Driving Supply Chain Value

Collaborating with Suppliers Under the Cost, Quality, and Outcomes (CQO) Approach

BY CHRISTOPHER J. O'CONNOR, FACHE, FAHRMM,
PRESIDENT, GNYHA SERVICES, INC., AND NEXERA INC., NEW YORK, NEW YORK

Healthcare reform is undeniably changing the way healthcare is delivered and consumed in the United States. And the biggest change may not be financial or organizational but rather philosophical. Healthcare has transcended treatment and now encompasses the ability to adapt, respond, and manage changes in the health status of a defined population. As anyone working in a provider organization knows, payment reform is the tool being leveraged to change healthcare delivery and consumption. When health reform was first passed into law, the payment changes focused on institutions through value-based purchasing and readmission penalties related to certain core measures. Payment reform has now extended beyond hospitals to individual clinicians through physician quality reporting and pay-for-performance as well as the new merit-based MACRA legislation that replaces the Medicare physician fee schedule.

How are health systems responding to these payment reforms? By organizing populations in data-driven disease and case management systems. These value-based care models (ACOs, clinically integrated networks, patient-centered medical homes) differ in structural details but are rooted in the sharing either of risk, savings, or both based on patient outcomes. As a result, hospital and health-system executives are focusing on the cost of inputs—supplies and services used to deliver care—and costs avoided by preventing hospital-acquired conditions and readmissions. Healthcare supply chain stakeholders—both hospital supply chain leaders and suppliers—have a critical, strategic role in supporting cost containment while improving these outcomes. The key is for the healthcare supply chain to support value-based care by finding the intersection of the cost of a product or input with quality of care provided, and reimbursement. This is CQO—the strategic evaluation of inputs against outcomes.

For hospital supply chain professionals, adopting the CQO approach means a shift from focusing on the lowest cost product to the product that delivers the best quality for the best price. Under the CQO approach, the health-system supply chain must collect and analyze product data to determine the comparative effectiveness of new products against existing treatments, identifying the ROI for higher-cost products under certain clinical conditions.

But the health-system supply chain can't implement CQO without help from what may seem like an unlikely partner: suppliers. For years, the relationship between supply chain executives and suppliers has been relatively adversarial, with supply chain executives pushing for the lowest prices while suppliers tried to introduce higher-cost product innovations. This dynamic places health systems and vendors on opposite sides of the supply chain. But CQO demands a sea of change in how hospitals interact with suppliers,

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creating a process that is more collaborative and objective than ever before.

Abandoning the race to the lowest price, CQO creates a framework for evaluating added expense as a function of patient outcomes and can include clinical nuances to justify different products at different input costs for different patient populations. Under CQO, comparative effectiveness can be viewed on a spectrum. One example that has been used in some of the AHRMM CQO education is biologic versus synthetic mesh for hernia patients with comorbidities. The price of biologic mesh is approximately six times that of synthetic; however, the cost avoidance benefit that comes with infection prevention in certain patient populations far outweighs the initial product investment. CQO looks to patient data to drive input selection, where outcomes are a function of cost and care quality.

In other words, downward cost pressures will prompt providers to treat all inputs—products, devices, pharmaceuticals, and equipment—as commodities until suppliers provide data that prove otherwise. As a result, suppliers can respond in several ways. First, suppliers can opt to compete as a commodity, prioritizing routine innovation to reduce production costs in order to lower product prices. Suppliers can also develop strategic alignment for a product-service offering that supports providers under value-based reimbursement. To develop a product-based strategic relationship, suppliers need to pivot from product-driven value propositions to population-driven value propositions (i.e., a product and related support services that align with a core provider priority, like clinical quality).

Alternatively, more innovative suppliers are adopting the same risk-sharing concepts that are driving delivery-system reorganization. To encourage hospitals to newer (higher-cost) products and therapies, several suppliers have created risk-sharing contracts with their customers, paying rebates or returning a percentage of the purchase price if the product doesn't meet certain performance goals. Of course, the key to risk-based agreements is data-sharing. Suppliers that offer risk-sharing agreements are working with hospitals and their GPOs to define outcome measures and track them against baseline measures.

As the trend toward value-based payment models continues, both suppliers and healthcare providers are recognizing that the more competitive landscape places financial pressure on both sides. Supply chain is in a unique position to lead a clinically integrated, data-driven approach to balancing investments in innovative products with quality and reimbursement outcomes, but it cannot shift to a CQO approach without support and collaboration from suppliers.

Christopher O'Connor, FACHE, FAHRMM, *serves as executive vice president of GNYHA Ventures, Inc., and president of two subsidiary companies under GNYHA Ventures: GNYHA Services, Inc., an acute care group purchasing organization, and Nexera, Inc., a healthcare consulting firm. O'Connor is currently a Fellow and Past Chair of AHRMM, as well as a Fellow of the American College of Healthcare Executives (ACHE).*