FALL 2012

streamlining HEALTHCARE

Innovations in supply chain management

Less is more

Providers reduce inventory to increase efficiency

5 WAYS TO MASTER SUPPLY CHAIN MANAGEMENT

NURSING HOMES BALANCE COSTS AND QUALITY

MAXIMIZING PATIENT OUTCOMES WITH ON-SITE LABS

Collaboration: We can't reform healthcare without it

As the owner of a distributor serving nursing homes and home care providers, my silo is the "post-acute" world. I know about Medicare reimbursement for nursing facilities and the challenges of incontinence for geriatric patients.

To succeed with healthcare reform, we have to reach way beyond these silos. We have to connect the dots to understand what happens in other healthcare segments and how that relates to what we do.

Take the challenge of reducing readmissions. Starting in October, hospitals risk losing one percent of their Medicare revenue if their 30-day readmission rates exceed set targets. As a result, hospital leaders are thinking more than ever about what happens to patients when they leave the hospital. Our silos are colliding!

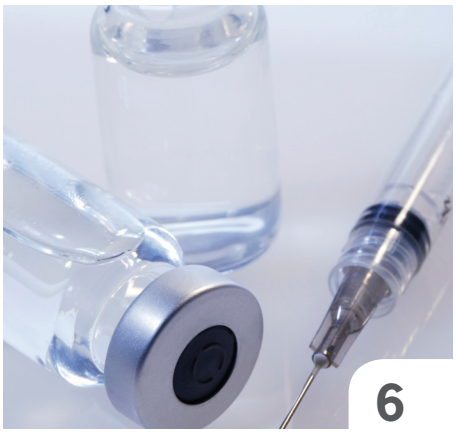
Never before have we had to be more connected as a supply chain. And it's not just a supply chain—it's a people chain, a network that includes providers, suppliers, referral sources, insurers, and consumers, just to name a few. We need collaboration at every level.

It's a challenging time but also an exciting one. Each of us involved in some piece of the healthcare supply chain has an obligation to learn more about what happens outside our own silos. Each of us has an opportunity to help our partners better understand our segment.

Together, we can connect the dots.

Andrea Logan
President
All Med Medical Supply, LLC
2012 HIDA Board Chairman

in this issue



DEPARTMENTS

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HIDA
HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

ACOs

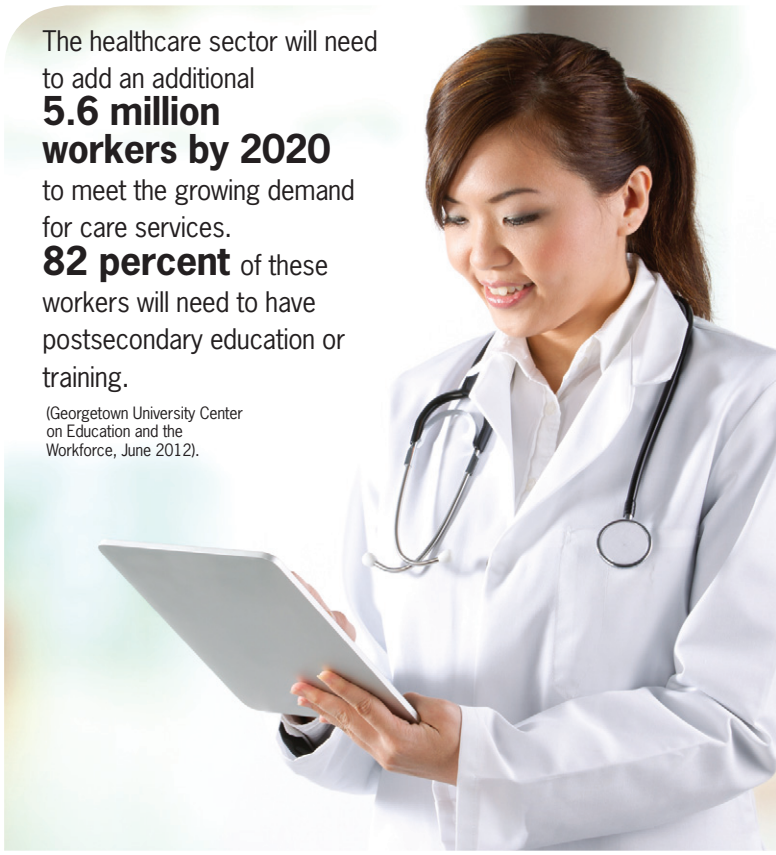
13 PERCENT of hospitals currently participate in ACOs or are considering ACO participation within a year *(Commonwealth Fund)*.

