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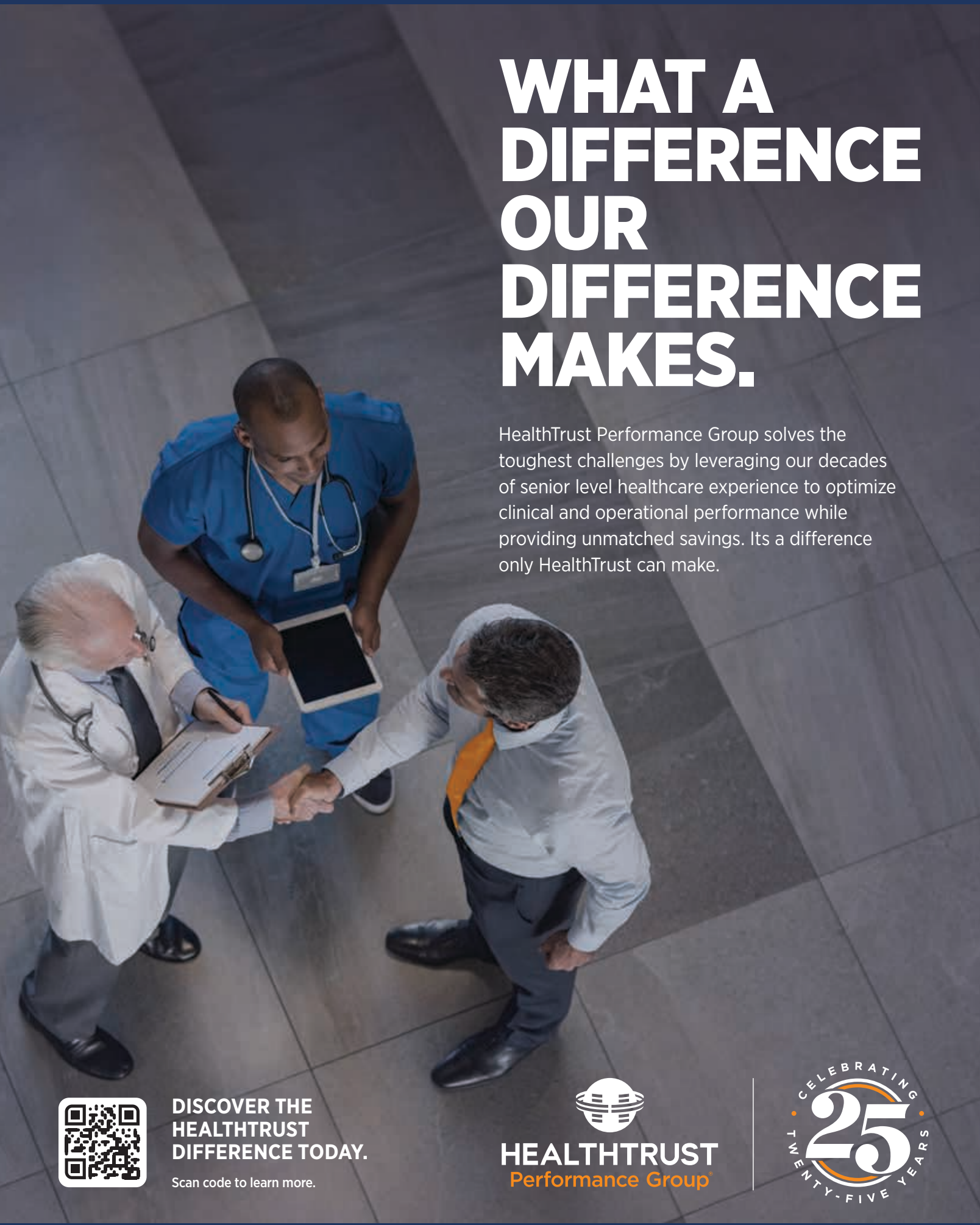
People to Watch
IN HEALTHCARE CONTRACTING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Suwanee, GA 30024 -6914
Phone: 770/263-5262
FAX: 770/236-8023
e-mail: info@jhconline.com
www.jhconline.com

Editorial Staff
Editor
Graham Garrison
ggarrison@sharemovingmedia.com

Art Director
Brent Cashman
bcashman@sharemovingmedia.com

Publisher
John Pritchard
jpritchard@sharemovingmedia.com

Circulation
Laura Gantert
lgantert@sharemovingmedia.com

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Adapting or Falling Behind: The New Mandate for Healthcare Supply Chains

John Pritchard

For today's IDN Supply Chain Leaders, it never gets easier, does it? Hospitals and health systems have so many things to worry about, including:

- Financial pressures
- Labor issues (shortages and escalating costs) ... not to mention burn out.
- Patient volume and retention uncertainty
- Regulatory/Policy uncertainty
- Technology and cybersecurity challenges

And now, Trump's "One Big Beautiful Bill" has layered on more stress with IDNs trying to figure out how to handle things like Medicaid cuts, rural hospital funding and increased uncompensated patient volume, plus the sense that more cuts are coming.

How does a Supply Chain Leader thrive in such turbulent times? I ask every Leader I talk to: "What are your top 3 or 4 initiatives in the next 3-5 years?" I get a lot of the same answers such as digitizing my supply chain, clinically integrating my supply chain, implementing procure to pay and many seem to have or are building a distribution center.

