Keeping ORs’ freight costs in bounds

With no margin for error in the operating room supply chain, the cost of obtaining the right products in the right quantities can easily get out of hand. While product prices can be somewhat regulated by contract, in an emergency, there is little point in quibbling over freight charges for delivery of critical care supplies.

If you need it, you need it.

Yet there are ways to keep emergency orders—or “hot shots,” as one hospital calls them—to a minimum.

As in many other management practices, planning is the key.

According to Irving, Texas-based group purchasing organization Novation, supply costs represent about 30% of health care expenses nationwide, and of that, 38% is for distribution and delivery. That means 11% of the nation’s health care costs are for supply chain logistics.

For an individual hospital, one way to control those costs is to avoid running out of a product, an event that often triggers an emergency order. Based on Novation estimates, the average freight charge by a third-party distributor such as FedEx is $40 per purchase order. In an emergency, the charge for same-day delivery can jump to $250, or more than the price of many products.

In addition, ordering direct from the manufacturer, a common occurrence for complex clinical items, costs more even not accounting for freight. The average cost of sending a PO through a distributor is about $12, including clerical labor and administrative functions. To place the same PO directly with the manufacturer costs an average of $60, again not including freight.

How to avoid running out

According to Ken Boggs, vice president of supply chain at Moses Cone Health System, a 5-hospital integrated delivery network in Greensboro, North Carolina, the trick is to monitor utilization to identify potential shortages.

“We try and limit how much we order overnight,” Boggs says. “The OR manager looks at a list monthly to make sure nothing has snuck through on us.”

Boggs recognizes that nurses are invested in having a reliable supply chain and want to stay involved.

“In general, OR nurses want to keep some of the responsibility to order supplies, because they know the products. In the Moses Cone ORs, the staff requests supplies from purchasing, so technically they are not ordering them.”

He says his department has good relations with OR departments. “My advice is to plan ahead,” he tells them, “so you don’t get so far down on stock.”

Diane Strack, vice president and nurse executive at West Allis (Wisconsin) Memorial Hospital, worked with her system’s centralized materials management department to overhaul par carts, eliminating the need for last-minute orders. For OR nurses, she explains, “the biggest concern is having the supplies available when they need them. The biggest fear is, in a case, being asked for specialized equipment, and it’s not available.”

Before the par cart overhaul last year, she recalls, overnight FedEx orders happened frequently “because someone thought someone else had ordered it.” Now, she adds, “there’s no overnight at all.”
Every 6 months the staff review par levels, noticing any changes in supplies physicians have been ordering, or if they have had to order additional items. They then reset par levels.

Travis Johnson, senior director of medical-surgical distribution at Novation, has seen similar situations. At one hospital, he recalls, “they had 3 years’ supply of one type of suture on hand. Maybe they just naturally kept ordering a supply and didn’t look at utilization, at how many turns.”

His advice to OR managers is to open up a good communication channel with the materials management department.

“I’ve seen where that relationship can be strained at times,” he notes. “The materials staff is really there to help you. That’s where the procurement expertise lies. You need to take a look at the appropriate reports and stocking levels.”

**A strategic approach to logistics**

The health care supply chain is complex. The typical hospital buys from about 440 different manufacturers, each with its own payment system and account numbers. Contracts, both group and local, have helped push prices down, so further savings must come from finding economies in logistics.

But distributor markups are also reaching the point of inflexibility. Fuel costs have risen more than 100% in the past several years, while contracts naming preferred distributors have bargained fees down to an average 5%.

The 3 major US med-surg distributors are Cardinal Health in Dublin, Ohio; Owens & Minor in Richmond, Virginia; and McKesson Corporation in San Francisco. Together, they represent about 75% of the $80 billion med-surg distribution market. A fourth company, Medline Industries in Mundelein, Illinois, is rapidly increasing its share of that market.

Unlike third-party shippers, health care distributors take ownership of the products they sell, and resell them to hospitals at cost plus their fee. However, as the prices of products such as gloves, gowns, and other commodity-type products are bargained down, the dollar value of the fee decreases also.

Distributors often try to avoid this revenue squeeze by promoting their own private label products, on which their profit margins are higher. Manufacturers respond by offering better deals to hospitals, sometimes even offering to sell to them directly.

Hospitals may choose to avoid the distributor fee by buying directly, but then they must bear the added costs of maintaining the inventory.

According to Johnson at Novation, hospitals need to look beyond distribution costs and improve the overall logistics pattern.

“One of the things we’re seeing is that hospitals spend so much through distributors they tend to look at just lowering the distribution price. We’re seeing a need to take a more strategic look at the supply chain all the way to the patient.”

That, he says, is where OR managers and other nursing staff can partner with materials management to keep the focus on getting the right supplies to patients. Johnson stresses “managing the most appropriate staff” for supply functions, which means giving more responsibility to materials managers and letting nurses get back to the bedside.

He has seen one Novation hospital that expects to save $40,000 annually in each of its critical care units “by getting the right people to get products to the patient.”

While OR managers rarely make hospitalwide logistic decisions, they should encourage, and participate in, long-range planning to improve the efficiency of the supply chain. Novation offers members a 4-part checklist for materials management departments considering distribution strategy:

- Analyze the existing warehouse and central storage space, noting current problems or inefficiencies and projecting future needs.
- Survey receiving dock space and consider how needs may change in the future.
- Assess the availability of staff and resources in each facility and determine how needs would change in a different logistics system.
- Map the physical arrangement of each hospital in the organization.
Bargain for savings

Ideally, distributors should deliver most commodity supplies. Physician preference items may follow a different route, because vendors often agree to deliver them directly to physicians. Under many contracts, vendors agree to absorb the costs of delivery of preference items. Clinicians can help streamline the process by working with materials management.

While it is not always possible to avoid last-minute purchase orders, hospitals can try to negotiate lower rates. At Moses Cone, Agoura Hills, California-based consultant and freight broker FDSI Logistics helped the hospital obtain a discount of about 18% from FedEx, UPS, and other delivery services.

On its web site, FDSI claims it is able to save hospitals between 15% and 25% through its Healthcare Inbound Program.

How to avoid freight costs is the “million-dollar question,” according to Johnson. “I don’t think you can ever get to a point where it’s perfect.”

But the more planning a hospital or department does, the closer it will approach the day when emergency orders will be a thing of the past and nurses will be able to concentrate more on patients than products.

—Paula DeJohn

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