Medical-surgical supplies are essential to the delivery of health care. That is why even small hospitals usually have a staff member who is in charge of ordering, buying, stocking, and distributing the thousands of supplies and who knows how to manage vendors and negotiate contracts. Larger hospitals have high-level executives who manage trained professionals running multi-million-dollar supply chain operations.

Few ambulatory surgery centers (ASCs) have such a luxury. Yet they still need supplies, and both business and clinical success depend on being able to procure the right products for the right price. Those materials management duties usually fall to nurses and office managers.

The ASC advantage

Knowing a few basic principles can help them perform those duties more easily and efficiently. Overflowing a room at the Ambulatory Surgery Center (ASC) Association conference in the spring, ASC managers demonstrated their interest in adding best practices in materials management to their range of knowledge.

There to help was Michael Neely, president of the consulting firm Perimeter Solutions Group in Atlanta. Neely, who spent 20 years as a hospital materials manager before becoming a consultant, founded Perimeter 5 years ago.

When it comes to dealing with vendors, he says, “ASCs don’t have the same leverage as hospitals in controlling expenses because of their lower purchasing volume.” At the same time, those owned by physician investors have an advantage, he says, when selecting high-priced devices subject to physician preference. Physicians who have a financial stake in the surgery center are more likely to consider standardizing their choices to save money.

Finding best practices

“Implementing best practices will pay dividends and go a long way toward creating a professionally managed materials department in any ASC,” Neely says.

Best practice, according to Neely, means having a strategy for managing materials and costs. Elements of that strategy include working with vendors, clinicians, and financial managers to establish supply budgets and procurement policies. Too often, Neely says, the focus is on reducing prices paid for products. A better practice is to look at the cost per case for each procedure and establish a process to stay within limits. Measure all cost variables for a case: products, time, and labor.

“Utilize performance measures and metrics,” he says, “because improving performance is dependent upon measuring progress.”

Items to measure may include linen use in pounds per patient, personal
care items provided on admission, and medical supplies used in procedures. He advises tracking:
• the number of expired products on hand at the end of each quarter
• fill rates, which reflect how well vendors comply with purchase orders
• inventory accuracy determined by comparison of products on hand with
  established par levels.

When surgical teams improve budget discipline, he adds, ASC managers should reward them and share news of their achievements with the rest of the staff.

**Value analysis means informed decisions**

Before selecting a new product, most hospital materials managers rely on the value analysis process. At too many ASCs, Neely says, the decision to introduce a new product includes little review of the proposed product, or of products already in use.

“The best practice is to implement value analysis,” he says.

Hospital value analysis can be rigorous. Often a committee shares the work, with representatives from purchasing, clinical departments, and perhaps specialties such as infection control, radiology, or facilities management where such product knowledge is helpful. Ideally, the value analysis committee also includes employees who actually use the products. For the most expensive devices and equipment, a financial manager or reimbursement expert might step in to describe the implications of choosing a particular product.

The process starts with a determination of need. Whether a physician wants to try a new type of instrument or the contract for housekeeping supplies is about to expire, there is an expectation that the organization needs to buy something.

Value analysis is the weighing of alternatives. Which products are clinically appropriate, or effective in the opinion of the user department? Of the acceptable products, which is the least expensive?

Expense is not limited to price. It also includes the expected useful life of the product, maintenance costs, and expenses related to implementation, such as staff training or allocation of additional space. The best choice will be the product that provides the most additional value (such as improved clinical outcomes) at the lowest expense.

**Benefits of standardizing**

A common result of the value analysis process is that the committee will identify the best product but find that the facility already uses a variety of similar items, often because of physician preferences. Convincing the group to standardize brings a host of benefits, such as the lower prices that come with higher purchasing volume; the efficiencies from having fewer product codes to order and inventory; and having a product that is familiar to all users.

According to Neely, the elements of effective value analysis are:
• a formal process
• an interdisciplinary team
• a review of expenditures
• defining the need
• application to all products and services
• elimination of unnecessary costs
Making the deal

The materials manager or the ASC staff member filling that role has the job of negotiating a contract for the selected product. Even if the facility’s group purchasing organization has the vendor and product on contract, the materials manager may be able to obtain a better price by pointing out that the ASC has decided to use the vendor’s product exclusively.

To make the value analysis committee’s decision stick and to maintain negotiating leverage with the vendor, the ASC must have a consistent purchasing policy for the entire organization.

According to Neely, it is common for purchasing decisions to be left up to individual departments. A better practice, he says, is for materials management to be covered under the administrative policies, which apply to all departments.

Among those policies should be the use of purchase orders. Strict guidelines should cover who may order products at various spending levels, how to ensure contract compliance, and how to obtain exemptions in special cases.

Vendors should be part of the system, not adversaries, most materials managers agree. There is a long tradition, however, of vendors seeking to maximize sales and profits by cultivating separate relationships with physicians and using them to override purchasing policies. Materials managers need to be aware of this and be prepared to treat vendor reps fairly but as equals.

For example, many companies have their own standard contracts containing their terms and conditions and expect customers to sign and accept them. There is no reason the ASC should not develop its own terms and conditions, incorporate them in a policy, and present them to the vendor.

“You gain leverage by presenting your terms first and establishing control from the start,” he explains. It helps to use a team approach, with both supply and clinical people at the negotiating table, to make it clear that the entire facility is united in its approach to purchasing.