If we roll the clock forward to 2030 when I ask this same question, I think we will hear about artificial intelligence, machine learning, robots and drones being ubiquitous with Healthcare Supply Chains.

I am hearing murmurs trebling into low roars about talent development and the need for more formal supply chain education. The industry is ripe for a proven curriculum that is engaging, thorough and contemporary. I greatly worry anyone training in yesteryears' manner is starting way behind our current day best practices and understanding of today's challenges.

The role of the IDN Supply Chain Leader is evolving faster than ever – no longer just about cost and logistics, but about strategy, adaptability, and innovation. As the external pressures mount and the landscape shifts, those who will lead successfully into 2030 are already investing in technology, talent, and transformation. It's a tough road – but for those who embrace the change, it's also a moment of unprecedented opportunity to shape the future of healthcare.

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CSC Turns: The Highs, Lows, Sighs and Woes

There's a time to plant, a time to reap, so your efforts aren't just for the birds.

BY R. DANA BARLOW

For provider-based healthcare supply chain, operating a consolidated service center (CSC) or distribution hub can mean big business – on both sides of the balance sheet.

Experts acknowledge that it's not for the ill-prepared, unprepared or even faint of heart.

For those serious about launching and operating a CSC with ongoing, long-term success in mind, the future likely is bright; for those who see it as a quick fix and short-term solution to deeply ingrained attitudes and problems, the future likely is dim and grim.

As if supply chain leaders have little else to do in their "spare" time, developing and launching a CSC and then operating it on a daily basis can be daunting, demanding and distressing. So why do it?

Taking the CSC plunge

The primary reason a hospital or integrated delivery network (IDN) supply chain team sets up a CSC varies by organization, spanning clinical, fiscal and operational performance – not necessarily in that order.

"Traditionally, IDNs implemented the CSC concept to consolidate and centralize support departments, and to improve their ability to make product and logistics decisions independent of third-party resources," said Paul Oppat, Executive Director, Supply Chain Services, Banner Health, Phoenix, Arizona. "The overall goal was to improve efficiency and reduce expense."

Oppat shares that the bulk of Banner's CSC focus supports acute care facilities within the IDN. In addition to medical/surgical product distribution services, CSC-based Banner Pharmacy Services supports thousands of customers through pharmaceutical home delivery and Banner Family Pharmacy locations. The CSC's non-pharma distribution volume exceeds $200 million annually, according to Oppat.

AdventHealth embraces a similar philosophy with its CSC operation.

"The primary reason that AdventHealth set up a CSC was to build a more resilient healthcare supply chain that can better serve our communities and patients," noted Marisa Farabaugh, Senior Vice President, Chief Supply Chain Officer and Co-Head Environmental Sustainability, AdventHealth, Altamonte Springs, Florida. "CSCs also offer an ability to optimize inventory management and demand predictability, which can create efficiencies and financial value."

Michael McCullough

AdventHealth's CSC serves about 30 acute care facilities across Florida, according to Farabaugh, and she fully expects "that will continue to evolve over time." She declined to share annual purchasing volume.

Although the provider-managed CSC concept emerged during the healthcare reform years of the mid-to-late 1990s, growth simmered for decades until the global COVID-19 pandemic stirred the pot to a boil.

Michael McCullough, Senior Vice President, Supply Chain, Wellstar Health System, Marietta, Georgia, points to a desire to control your own destiny, operationally and financially, exacerbated by the pandemic. He lists three reasons that resonate.

"The top reason would be to gain more control over their supply chains," McCullough insisted. "This has accelerated post-COVID as so many health systems found themselves at the mercy of their third-party distributor. Another great reason is to collect the distribution fees that are collected by the third-party distributor when not self-distributing. This income stream can be significant and helps offset the cost of self-distribution. A third reason would be to control the supply chain regarding standardization and contract compliance. By owning the channel, it's nearly impossible for 'non-formulary' supplies to find their way into the supply chain and negatively impact standardization and contract compliance."

Roughly $200 million in annual purchasing volume flows through Wellstar's CSC that services 10 acute care facilities and approximately 400 ambulatory customers/sites, with supplies, mail and some pharmacy, according to McCullough.

Ryan Rotar, Executive Director, Supply Chain, UNC Health, Chapel Hill, North Carolina, echoes the motivations of other CSC operators and shares a bit of his own history. He also sees CSC development as something of a pendulum that swings between control and partnership.

"There has been a demonstrable shift in the 'why' organizations chose to deploy a CSC model," Rotar indicated. "The original use case revolved around a health system being its own distributor,

contracting for themselves and receiving consistent revenue being a self-distributed health system. In this model the goal was to disintermediate themselves from retail distributors and GPOs and take on the work those organizations would have done for you. The newer model I'm seeing is more simplistic and requires more partnership and less separation from your GPO and distribution partners. This model is more about offsite logistics, consolidating product flow to a single location and partnering with your current distributor and GPO to add value in a customer-owned offsite warehouse rather than generating revenue."

UNC Health's CSC funnels about $74 million in annual purchasing volume

Flights of fancy: CSCs need not be air castles

Consolidated service centers (CSCs) or distribution centers (DCs) can come with a bit of baggage – unrealized gains, unexpected losses and unrealistic expectations.