221 **public or private sector ACOs** are operating in the U.S. as of May 2012.

2.4 MILLION+ **Medicare beneficiaries** are currently being served by ACOs.

The healthcare sector will need to add an additional **5.6 million workers by 2020** to meet the growing demand for care services. **82 percent** of these workers will need to have postsecondary education or training.

(Georgetown University Center on Education and the Workforce, June 2012).



The elderly and disabled make up **25 percent** **of Medicaid enrollees,** and account for **66 percent** **of Medicaid expenditures.** This totals nearly **$228.7 billion**—or more than $14,600 per beneficiary *(CMS)*.

Affordable Care Act (ACA)

54 percent of physicians believe that the ACA will increase patients' access to care, yet **70 percent** believe the law will not prevent rising healthcare costs *(Jackson Healthcare, 2012)*.

17.8 **million** Medicaid-eligible Americans could remain uninsured if states opt out of the law's Medicaid expansion program *(The Urban Institute, June 2012)*.

Managing physician practices requires patience, flexibility

Don't worry about the things you can't change. I always apply that advice—which my mom gave me growing up—to my work. For instance, health reform rules that are still in flux. So I focus on what I can do: help physicians purchase products more cost-effectively—which will help no matter what the final rules are.

You can't be all things to all people, so focus on what you do best. In my case, that's managing physician practices. I lean on others for things outside my expertise.

Don't be afraid. Take advantage of every opportunity to gain expertise from your supply chain partners. For instance, I ask my distributor to come in and teach our staff about product utilization, and it's a tremendous value.

Embrace new tools. Barcoding single-use vials, for example, presents supply chain managers with the opportunity for predictive inventory, better cash flow, and more time to focus on patients rather than supply negotiations. The right innovative tools can really change the game.

It's all about data. If my team is evaluating a new product, glossy brochures and "bells and whistles" mean nothing. What counts is the hard data guaranteeing the most value for my spend while ensuring improved, measureable outcomes.

Just say "no." I've always been the nun with the yardstick when it comes to GPOs—join if they meet a clear need, then follow their rules carefully; otherwise, just say "no."

Don't wait for external pressures to force needed improvements. We can't wait for healthcare reform to shape future purchasing practices. Careless supply spending makes costs soar past a sustainable level. We're evaluating supply chain management options and alternatives today to avoid getting caught flat-footed tomorrow. It can only benefit our organization, regardless of healthcare reform's final outcome.

Welcome market shifts. In my world, the trend I see is from acute to post-acute care. We're seeing better care coordination and consolidation between these two settings, but the lion's share of healthcare lobbying money remains where the most money is made—acute care. Expanding outpatient will reduce long term costs and may even grow health system revenues.

D. Ryan Champlin
Vice President
Cook Children's Health Services, Inc.

With experience managing more than 350 providers performing more than a million outpatient procedures per year, one healthcare executive shares his insights.

"You can't be all things to all people, so focus on what you do best."

Pedigree gains momentum

Advocates for a uniform, national pharmaceutical pedigree solution are encouraged by recent progress on Capitol Hill. Currently, pedigree requirements (translation: documentation of drug product transaction histories) vary by state, but key lawmakers have expressed their commitment to passing legislation this year to replace the current patchwork of pedigree laws.

