 45 years old, in surgical specialties, or dermatology and anesthesiology.

• Dissatisfied physicians tend to be less than 45, practicing in primary care, ER, critical care or musculoskeletal specialties.

• Between 2012 and 2015, solo practitioners decreased from 21 to 15 percent.

• Happiest physicians are in hospital or group practice.
Physician attitudes: Miscellaneous trends

- 28% of doctors work more than 10 hours per day.
- Doctors prefer working with physician assistants over nurse practitioners (35 to 28%).