Certainly, the first two beget the third one or perhaps more accurately, the first two just may be the offspring of the third one. So what are some of the unrealistic expectations that healthcare provider organizations have about the promise and payout of the CSC model?

"In literal terms of 'payout' I see supply chain leaders believe that they'll somehow begin to receive financial benefit from manufacturers just for having a CSC. While false, there just aren't many healthcare CSC experts out there that can educate, plan, execute and evangelize the CSC model to get their health system maximum financial benefit. I also too often see providers underestimate the level of complexity to operate the day to day, let alone be proficient enough to generate revenue. Remember while offsite warehouses may be more and more prevalent post-pandemic, those that operate a truly successful CSC model are in short supply. I attribute this and the underestimation of the level of work, and the fact that this work is often difficult and challenges provider organizations to move into strategies that are typically the main competency of a health system. Being realistic about the benefits of a CSC is key, especially if this is your first foray into the space."

Ryan Rotar, Executive Director, Supply Chain, UNC Health, Chapel Hill, NC

"There also is a misnomer that having a CSC is for a financial windfall, whereas I would advise it is instead thought of as a minor savings or financially neutral and that value comes from control, risk mitigation, driving standardization, non-traditional item distribution etc. We do distribution ourselves but not for a mega cost savings. We mitigate risk, recovery time, redeploy inventory and overall use the CSC as a tool to drive standardization. I think sometimes people naively think building a CSC will save millions of dollars. It is a long game. Expect to break even at least until you get to the point you can optimize operations."

Allison Corry, Chief Supply Chain Officer, Intermountain Health, Midvale, UT

"It's important to understand that this is a different operating model than a traditional healthcare organization but still requires IT, HR and Finance partner engagement and contribution. A continued time and resource investment from an active, cross-functional governance group ensures that CSCs meet hospital needs, while evolving over time. If the organization is aligned and dedicated, a CSC can be a remarkable asset for a health system with sophisticated operations and technology that evolves over time. At a macro level, this has the potential to move the healthcare supply chain industry forward."

Marisa Farabaugh, Senior Vice President, Chief Supply Chain Officer and Co-Head Environmental Sustainability, AdventHealth, Altamonte Springs, FL

"The CSC model brings long-term gain and value; the results will take time."

Paul Oppat, Executive Director, Supply Chain Services, Banner Health, Phoenix, AZ

"You will make money self-distributing general med/surg supplies. This is hard to do and pursuing the model based on this alone will lead to failure. The value comes in a combination of points and propositions, such as significantly improved supply continuity, controlling the cost structure, harmonizing, and synchronizing the supply chain (vendor to CSC, CSC to care site), securing fees to offset costs."

Michael McCullough, Senior Vice President, Supply Chain, Wellstar Health System, Marietta, GA

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At press time in May, Rotar left UNC Health for Tecsys to serve as vice president, healthcare strategy.

Some CSC operations extend well beyond inventory and internal distribution to include other services that directly support Sterile Processing and Distribution (SPD) and Surgical Services for the Operating Room. Midvale, Utah-based Intermountain Health represents one of the leading examples.

Intermountain Health's Allison Corry, Chief Supply Chain Officer, points to risk mitigation and control as the key motivators for its CSC.

"If you have the organizational size and sophistication to have the internal resources and volumes to be competitive in the CSC space, mitigating risk is the biggest advantage of having the facility," Corry explained. "We store/distribute many 'nontraditional' distributed items (e.g., contrast, lot/serial-tracked items, high-cost PPI items) as it allows us control and visibility of the inventory assets centrally. We were successful during COVID and the IV shortage as we had already identified those items as high-risk/fragile supply chains and critical to care delivery and had stocked up, which meant we controlled our own inventory vs. competing for shared inventory through distribution partners. We also do our own kitting and bundling to make our front-line field operations more efficient and leverage a control tower team to manage all inventory assets across the enterprise. Having our own CSC also allows us to make product decisions separately from distribution decisions and allows us to better drive standardization for our facilities through the warehouse."

Corry expresses caution about extending services beyond the Intermountain Health brand as a potential influence expansion and revenue generator, which some have embraced. But she hints that it may be on the horizon.

"We do not distribute for other health systems given the way we contract," Corry noted. "We are not authorized as a re-seller, which allows us to negotiate differently with some suppliers. To be a distributor officially we would then start competing with Medline, etc. We are not a revenue generator for distribution services. We do provide services for Intermountain-managed or affiliated hospitals (like one of them). [But] this is something we are entertaining. Our other services, and distribution, are set for scale and efficiency, so we have steered away from trying to pull in new affiliates until we're on a single EHR and ERP so we can scale the operation-required systems and tools."

Intermountain Health's CSC services 26 Intermountain Health hospitals and approximately 350 clinics located in four states, according to Gordon Slade, Senior Director, Distribution Services. "Plans are underway to add additional regional CSCs to service all of our 34 hospitals and 400+ clinics located in 6 states. In 2024, our supply chain center CSC shipped more than 4.5 million medical/surgical supply items to our hospitals and clinics.

Legitimate motivations for CSCs

Stowed among the myriad reasons for launching and operating a CSC – both selfish and selfless – are gilded nuggets valuable enough to ponder the possibilities.