The clock is ticking on federal legislative opportunities with state requirements slated to grow increasingly complex by 2015. A standardized, national approach to pharmaceutical traceability is expected to provide consistency and improved supply chain security, enhancing patient safety efforts and saving money for suppliers and providers alike.

KEY DATES TO KNOW:

OCTOBER 1, 2012 – Medicare ties hospital payments to quality via value-based purchasing. Medicare also begins penalizing hospitals for higher than expected readmission rates for heart attack, heart failure, and pneumonia.

DECEMBER 31, 2012 – Deadline for states and territories—from Maine to Guam— to commit and outline their own state-based health insurance exchanges.

JANUARY 1, 2013 – Medical device tax kicks in. This 2.3 percent tax was created by the reform law and is expected to generate $20 billion over the next 10 years.

Boomers aren't counting on Medicare

A new survey from AARP found that baby boomers, 95 percent of whom believe Medicare is critical to maintaining senior health, are not confident the program will be there for them or future generations.

The survey measures AARP's "anxiety index." When asked their top five financial concerns, respondents listed health expenses fourth after rising prices, taxes, and financial security in retirement. Expect Medicare solvency concerns to bubble over into election issues at every level, from mayoral races to the Presidency.

Workforce shortage looms large

Most folks have heard that the U.S. faces a growing shortage of nurses and physicians, but the U.S. Labor Department has also flagged the growing need for home health providers.

With baby boomers aging into retirement, many are already enlisting the help of home health aides to delay nursing home care. It's expected that the home health industry will add 1.3 million jobs over the next decade, increasing at a rate higher than any other occupation.

> It's expected that the home health industry will add **1.3 million jobs** over the next decade.

In 2011, the median pay for home health workers was $9.70 per hour, a few dollars over the federal minimum wage rate, but low enough that employers face competition from shift work, including McDonalds and Starbucks.

The Direct Care Job Quality Improvement Act, introduced in the House and Senate, would establish a National Health Care Workforce Commission, tasking the group to analyze and address workforce supply and demand while also funding grants to improve the recruitment, retention, and education of direct care providers. However, the nursing and physician workforce challenges dominate Congressional attention. Neither bill is likely to become law.

On-site labs meet health reform goals

Canyon Medical Center improves patient outcomes and revenue

More than a half-million times a year, the physicians and patients of Canyon Medical Center take advantage of the fastest way possible to get the accurate diagnostics results they need. It's a simple matter of geography: Tests are run down the hall, not across town to a centralized lab.

"When the lab is in the physician's office, it's just more efficient and leads to better patient outcomes," says Sue Noon, lab manager for the 10-physician practice, which focuses on internal medicine and pediatrics in Columbus, Ohio.

"Diagnostics is an extremely important tool that doctors embrace," she says. "On-site testing helps them decide faster what's best for patient care. In a half hour, they can get the results back and make a decision, vs. writing an order, sending the patient to a lab somewhere else, and then waiting for the results. Who knows what can happen to the patient in the meantime? That's why health systems that embrace quality care leave the labs in the physician offices."

On-site labs improve the health not only of patients, but of practices as well, according to Noon. In an age of declining reimbursements, the on-site lab at Canyon Medical Center is a viable source of additional revenue. So what are her keys to managing a healthy lab in a small physician practice?

Noon helps ensure her lab's ongoing health in many ways, such as:

1. Enhancing **cash flow** by arranging fixed, monthly billing for all supplies.
2. Eliminating **on-site inventory challenges** (such as limited storage space) by having the distributor store supplies.
3. Ensuring an acceptable **return-on-investment (ROI)** for every major purchase, such as capital equipment.
4. Planning ahead for **seasonal needs** (for example, adjusting the inventory levels of flu supplies to anticipate varying demand).
5. Improving **staff productivity** by having the distributor monitor and reorder supplies as needed.

