Healthcare Reform Brings Supply Chain Management to the Forefront

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Recent legislation, including the American Recovery and Reinvestment Act (ARRA) of 2009 and the Patient Protection and Affordable Care Act (PPACA) of 2010, is changing the way hospital and healthcare systems operate. These acts are meant, in part, to create better efficiencies and reduce the ever-increasing cost of healthcare in the United States. In 2011, national healthcare expenditures reached 2.7 trillion and were approximately 17.9 percent of the US GDP. That percentage is expected to reach nearly 20 percent by 2021.[1] Not only does the Affordable Care Act aim to reduce cost, but also baked into the legislation is a new reality that cost and quality cannot be mutually exclusive. To be successful in the new industry landscape, healthcare systems must treat each measure equally to achieve the "must-do" strategy of efficiency through productivity and financial management. Supply chain management will be an essential piece of this puzzle.

Healthcare reform was largely designed to achieve the Triple Aim. Developed by the Institute for Healthcare Improvement (IHI), the Triple Aim consists of three main goals:

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing the per capita cost for healthcare.

All healthcare facilities should be working toward these goals.[2]

Also included in the Affordable Care Act is the establishment of The Hospital Value-Based Purchasing Program (VBP), which was designed by the Centers for Medicare and Medicaid Services (CMS) to reward acute-care hospitals with incentive payments for quality of care. It aims to improve quality and patient satisfaction, and reduce readmissions and hospital-acquired conditions.[3] In short, it is forcing the industry to move from a fee-for-service to a fee-for-performance–based payment and incentive model (from quantity to quality). Given that the majority of growth for hospitals will be from Medicare patients, this is particularly important.

As hospitals migrate to this "volume to value" business environment, there is an obvious and inextricable link between optimizing the supply chain strategy and managing the expense per episode of care, which is critical in an accountable care model. The number of healthcare systems that have joined an Accountable Care Association (ACO) has increased dramatically over the past few years. It is one way systems are creating an infrastructure to better coordinate care, increase quality and decrease costs. An ACO is a group of health care providers who come together voluntarily to give coordinated high-quality care.[4] These can be independent organizations or part of a payment program such as the Medicare Shared Savings Program. Evidence of the quick growth of these organizations can be seen in the fact that CMS added more than 100 ACOs to its program in January 2013, followed by an additional 89 in July 2013. Some estimates place the total number of all types of ACOs in the US at more than 450.[5]

Cost per unit of service and cost per stay will be part of these organizations' DNA in a value-based system. Therefore, managing risk is paramount. This cost-management imperative has been highlighted by think tanks such as The Advisory Board in its illustration of how the cost of supplies and services is growing at a faster rate than labor cost. It has also demonstrated that a dollar of cost savings has a more profound impact on the operating margin of a hospital than a dollar of revenue. This is not an insignificant fact if you subscribe to the suggestion that the hospital business is now a cost-management game as opposed to a revenue game.

Hospitals, though, can adapt their supply chains to successfully navigate these changes by recognizing that care coordination is the glue that holds a population-based system

of care together. Care coordination requires aligning the incentives of physicians and clinicians to assure the patient is receiving the right care, at the right place, at the right time. This is the same philosophy that has traditionally defined a successful supply-chain strategy. The ideal goal has always been to have the right supplies, at the right time, at the right place and in the right amount.

Still, this goal has remained elusive for some hospitals. Hospital leaders should use the short time they have between the fee-for-service business model and the fee-for-value model to integrate the supply chain into the care-coordination strategy. This can be done by using the same approach to a supply-chain strategy that hospitals have implemented on the quality side with obvious success. Set goals and objectives for quality and supply-chain improvements and build targets into the strategic plan of the organization. Finally, use internal and external data to measure and monitor performance.)

Another important component of reform is the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is part of the ARRA. It was designed to promote the adoption and meaningful use of health information technology.[6] Electronic Health Record (EHR) use is required to manage population health. Currently, incentives for implementation are available if meaningful use is demonstrated, but penalties will begin in 2015 for violations of this act. Implementation is occurring in both physician offices and hospitals and is consuming a considerable part of budgets nationwide.[7] The cost is showing great benefit, however. Information technology and EHR use have allowed hospitals to improve care, reduce cost and improve work processes. This is accomplished with the use of internal and external data to monitor progress. To date, hospitals have not made the same capital investments on the supply side in IT that they have on the quality side for obvious priority reasons. Quality programs are also characterized by an infrastructure that formalizes the initiative. On the supply side, hospitals started to build this infrastructure in the 1990s with value analysis programs, but now need to recommit themselves to this strategy for working collaboratively with physicians and other caregivers.

Coordination in managing an episode of also requires influencing those care points of service that may not be under the direct influence of the hospital. Facilities may need to work with the community, outpatient centers, urgent care clinics and homecare or long term care facilities in an effort to improve quality and reduce cost .This is particularly true in light of penalties associated with things like readmission rates. On the supply-chain side, this “continuum of care” concept extends to the manufacturer and the distributor, who ultimately influence the cost of the service to patients and families we are privileged to serve.

Clearly, the delivery of care in the U.S. is transforming in all areas, from the very infrastructure of healthcare systems to payment models and incentives. The new payment model rewards quality over quantity and places heavy penalties on those who do not continually improve patient outcomes and deliver high-quality care. The risk in revenue due to decreasing reimbursement puts more pressure on improving cost efficiency and improving the supply can help manage the cost per patient.

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[1] National Health Expenditure Projections 2011-2021. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

[2] Institute for Healthcare Improvement. Triple Aim. Accessed August 30, 2013. http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

[3] Centers for Medicare and Medicaid Services. FY 2013 Program: Frequently Asked Questions about Hospital VBP. www.cms.gov. Updated March 8, 2012. Accessed August 30, 2013.

[4] Centers for Medicare and Medicaid Services. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

[5] Leavitt Partners. Center for Accountable Care Intelligence. The Accountable Care Paradigm: More Than Just Managed Care 2.0. http://leavittpartners.com/wp-content/uploads/2013/03/Accountable-Care-Paradigm.pdf. Accessed August 13, 2013.

[6] US Department of Health and Human Services. http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitechenforcementifr.html Accessed July 29, 2013.

[7] Centers for Medicare and Medicaid Services . Medicare and Medicaid EHR Incentive Program Basics. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html. Accessed August 13, 2013.