"We believe the No. 1 issue at stake is our ability to consistently deliver high-quality healthcare to the patients we serve," indicated Wellstar's McCullough. "Without our CSC, the recent mega-disruptions on IV solutions, contract media, infant nutritionals and others, would have left us at risk for having critical medical supplies available to our clinicians. In addition, our ability to deliver low unit of measure to all of our 400+ sites helps reduce supply waste at the point of care and streamlines our supply chain operations."

While that may be an – if not the – overarching motivation, other components that buttress and fortify that philosophy abound.

Banner Health's Oppat identifies five notable reasons worth considering that include increasing resilience in the supply chain, creating a greater level of independence in supply chain management, reducing expenses through economies of scale and implementation of best practices, centralizing controls and practice for support services and reducing the use of expensive hospital space for support services and warehousing so that real estate can be used more directly for patient care.

Still, UNC Health's Rotar observes that post-pandemic reactions fostered the newest trend of embracing a CSC "to simply insulate your supply chain from supply disruptions through bulk purchasing at an offsite storage facility.

"While basic and likely non-revenue-generating, this model is meeting the needs of many today and is enough motivation to start a CSC journey," Rotar continued. "Frankly speaking, oftentimes the largest hurdle for many is securing a facility at all, so if you're able to justify

a building for this purpose alone you're already ahead of the curve. A more advanced motivation for establishing a CSC is the desire for a provider to have more control over their supply chain and be less dependent on current distributor partners. This more sophisticated approach has significantly more value to a provider as it is likely aimed at self-contracting and self-distribution, which likely would generate revenue as well as reduce costs through less use of both GPO and distributor partners."

Intermountain Health's Corry emphasizes keeping the big picture in mind while recognizing the amount of effort required. She cites "your organization is interested in and willing to manage your inventory holistically and centrally," as a legitimate motivator. "This can be great but requires ongoing work and effort and deliberate effort," she countered. "It can be easier to just entrust someone else to do this at scale for your organization. Geography and volumes change the viability of a CSC being a fit for your organization."

Healthcare providers interested in setting up and operating a CSC should be mindful of several factors and ask themselves six questions, according to AdventHealth's Farabaugh.

"To ensure an offsite CSC can generate value to an organization, there should be a minimum amount of distribution spend that runs through the facility," she recommended. "There are many overhead costs associated with CSC operations that need to get spread across a large amount of spend."

Farabaugh encourages CSC-minded health system leaders to ask themselves the following fundamental questions:

- Is this a core competency that the health system wants to assume, or does it make sense to stay with a distributor that specializes in this space?
- Can a health system hire the right talent to lead this unique operation?
- Is the organization willing to set up different HR practices and incentives for CSC personnel?
- What is the emergency backup plan in case something happens to the new CSC?
- What partners should be considered across operations, i.e., picking, put away, transportation, systems, etc.
- Does the health system want to own the inventory?

Challenges abound

One of the reasons healthcare supply chain leaders should carefully consider the prospect and potential of CSC operations involves the myriad challenges they may face – both initially and ongoing.

"It's important to do the work to determine the right implementation and operating model," Farabaugh advised. "AdventHealth partnered with a trusted third party to benchmark the national landscape. Those insights informed potential models and proformas with different variations of ownership, implementation, management, etc. This allowed us to make an informed decision on our best path forward."

Follow the money even as you pursue it, according to Oppat, and keep an eye on space allocation and any clamoring for it.

"The initial investment can be significant when designing and implementing a CSC," he indicated. "Competing for investment dollars can be a challenge as other requests may have a better and quicker return on investment. ROI is just one of many justifications for the implementation of a CSC, and that story must be well-communicated.

"Space allocation within a CSC can become competitive between service groups," Oppat continued. "With that in mind, the priorities and scope of the CSC should be clearly defined prior to implementing the concept."

As one of the veteran CSC operators, Corry knows the breadth and depth of possible complications to ROI.

"The short answer here is that you must have the volumes needed and be able to appropriately resource for the tools and talent you need," she noted. "There also is a misnomer that having a CSC is for a financial windfall, whereas I would advise it is instead thought of as a minor savings or financially neutral and that value comes from control, risk mitigation, driving standardization, non-traditional item distribution, etc. Organizations need to overcome the perspective that this offers an immediate return on investment. This is a long infrastructure game to enable other supply chain optimization, not a windfall in and of itself in the immediate."

Another veteran CSC operator, McCullough acknowledges that starting and operating one remains a "very complex undertaking.

"Having launched, led, or been involved with four of these projects, I can say that if you have seen one CSC, you have seen one CSC," he observed. "The four I have been involved in all started with med/surg distribution and grew into other service offerings from there. The challenges are many and perhaps too many to easily list out. In general, make sure that you have prepared for the collection of distribution fees. This is a significant body

of work, but essential to offsetting the cost of the operation. Other key areas requiring attention would be setting up the proper technology for maximizing throughput within the facility, securing a quality warehouse management system and other related information systems, and securing proper staffing and the critical training associated with the staffing the operation."

McCullough further recommends strongly that an organization recruit one or more professionals who have successfully completed the launch of a few CSCs in their past because such resources will be invaluable in successfully launching and operating a CSC.