Making an on-site lab work

Noon focuses on mitigating the cost and logistics challenges that would otherwise make an on-site lab difficult to maintain, if not impossible. "Medical centers and physician offices work on very tight budgets and close margins. We're not like hospitals, where you have a lot of money to stock supplies," she says. "If I ordered a three- or six-month supply of reagents, it could cost up to $100,000. Our doctors would have a heart attack!"

Less is more

By Elizabeth Hilla

Providers find increased efficiency and savings with less-is-more models

Healthcare provider organizations are looking to their supply chain for savings as they meet the demands of healthcare reform. This has triggered renewed interest in models that significantly reduce inventory. Many hospitals are adopting them—with unique features in each facility—and report efficiencies and savings. Here are some examples:

CASE STUDY: Vanderbilt University Medical Center

Teaching hospital, children's hospital, and clinic network, all located in same urban area

Challenges:

- New surgical tower triggered reevaluation of current supply chain strategy
- "Landlocked"—no room to expand sterile processing to accommodate increased surgery volume

Outcomes from stockless adoption:

- Storeroom eliminated, freeing up space for clinical expansion needs
- More than 40 vendors converted direct to distribution, eliminating transactions and reducing complexity.
- Fill rates increased to >99%; rush orders dramatically reduced

CASE STUDY: ProMedica Health System

Not-for-profit health system with 11 hospitals and more than 100 non-acute sites

Challenges:

- Duplicative storeroom locations across all system hospitals resulted in redundant inventory
- Upgrade/expansion triggered a strategic value assessment of off-site warehouse
- Inconsistent PAR location designs created inefficiencies and reduced clinical staff productivity
- Storeroom space needed for patient care improvements and revenue optimization

Outcomes from LUM adoption:

- Redeployment of both clinical and materials staff to more productive activities
- Improved use of hospital space: for example, storeroom converted into training area
- Elimination of off-site warehouse and $1 million in inventory

Less-is-more models can improve hospital efficiency and the additional benefits are numerous.

Consider low-inventory models if:

- **You want more space.** Hospitals or health centers are able to convert unused storerooms into productive space.
- **You need more cash.** Cash that is normally tied up in inventory is dramatically reduced.
- **You want increased staff productivity.** Many routine logistics activities are transferred to the distributor, allowing materials management staff to focus on higher-payoff functions like value analysis.

Model benefits:

- Less clinical staff time devoted to ordering/handling products
- Materials management time freed up for higher-value activities
- Inventory reduction: warehouse, storeroom, unofficial inventory
- Storage space turned into clinical, revenue-producing space
- Reduced corrugated waste and shrink wrap decreases disposal costs and infection risks
- Capital freed up for other priorities
- Cleaner data tied to more automation and fewer vendors

There are variations to less-is-more models and what is required by both a hospital and distributor. Below is a helpful primer to guide your decision-making process as you evaluate options.

Key terms:

Bulk distribution: traditional distribution in case quantities to the healthcare facility's loading dock

Just-in-time (JIT): provider reduces storeroom inventory, distributor increases inventory levels and delivery frequency

Stockless: shifts storeroom, central distribution function from the hospital to the distributor. Supplies are delivered in totes pre-organized by specific care level/department for immediate use.

Low unit-of-measure: deliveries in smaller quantities (typically etches or boxes) rather than cases. Often used interchangeably with JIT or stockless

Logical unit-of-measure or best unit-of-measure: deliveries in optimal quantities based on usage and other considerations

Adoption and implementation require close alignment between the hospital and its distributor:

- Distributor services 100+ more ship-to locations per hospital
- More complete "end-to-end" supply chain
- Many items shift from "direct" channels to distributor

Meeting THE challenge

By Andy Bartling

Nursing homes offer smart solutions for balancing costs with quality.

Today, providers across the continuum are challenged to lower costs while maintaining quality. Small nursing homes are no exception. How are they meeting the challenge, and what practices can they share with providers who serve other segments?