Managing orders and inventory

How often and how much to order vary by product. For each product, determine the annual usage, the cost of issuing a purchase order, the price of the item, and the annual cost of holding it in inventory. In general, higher cost items should turn over more frequently, while lower cost items can be ordered less frequently in larger quantities. However, products with expiration dates need to be ordered with those life cycles in mind to avoid having to dispose of expired items or, worse, to need an item for a procedure and find it has expired. Rather than comprehensive annual inventories, he recommends shorter cycles and regular reports based on item counts as well as dollar values.

“It’s not about keeping inventory as low as you can,” Neely notes. “It’s about finding the right level, one that optimizes turnover.”

Custom packs are susceptible to becoming obsolete as preferences change. “Routinely review packs for usage, alternatives, and cost,” he says. There may be a standard kit that provides the same items at a lower cost.

At most ASCs, space is limited, and supplies tend to be kept in multiple locations. Try to find a central storage location, Neely advises. That makes
inventory control easier and makes the supplies accessible to all. It also frees space in procedure rooms.

Outdated equipment and supplies that are no longer needed may also be taking up precious space. Consider selling or donating them, he says. “One facility’s junk is someone else’s treasure.”

A well-organized materials management system will save money, often a substantial amount soon after implementation. Volume discounts will increase; case costs will decrease; there will be fewer expensive off-contract orders and emergency orders.

The materials manager should document these results and produce written reports for top management, Neely says. “It’s too easy to forget or undervalue these accomplishments.”

It is especially important to track savings, he adds. Once physicians and owners see the numbers that prove the value of the effort, the credibility of the materials manager will increase.

“Documentation validates the effort, and is a powerful demonstration of ROI,” he notes.

It is also important to check regularly with “customers” who use the supplies. Procedure volumes and types may change, making former par levels inadequate.

“Many unhappy customers don’t complain,” Neely says.

The next step: Automation

During the past several decades, the hospital supply chain industry has developed increasingly sophisticated computer systems designed to track inventory, issue purchase orders, record usage, and receive and pay vendor invoices. Unless an ASC is affiliated with a hospital and can tap into the hospital’s materials management information system (MMIS), it will probably find such complete automation unaffordable.

One company, SourceMedical in Birmingham, Alabama, has developed inventory control software designed to serve the ASC market specifically. About 2,400 ASCs have become its customers, installing components of its Vision software package.

“Most ASCs use inventory control systems for case costing,” says Patrick Doyle, vice president of sales at SourceMedical. But they don’t have materials management systems to track par levels.”

Those who do automate, he says, generally try to adapt systems designed for physician practices. “They get the bills out, but they don’t do anything else,” he notes.

The SourceMedical systems monitor usage with “perpetual inventory” based on preference cards. When the level drops below par, the system automatically generates a purchase order. SourceMedical systems interface with those of all major distributors, Doyle adds.

What they lack and what ASCs do not need, Doyle says, are huge, complex financial and distribution elements. “You don’t need a hospital system because you don’t have a central supply department. You don’t have departmental levels. That doesn’t translate to a surgery center.”

With a price tag of about $30,000, the latest Vision update contains components for scheduling, billing, case costing, and inventory control. It may also be rented for about $1,000 per month.

“If you use all the functions, it becomes part of the workflow,” Doyle says. While it is easier for newly built ASCs to open with the full package
operating, existing centers can expect implementation to take 8 to 12 weeks because of their limited staffing.

“If you had a full-time person it would take a week,” he says. Much of the implementation time is devoted to building libraries and transferring data to the facility’s server.

**Efficiency means savings**

Surgery Center at Pelham in Greer, South Carolina, was one of the first ASCs to install SourceMedical’s Vision products, when it opened in 2004. The software monitors charges during procedures and tracks supply costs at the item level. Pelham is jointly owned by 33 surgeons and Spartanburg (South Carolina) Regional Hospital.

According to administrator Bill Hazen, RN, one of the most useful features is the case cost report that each physician receives, allowing them to compare notes on supply use. “It helps us to educate physicians,” he says. Hazen also finds the cost reports useful in dealing with suppliers. By showing them the ASC’s profit margin for a given procedure, he can convince them to keep prices in line. Even employees, who participate in profit sharing, have become aware of costs and supply prices. “It’s teaching employees,” Hazen says. “My surgery techs know what every product costs.”

At Specialty Surgical Center (SSC) in Sparta, New Jersey, patient satisfaction has increased to 97% since adoption of Vision in 2009. Returns of patient surveys and online registration increased to 85% from 20%, according to administrator Bonnie Brady, RN.

SSC also uses the supply chain component of Vision.

“I spend 95% of my day working with the Vision Resource Management system,” says materials manager Lisa Martin. “It is a very efficient system for managing the inventory of a small ASC that is not a small inventory at all.”

The system initiates purchase orders, and when products are delivered, it automatically updates inventory records.

Martin says the system is especially useful for documenting implant use. It is used to maintain an implant log, listing manufacturer, lot number, and expiration date of each item used. In case of a recall, the log would be used to show whether the recall would affect any listed products and to identify the affected patients.

Martin also uses the system to produce an accurate daily inventory report, for the entire center or for specific areas, a function she says is invaluable in inventory management.

“Vision has the capability of producing count sheets for each shelf of each room,” she notes, “so the staff needs only to count items and enter data to have a same-day evaluation of the value of the resources on hand.”

—Paula DeJohn