For Rotar, embarking on a CSC trajectory calls for crafting the right narrative.

"The challenge I see most providers encountering is simply the ability to articulate the financial and operational benefits to those who ultimately have decision-making authority," he said. "The pandemic taught us that having a CSC provided some level of insulation from product shortages but didn't teach anyone how to operationalize a CSC other than 'if you buy and keep more stuff' you'll be better off in times of shortage. For these organizations who are serious about starting their own CSC, they should reach out to peers who have already embarked on the CSC journey to understand the WHY and HOW they gleaned internal stakeholder buy-in before finalizing their own business plan. Seeking to understand what a high-functioning CSC model can deliver typically improves the ability to articulate its value proposition."

Sidestepping the ottoman

Just like Dick Van Dyke alternately sidestepped or tripped over the ottoman in the opening theme song of his eponymous television sitcom in the early-to-mid 1960s, healthcare supply chain executives and leaders can find varying reasons to avert calls for and avoid the complications of managing a CSC.

In short, there's nothing light-hearted or quick-witted about CSC operations so working with a third party, be it a distributor or some other service company may not be short-sighted.

"If providers are looking for a quick win, a CSC certainly isn't it, but I do still see organizations looking for quick wins in this space," Rotar said. "Outside of looking for a fast fix I often see organizations that don't fully understand the economics and general requirements of operating a CSC. Far too often I hear of a provider engaged in a project only to realize what they had previously based their model on was flawed. This is where partnering with a distributor can be helpful. While partnering with a distributor may seem at odds to some, I think it makes sense to partner with an organization that already does this work well and is willing to make investments in areas where health systems sometimes struggle, such as facilities/storage, operations management, automation and technology specific to CSC operations. If an organization doesn't have deep expertise in this space and it's amenable to partnering, a distributor partner is a great approach to solve an otherwise complex problem of CSC operation."

Corry recommends healthcare provider executives be realistic and set their sights on what they can handle.

"If there's not enough volume or better synergy from partnering with other systems leveraging a distributor, be clever enough to acknowledge that. If your organization isn't savvy enough to understand the behind-the-scenes distribution company self-manufactured items and how they subsidize distribution fees, acknowledge a CSC isn't likely for you. On paper, the exercise will look like a cost increase and that logistics costs, unsubsidized by private label margin, are far more costly than people think. Distribution expenses typically range between 6% to 8% of total revenue for consumer-packaged goods companies so recognizing that logistics and distribution services fees are baked in somewhere.

For Oppat, short-term losses may be offset by long-term gains, and providers should not see partnerships as a cop-out to independence.

"The 'value statement' of the CSC needs to go beyond the typical indicators of a good financial ROI. In the short term, the CSC may increase cost, but the value derived will be realized in the long term," he noted. "Partnering with a third-party distributor or service provider can be an accelerator and can reduce risk, especially if resources are limited. Many IDNs have partnerships like this."

McCullough, however, favors as much independence as a provider can generate through its CSC.

"Our preference would be to operate our facilities independently," he asserted. "When partnering with a third-party distributor you are not independent of their control. We have seen others go this route and not experience the cost savings that may be promised and continue to see product disruptions in the supply chain, frequently solved by the distributors' private label solutions. Today's third-party distributors are also product manufacturers, who use distribution as a means to an end." ■

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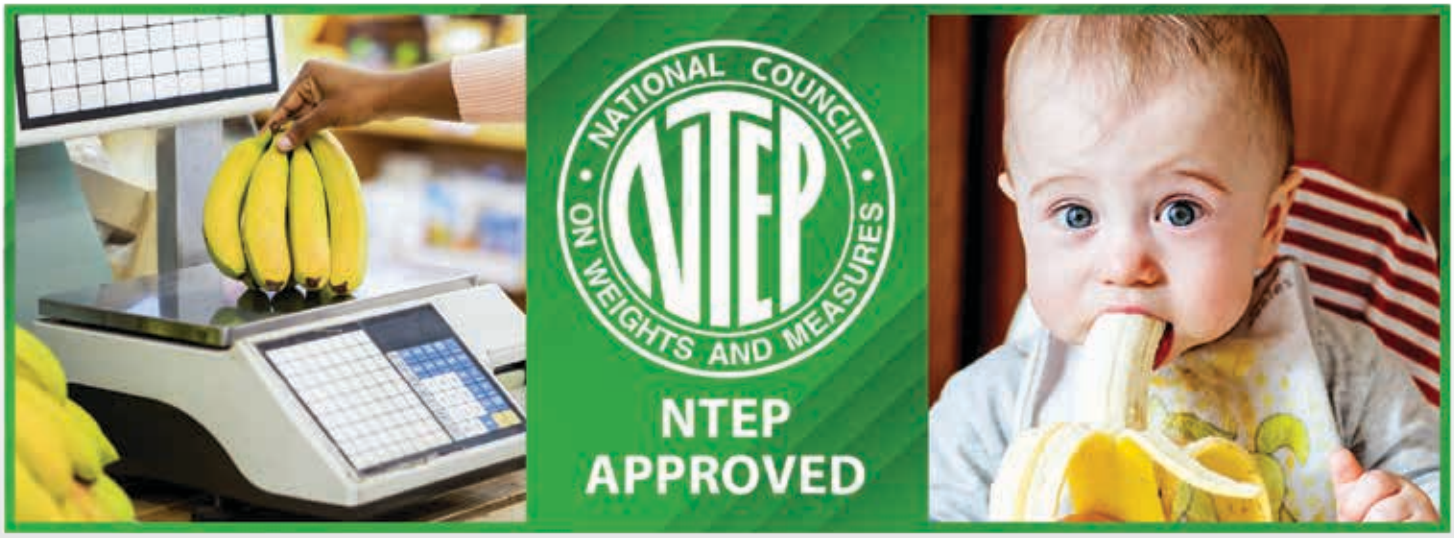