Look at product utilization—not just price.

There's more to the total cost of a product than price. Product utilization—easy to overlook—is a critical factor as well. Yet, product price is far too often the sole consideration in purchase decisions.

"As reimbursements are cut, facilities are shopping more than ever," says A. Brien Cornett, general manager for Turenne PharMedCo, a medical supply subsidiary of nursing home operator Turenne & Associates. "Focusing on price alone can compromise quality, which may ultimately result in higher utilization costs. So understanding the difference between product price and total cost is very important."

Consider a wound care product, for example. How many changes does one product require versus another? The product that needs changing more often may have a lower per-item price, but the total cost will be higher.

Factor in logistics costs. Beyond utilization, freight handling and inventory carrying costs also weigh in to a product's total cost. The key is to look at the entire supply chain—from manufacturer to bedside. Then, work with your distributor to maximize workflow efficiency, which helps lower costs every step of the way. Just-in-time delivery, for example, is one commonly used strategy for improving efficiency.

Set inventory levels to save even more. Are you carrying too much inventory? Not enough? One Midwest nursing home system took a closer look and reduced its supply cost per patient day by more than *20 percent*. This system had unnecessary supplies sitting on the shelves and was stocking wrong sizes. Plus, supplies were disorganized, which made an accurate inventory difficult.

By setting par levels based on product utilization, this nursing home system reduced inventory levels, while minimizing back orders, stockouts, and expired inventory.

Consolidate purchases to save more time.

Use a single distributor to avoid spending time shopping for manufacturers, cutting dozens of purchase orders, and paying dozens of invoices. You'll receive one P.O. and invoice for all of it, so you'll have more staff time to focus elsewhere.

Standardize the right way.

For Neil Medical Group, a long-term care supplier and accredited Medicare billing solutions provider, the best way to standardize products is to think backwards. "We create formularies by reverse engineering," says Zach Sheeran, general manager. "We look at the top 20 expenses, where 80 percent of the spend is. Then we focus on what's not working right.

"When you try an all-at-once formulary, you're changing too many things at the same time," says Sheeran. "So you don't know where the improvements are truly coming from. The better way is to change one variable at a time, measure and improve the outcome, and then move on to the next variable."

Use data for better decisions.

Utilization data is key to making more cost-effective formulary decisions. So what's the best information source for a small nursing home? Tap into the manufacturers themselves, who have a wealth of product data and can tell you how much the average nursing home spends on a certain item. "For example, based on a facility's number of beds, you can find out how much you should be spending on various products," says Sheeran.

Andy Bartling is a contributing writer for Streamlining Healthcare. *Reach him at andy@salesmessagemarketing.com.*

5 Aha! moments on supply chain management

Insights from AHRMM 2012 on maximizing management, financials, and productivity

What's on the minds of healthcare supply chain professionals? Healthcare reform, value analysis, and of course cost reduction, to name a few. At the Association for Healthcare Resource & Materials Management annual conference in San Antonio, supply chain managers shared their challenges and successes.

Here are just a few insights from that event.

Photo Provided by Universal Image

From "Health Care Reform's Impact on Supply Chain Management"

To have good partnerships, be a good partner.
"If you really want to get into a partnership that involves more than just price, think about how hard it is to do business with you. Are we holding an invoice because it's off by 12 cents? How much waste is involved in correcting that?"
Mike Rudomin, Principal, HealthCare Solutions Bureau

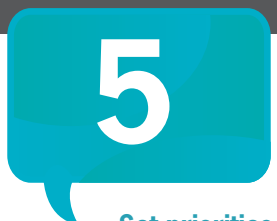
Maximize use of distributors for regularly purchased supplies.
"About 8 percent of our purchase orders still have manual data entry. Most of those are direct-to-manufacturer orders. The manual processes, the adding of incomplete data, and the review and sign-off, means that we spend a disproportionate amount of time on these orders. In the distribution transaction, many of those issues are resolved and result in less time spent on a per-line basis. Increased automation also means greater accuracy. We have 0.5 percent price discrepancy with distribution compared to price discrepancy rates of three to 27 percent with direct manufacturers."
David McCombs, Vice President, Supply Chain, Bon Secours Health System

