



C-Suite Expectations Misaligned With The Supply Chain Reality

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The traditional reaction of hospital leadership to rising supply-related costs has largely been to ask contracting departments to obtain price reductions from vendors. Contracting staff achieves this through negotiations with vendors, and they have hundreds, if not thousands, of contracts to deal with. Part of this negotiation process often involves Value Analysis committees and feedback from multiple constituents, from physicians to finance, especially when new products are being examined.

This myopic focus on reducing the prices of individual items unfortunately leaves little to no room for appreciating and addressing how supply chain and other operational processes can both mitigate these increasing expenditures and contribute to the overall profitability of the organization. Hospitals would benefit by paying greater attention to what happens *after* an item is purchased – for example, has it been used or has it expired? After all, what good does it do to negotiate a discount for an item which just ends up sitting unused on the shelves for months?

The bottom line is that you can't achieve your cost reduction strategies without addressing operational and inventory management issues as well as contracting. The complexity of these operations today causes plenty of "bleed out" issues financially, such as when items expire on the shelves or aren't billed for, plus there are other implications for patient care, such as when a product is not in stock and thus not available for a procedure. Yet, supply chain management lacks discipline and organizational support, even at the departmental level.

Supply chain related processes, and therefore their impact, are extremely broad-reaching, touching essentially every aspect of the patient care process. They are so ubiquitous in fact, that they aren't even really assessed in their effectiveness financially and operationally; it is just assumed that stuff will show up when and where it's needed, and the "how" of what it takes to make it happen is rarely considered. Clinicians will occasionally call (and complain to) someone in distribution or their inventory manager for something they are missing. As far as C-suite is concerned, that's pretty much the oversight system most hospitals have when it comes to supply chain management. No one examines the magnitude and impact of wasted (expired, obsolete) items, the productivity hits on clinicians due to unavailable, displaced, recalled, or expired items (not to mention patient risk), or the impact of reactive (just in case) purchasing habits, not to mention the failure to ensure the accuracy of supply documentation at the point of care.

One explanation is that as most healthcare providers have invested in Enterprise Resource Planning (ERP) systems, which typically include financials and supply chain modules, they have assumed (understandably so) that all of the key supply chain functionalities, including tracking all purchased and used items and related inventory management tasks, would in fact be covered. Unfortunately, as with most things in healthcare, it's not that simple. The healthcare supply chain, particularly in the

acute care settings, is much more complex. There are, in fact, multiple supply chains at play, each of which is handled differently, both financially and operationally. I would describe supply chain for consumable medical devices and supplies as generally falling into one of the following 4 categories:

Type of Supplies	Description	Method of Handling	Responsible Party
Med/surg	Low cost high volume/high velocity items, used throughout the hospital, e.g., bandages, exam gloves, patient care kits. Typically considered commodities; not clinically differentiated products, but basic necessities for daily patient care.	Typically set up in ERP systems by inventory location (in each relevant hospital area or department), and managed perpetually: each inventory location has a min/max par level and gets replenished accordingly. Replenishment for each inventory location is often done from the main warehouse or distribution center, which is also maintained perpetually, typically in the ERP system.	Supply Chain (logistics & distribution function)
Clinical preference (owned)	Typically higher priced items involved in specific clinical procedures; their purchase and use is often dictated by physicians and/or Value Analysis committees	Orders are placed in the ERP system, but expensed to the individual clinical department upon receipt. Only managed perpetually through a third-party system (if one is installed). These items are financially owned by the purchasing department.	Each relevant clinical department
Clinical preference (consigned)	Typically higher priced items involved in specific clinical procedures; their purchase and use is often dictated by physicians and/or Value Analysis committees	Orders are placed in the ERP system, but expensed to the individual clinical department upon receipt. Only managed perpetually through a third-party system (if one is installed). These items are financially owned by the manufacturer/vendor with which a hospital or department has a consignment agreement. As part of such agreement, consigned items must be replenished to the levels defined in the agreement. Hospital pays only upon replenishment.	Each relevant clinical department
Specialty Items ("Trunk stock" and Loaner Trays)	Typically expensive items used for select medical procedures, brought by the manufacturer's rep for each patient case, as requested by physician/hospital	Not stocked in inventory; billed for each item upon use; requires the financial reconciliation between relevant patient case, invoice submitted by vendor, and a PO issued for the invoice.	Each relevant clinical department, Billers, Finance, Supply Chain (Buyers)

Now multiply these different supply chains by the number of clinical areas and inventory locations, and you'll get a picture of the resulting complexity. To illustrate this complexity and its implications, we looked at the situation from the point of view of a day in the life of a product:



A Day in the Life of a Product A Story of Many Supply Chains and Unreliable Demand Data

	Receipt	Putaway	Dispense	Use	Bill	Order	Pay
System Used	ERP	ERP	ERP	Procedural Documentation	Billing	ERP/MMIS	ERP/MMIS
Type of Supply							
Med-Surg Item Central Supply/Warehouse							
Clinical preference item (owned) Procedural departments (cath, EP, IR, OR, GI)							
Clinical preference item (consigned) Procedural departments (cath, EP, IR, OR, GI)							
Specialty Item (i.e., trunk stock) Procedural departments (cath, EP, IR, OR, GI)	NA	NA	NA			NA	

Error-prone manual data entry, lack of, incomplete or inaccurate data entry

Mostly automated data entry, complete and accurate, electronic format

Perpetual Status available

Perpetual Status NOT available; no data entry or tracking

It's clear that trying to manage this complexity – and more importantly finding ways to gain financial and operational efficiencies given this complexity – cannot be accomplished by simply looking at total supply purchases or by doing periodic inventory valuations. Simply trying to reconcile inventory figures and write off any discrepancies for a financial balance sheet isn't going to help identify the sources of inefficiencies, causes of discrepancies, or insights into ways to reduce the financial impact. Nor is it sufficient to only focus on price negotiations as the primary means of achieving savings.

It is necessary to understand how *all* aspects of supply-related expenses – the second largest source of expenses in hospitals after labor (and by some estimates soon to be the first) function and are handled in order to understand how best to solve the lack of organization and oversight, and to prevent waste and find savings.