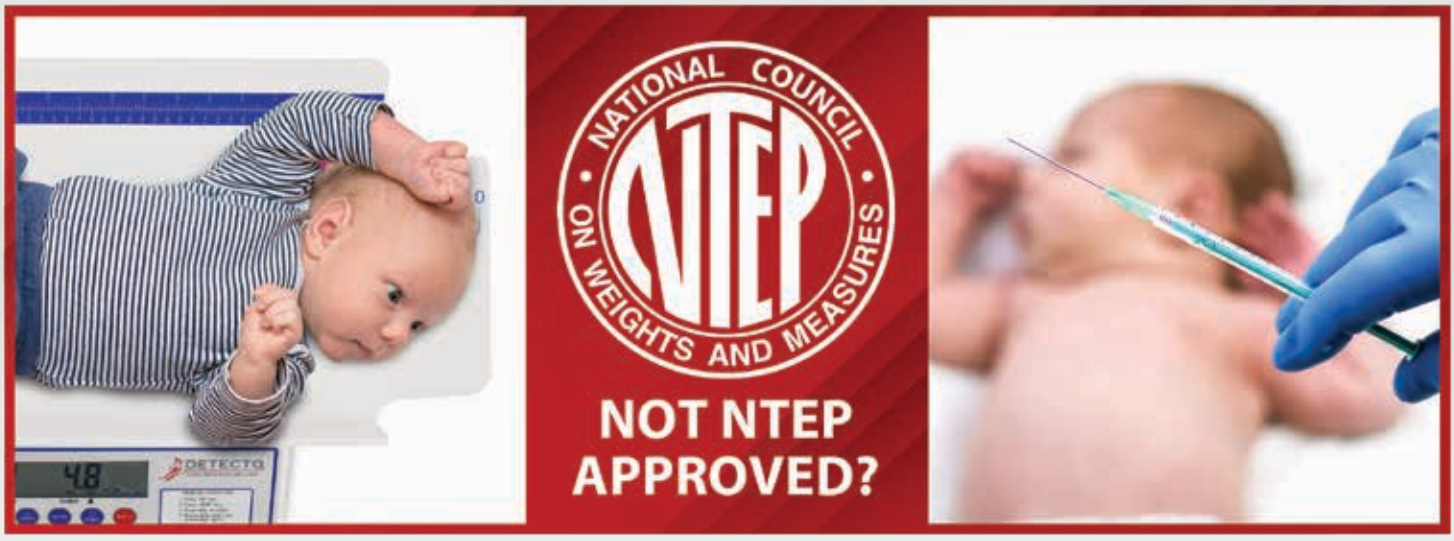

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Proverbial pain points in CSC operations

Healthcare provider supply chain executives and leaders certainly deal with their share of pain on a daily basis, ranging from shortages to stockouts and customer demands related to them as well as changing attitudes toward products and services, particularly when new tools and toys are espied at conferences and trade shows.

Establishing a need for, developing, launching and operating a consolidated service center (CSC) to streamline processes, serve customers directly and patients indirectly, offer up another set of pain points that shift back-office operations to the forefront of visibility.

"I think while most health systems can see the financial and clinical benefits of the CSC model, they have to compete internally for funding to do this project justice," noted Ryan Rotar, Executive Director, Supply Chain, UNC Health, Chapel Hill, NC. "I usually see this manifest itself in a provider securing an offsite facility and a nominal budget for new storage but not enough investment to fully equip the facility to be best in class. It's these kinds of models that are at the most risk of having to sunset. If a provider is able to secure sufficient funding, I also often see these organizations fail to understand that in this model you're moving outside the normal bounds of healthcare supply chain. You'll need new expertise that likely comes from industrial distribution – not healthcare – and that at the end of the day your CSC will more closely resemble a third-party logistics provider or Amazon fulfillment center rather than a hospital storeroom.

"The way to overcome this is to have a strong change agent and the organization desire to change the way the traditional supply chain operates in lieu of a more sophisticated model," Rotar continued. "If the understanding of the model is there as well as the willingness to change, securing funding will be significantly easier than the alternative of opening a CSC and changing little about your current supply chain operation."