Embrace sales reps.
"They are really close to your doctors and can help you achieve your goals. Vendors today understand that they have to sell to both economic and clinical buyers."
Eugene Schneller, PhD, Director, Health Sector Supply Chain Research Consortium, W.P. Carey School of Business, Arizona State University

From "Ohio State University Medical Center Productivity Dashboard"

Work to reduce special orders.
"Our percentage of special orders is 13 percent (down from 20 percent). This is a very important metric. We want special orders to be special—the ones that really require human intervention. If we could eliminate all the 'special orders' that actually could be automated, we could devote more purchasing effort to those items that are truly special."
Rosalind Parkinson, Administrative Director, The Ohio State University Medical Center

From "The Economy of Distributors in the Supply Chain"



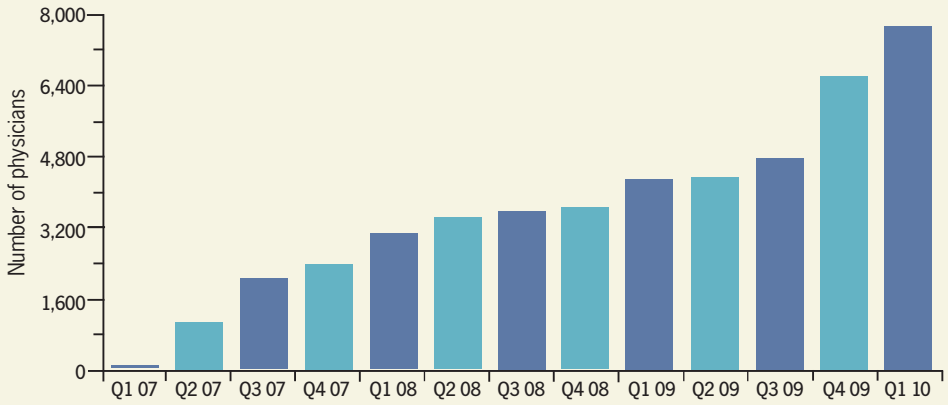
Set priorities and act accordingly.
"Give up some things that don't make a big difference. Don't count 4x4s on the floor if doing so means you are not managing high-dollar items like stents or implants. You may have to give up something in order to go after the bigger gain."
Mike Rudomin

Physician integration continues at rapid pace

PHYSICIAN PRACTICES

According to Irving Levin Associates, physician practices are the fastest increasing segment of healthcare mergers and acquisitions based on year-to-year growth. For example, in the period ranging from the first fiscal quarter of 2007 to the first fiscal quarter of 2010, the total number of physicians engaging in mergers and acquisitions surpassed 7,000. In the state of California, eight physician group mergers occurred between 2007 and 2010, while another 13 physician groups were purchased by another organization.

Number of physicians involved in mergers and acquisitions (cumulative), 2007–2010

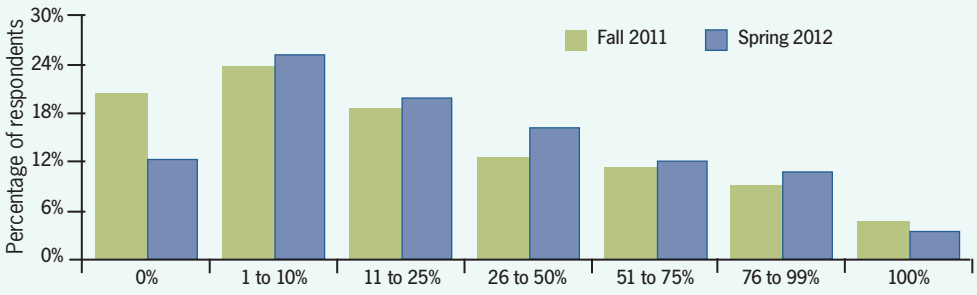


Source: Irving Levin Associates, as reported by PricewaterhouseCoopers' Health Research Institute, "Behind the numbers: Medical cost trends for 2011," 2010 , as shown in Health Industry Distributors Association, 2012 Market Integration Study, September 2012.

