Supply Chain's Role in Reimbursement

Creating and Managing Evidence-Based Medicine in the New Era

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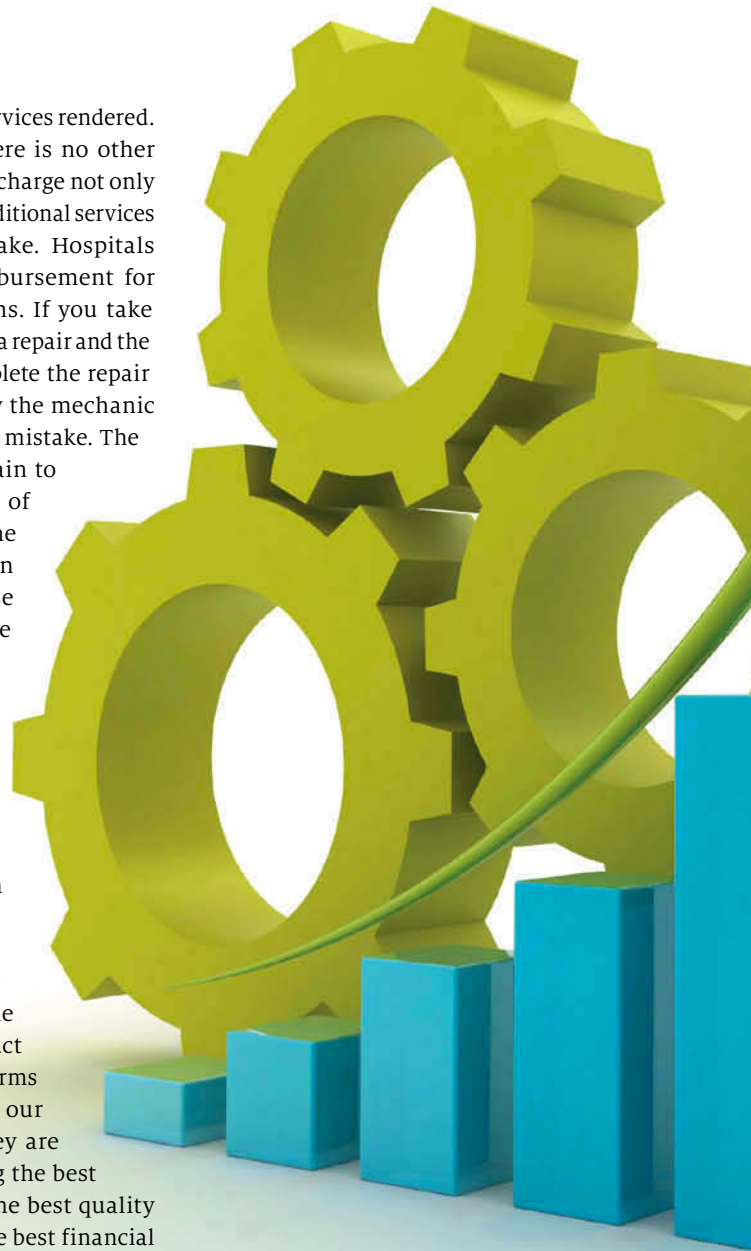
Supply chain has always played an important role in reimbursement outcomes. In the 1980s before the introduction of Diagnosis Related Groups (DRGs), supply chain (generally referred to as materials management) was a revenue-generating department. The department was tactical in nature, purchasing the requested supplies and charging for them to generate reimbursement. In this model, cost was not of paramount concern as reimbursement was mostly based on billed charges. With the advent of DRGs, supply chain's role required a new level of sophistication. Not only did supply chain need to ensure proper charging as many payors continued to reimburse based on this model, but we also now had to manage product cost. As commercial payors began to adopt a capitated reimbursement model, the level of sophistication required by supply chain increased again. Cost management became paramount and negotiation skills were now required in order to be successful and ensure the financial health of our hospitals. Product cost alone was not the focus; it was the Total Cost of Ownership including all aspects of the acquisition process. As hospital reimbursement remained fee for service, the focus remained on cost reduction and cost control more so than a product's relative performance.

Fast forward to today. The Affordable Care Act appropriately reimburses hospitals for performance—not just services rendered. I say appropriate, as there is no other industry that was able to charge not only for a service but also for additional services in the event of a mistake. Hospitals no longer receive reimbursement for preventable readmissions. If you take your car to a mechanic for a repair and the mechanic does not complete the repair correctly, you do not pay the mechanic to correct his or her own mistake. The ACA requires supply chain to advance to a new level of sophistication. All of the skills and sophistication we accumulated because of changes in healthcare over the years are still essential; we must now integrate them towards AHRMM's Cost, Quality, and Outcomes (CQO) Movement. CQO means that we focus not just on the cost of the product, but all costs associated with delivering patient care and supporting the care environment. Product quality means how it performs after the patient leaves our care, not only while they are in the hospital. Selecting the best product that produces the best quality outcome will result in the best financial outcomes. CQO is a balanced scorecard for



supply chain; it requires us to consider all aspects of a product or service.

The challenge facing not only supply chain but also the healthcare industry as a whole is finding evidence that differentiates the efficacy of one product versus that of similar products. Much like a unicorn, we can all describe what that should look like but we have yet to see it. If we want to ensure the best outcomes for our patients and institutions, and make decisions based on empirical evidence, then we are going to have to help create the body of evidenced-based medicine. This is the next level of sophistication for supply chain and perhaps the most strategic. This 'holy grail' of information is what will help ensure the best reimbursement outcomes for our institutions, balancing the selection and contracting for products that have the highest quality and result in the best clinical and financial outcomes.

The question is: How? How do we connect the silos of information of products purchased, products used, and the resulting outcome? We need to leverage our legacy processes with new standards to create robust data sets. Legacy practices such as the use of a charge master, for all its shortcomings, are still the dominant methods by which we capture product usage and processes used to care for patients. We use it as support for coding and couple it with other information to determine the patient's condition and severity. We use readmissions, core measures performance, and mortality indexes as proxies for outcomes. We can fill the gap of the product actually used by enumerating a data set, commonly the MMIS Item Master, with UDI/GTIN information and connecting the charge master with this data set. A highly accurate, fully enumerated, Item Master allows us to transact efficiently, contract effectively, and, when connected to outcomes data, evaluate the efficacy of the products that we use. The resulting 'Big Data' brings together all the components of CQO needed to maximize reimbursement outcomes.

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Supply chain continues to have an important role in reimbursement outcomes, one with more significance than ever. What has changed is the level of sophistication required to accomplish this. No longer a tactical responsibility of charging for supplies to generate revenue, we are charged with guiding the selection and procurement of supplies that maximize the intersection of CQO, improves the health and wellbeing of our patients, and contributes to the overall body of knowledge used to make evidence-based decisions. Supply chain occupies the unique position at the intersection of CQO; let us carry forward this charge and continue to lead this movement within healthcare.

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