Marisa Farabaugh, Senior Vice President, Chief Supply Chain Officer and Co-Head Environmental Sustainability, AdventHealth, Altamonte Springs, FL, calls the prospect "exciting and opportunistic work, but does require the right diligence in key areas to manage or avoid challenges." Farabaugh lists five to note:

- "**Communicating to ensure internal alignment** – make sure consistent updates are delivered through appropriate content and channels; allow two-way engagement to answer key questions.
- "**Working closely with design and construction teams** – gather updates and ideas from teams conducting this work; marry ideas with the long-term vision for growth/expansion; leverage external partners with experience in design, layout and construction to supplement ideation.
- "**Determining the proforma and financial value** – work closely with financial leaders and external partners to ensure accurate representation of costs and savings; work closely with internal financial teams to understand allocation of costs and savings methodology.
- "**Prioritizing a ZERO facility and patients disruption plan over a quicker 'go live' date** – AdventHealth opened one facility at a time, one week at a time over roughly eight months, but avoided any patient or facility disruptions or issues.
- "**Enabling/empowering a strong warehouse management team and system** – test, test, test and set up clear training and implementation plans prior to 'go-live.'"

The Journal of Healthcare Contracting asked a quartet of healthcare provider supply chain executives and leaders who operate CSCs to share their insights on the pain points CSCs create – clinically, financially and operationally. Here's what they shared.

Clinical pain points

"The CSC model works best when it's clinically integrated and has significant clinical input as to what kinds of products and services the CSC provides. The hardest part in establishing a CSC is often forging a relationship with clinical leadership, especially where one may not exist. After forming a relationship though, the two teams need to work collaboratively to decide what products to provide. However, that also includes removing items from formulary so difficult conversations are needed. The creation of a CSC formulary, while seemingly basic, doesn't tend to be easy or fast to achieve and cannot be done without heavy clinical involvement and contract/sourcing rationalization of some variety."
Ryan Rotar, Executive Director, Supply Chain, UNC Health, Chapel Hill, NC

"You can drive simplification of work especially in clinical areas if you're willing to explore kitting and bundling to reduce in-facility clinical work needed."
Allison Corry, Chief Supply Chain Officer, Intermountain Health, Midvale, UT

"Support services departments compete with clinical services for budgetary allocation. Clinical services are core to the mission of IDNs, so they take priority in planning and strategy. We all know that clinical services require solid support in the background, and that is where the CSC concept can make a difference. Also, supply warehouses within a CSC are used to support emergency preparedness and clinical formularies, which adds value to the clinical mission."

Paul Oppat, Executive Director, Supply Chain Services, Banner Health, Phoenix, AZ

"Awareness training for clinical and non-clinical staff alike is critical. All requisitioners should understand the value and benefit of ordering from the CSC for items stocked at the CSC."

Michael McCullough, Senior Vice President, Supply Chain, Wellstar Health System, Marietta, GA

Financial pain points

ROTAR: "If you're not ultimately trying to generate revenue in this model the fiscal hurdle is simply time. The time horizon for an expensive CSC that doesn't generate revenue is significantly longer than one that does. That said, the short-term financial investment is easily justifiable, especially if you're trying to solve space constraints, but the long-term operating costs often put these kinds of models at risk, particularly in times of budget tightening. At the end of the day, the best way to overcome the financial hurdle is to establish a realistic ROI for your CSC based on an honest assessment of how advanced your CSC can be with the resources you currently have."

CORRY: "This is a long game play, not a short-term financial win. Having a CSC is an enabler not a destination in and of itself."

OPPAT: "Startup costs for a CSC can be significant, and available investment dollars may limit what can be done at first. Many CSCs start small and grow over time; ideally that would be part of the plan."

McCULLOUGH: "Securing distribution fees, properly budgeting for staffing, software and material handling needs, and effectively communicating to finance the financial benefits of the CSC model as compared to other models, such as third-party distribution.

Operational pain points

ROTAR: "Labor, with general warehousing jobs abundant in many markets, the cost of living on the rise and historically low wages in the healthcare supply chain sector; recruiting, retaining and developing staff is a challenge. A simple solution I've seen successfully deployed to reduce this challenge is to right-size wages based on other industrial/retail distributors rather than healthcare. While costly, it will put a CSC operator in the best possible place to recruit talent that is specific to this type of environment. If you're still thinking a CSC can be operated like a hospital materials management department, you're in for a shock when you inevitably realize it cannot.

CORRY: "Ongoing justification of investment in non-traditional healthcare talent when our HR teams don't understand comparable for non-clinical roles as well as they do for standard clinical roles. You need serious tech and high-caliber people talent to make this model plausible and/or to thrive. This can be higher risk for your organization if you do it poorly."

OPPAT: "The CSC concept can be viewed as a risk by some, and certainly comes with change management challenges. Local versus centralized controls may leave individual stakeholders feeling uneasy, and they resent resources being reallocated to the CSC. In the end these changes bring significant benefits. Once those benefits are proven, both internal and external stakeholders become more accepting of the concept."

McCULLOUGH: "Ensuring that there is an effective formulary management process and program. This is critical for managing the hundreds of substitute items encountered annually. Also, there is a tight relationship between vendor and CSC and CSC and hospital. This is the supply chain! At Wellstar, we deliver Low Unit of Measure (LUM), and case-pick units of measure to over 400 locations. Coordinating cutoff times, and optimizing routes is critical for the smooth and efficient flow of goods from CSC to our hospitals and ambulatory sites. Coordinating the inbound side is equally as important as we seek to balance the workload on the receiving dock and ensure that we have between 20 and 40 days of inventory on hand. This work, in conjunction with ordering full pallet quantities to minimize receiving time, is critical to driving operational efficiencies in receiving."