U.S. HOSPITALS

Percentage of physicians employed through hospital-owned practices

In response to healthcare reform provisions, U.S. hospitals have increased their hiring of physicians. More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery networks (IDNs), a trend bolstered by the creation of ACOs and an industry-wide shift toward bundled payments.



Source: Premier, Economic outlook: Spring 2012, 2012 , as shown in Health Industry Distributors Association, 2012 Market Integration Study, September 2012.

Physician affiliation with hospitals has been especially pronounced among areas of primary care such as internal medicine, emergency medicine, family practices, and pediatrics.

RANK	TOP HOSPITAL-EMPLOYED SPECIALTIES
1	Internal medicine
2	Emergency medicine
3	Family practice/primary care
4	Pediatrics
5	Anesthesiology
6	Ob/Gyn
7	Surgery
8	Psychiatry
9	Radiology
10	Orthopedics

Source: Billian's HEALTHDATA, The Power of the Physician Market, April 2012 , as shown in Health Industry Distributors Association, 2012 Market Integration Study, September 2012.

Diagnosing the future

Streamlining Healthcare: *In an age of healthcare reform, what is the value of lab testing today?*

Spradling: Today, every provider is seeking new ways to improve patient outcomes. That's why lab testing has never been more important: It's critical for helping physicians make better treatment decisions. In fact, while diagnostics accounts for less than five percent of the total cost of care, it impacts roughly 80 percent of a doctor's decisions.

> "DIAGNOSTICS IS LESS THAN 5 PERCENT OF TOTAL CARE COSTS, YET IMPACTS 80 PERCENT OF DOCTORS' DECISIONS."

Streamlining Healthcare: *How do labs impact total costs of care?*

Spradling: Everyone is talking about cutting costs to help offset declines in reimbursement. And accurate diagnostic testing is a piece of that—test results ensure that physicians quickly diagnose patient conditions and also help them manage chronic illnesses cost effectively. But for provider organizations, cutting expenses is a moot point if you're not also generating revenue. Labs are strong revenue generators. For example, physician offices that retain lab testing on-site should be looking at ways to expand the number and breadth of tests they offer.

Streamlining Healthcare: *Your point about testing in physician offices raises a question: In this time of health system consolidation, what's the future of on-site labs at physician offices?*

Spradling: As you know, there's a migration of physicians to hospitals and IDNs, as they buy practices at a rapid pace to align with new reimbursement models, such as ACOs. In recent years, a lot of our own physician customers and their office labs have been absorbed by hospitals and health systems.

As they consolidate, health systems are looking for new ways to create efficiencies and cost savings. One way is to standardize the products used in their core labs, as well as in the physician labs they acquire. They're asking, "Which tests can I standardize across my entire network?" And that makes sense to me.

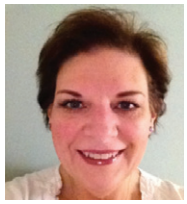
Another strategy is to centralize the lab function itself. I'm not so sure that's a good idea. Generating lab results immediately at the point of care is an important way to improve patient outcomes. An on-site lab helps physicians make decisions faster and is more convenient for patients, as well. And of course, it produces a much-needed source of additional revenue for the practice.

Learn about healthcare changes firsthand from providers including

Eric Mooss
Alegent Health Clinic

Carol Henrichs
Alegent Health Clinic

Terry Niver
Billings Clinic



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