Highlighting overt, covert myths of CSC operations

Healthcare provider-based supply chain executives and leaders either pursue the opportunity of developing, launching and running a consolidated service center (CSC) with their eyes wide open or squinting with a powerful magnifying glass to ensure they see all of the exposed and hidden challenges and myths.

What might those overt and covert myths be? Four CSC experts share their thoughts.

Overt myths

"My health system isn't large enough and/or we don't have enough spend to make the CSC model work. Once you take the time to fully understand that the CSC model is really more about consolidating behavior to your supplier community in a unified voice though strict procedures, you'll see that CSC models are more about behavior consolidation and being an efficient customer rather than having significant throughput. If you have significant scale and spend that's all the better, but with today's CSC models it's no longer a requirement."
Ryan Rotar, Executive Director, Supply Chain, UNC Health, Chapel Hill, NC

"Slow-moving items shouldn't be distributed. We like to leverage our CSC for non-traditional items that are more clinical and slower moving. The risk mitigation benefits and control over single purchasing channels and distributing non-commodities out to the field is key. Items that go direct to the facilities have to be ordered by each facility in [per unit of measure]."
Allison Corry, Chief Supply Chain Officer, Intermountain Health, Midvale, UT

"A CSC warehouse is the answer to eliminating supply chain resilience concerns. The more space consumed in the warehouse for added inventory resilience, the less SKUs are available from the CSC, thus a lower ROI. Supply chain resilience is a balance between cost, space, and priorities. Supply chain risk assessment is the most important part of a resiliency plan."
Paul Oppat, Executive Director, Supply Chain Services, Banner Health, Phoenix, AZ

"This is easy, anybody can do this. It's just moving boxes."
Michael McCullough, Senior Vice President, Supply Chain, Wellstar Health System, Marietta, GA

Covert myths

"This isn't a business segment that healthcare should be involved in, and we should just rely on distributors is something I hear too often. While this myth is easy to understand, it's also flawed because what is often easy isn't also the best course of action. I tend to believe that anytime an organization has the responsibility of contracting, purchasing and distributing products to care for its patients they should try to do so at the very highest level possible. Allowing a distributor to do this work for a small fee may seem advantageous in the short term, but the net benefits a provider can achieve in the long run is significantly more.

This will hurt patient care. This is typically a myth that most who operate CSC have heard at one time or another, and while it may be true for some, the CSC model actually better supports clinicians and the patients they serve in several ways. 1) More consistency and better management of inventory such that the level of stockouts/supply disruptions is significantly decreased. 2) Enhanced clinical partnership, in high-functioning CSC models you see a much stronger partnership between clinical decision makers and the supply chain teams. This partnership not only enhances trust but also better positions the supply chain team to take on work in support of clinicians that aren't ordinarily seen. This could be as simple as stocking non-standard products or providing advanced logistics support to clinical areas that have unique demands. Regardless, the CSC model is one that enhances patient care and builds trust in a supply chain organization."
Ryan Rotar, Executive Director, Supply Chain, UNC Health, Chapel Hill, NC

"People really underestimate the true cost of distribution and logistics and often forget to invest in talent necessary to be competitive. Hospital behavior and patterns about what is stocked locally and when to order is an untapped area of optimization critical for maximizing CSC value."
Allison Corry, Chief Supply Chain Officer, Intermountain Health, Midvale, UT

"Everyone should have a CSC. Running a CSC is not as easy as it looks. A great deal of relationship building, planning and strategy execution are involved in the daily operations of a CSC. Logistics across metropolitan areas or geographic regions add complexity. CSCs have regulatory and safety requirements and are often trying to attract talent that is very different from the rest of the healthcare organization."
Paul Oppat, Executive Director, Supply Chain Services, Banner Health, Phoenix, AZ

"Outsourcing means we will not have to worry about staffing."
Michael McCullough, Senior Vice President, Supply Chain, Wellstar Health System, Marietta, GA

Protecting Patients from Hidden Harm: Hospitals Confront Toxic Chemicals in IV Therapy

All patients face some risk with IV therapy, but the neonate and pediatric population, the elderly, and oncology patients are especially vulnerable due to their immunocompromised status.

A key concern is exposure to DEHP, a chemical found in some IV products that acts as an endocrine disruptor. Despite being banned from children's toys, DEHP is still present in medical devices, raising concern particularly for pediatric and breast cancer patients due to its hormonal impact, said Anita Zado, Vice President Clinical Services with Capstone Health Alliance.

"It has been proven time and time again that DEHP increases the risk around these patients," she said.

During a recent podcast with *The Journal of Healthcare Contracting*, Zado and several other clinical supply chain leaders from hospitals and health systems said that hospitals must engage multiple departments to manage risks, communicate changes, and ensure safe product use. These leaders discussed patient safety and environmental sustainability, as well as how they were assessing new patient safety legislation in California, the Toxic Free Medical Device Act or AB 2300, and its potential impact on the IV therapy products they utilize at their facilities. The panelists were:

- Angelique Vuilleumier, Senior Director, Supply Chain Legacy Health
- Anita Zado, Vice President Clinical Services with Capstone Health Alliance
- Grace Kistner, Project and Policy Analyst
- Lobel Lurie, Manager, Clinical Value Analysis, Strategic Sourcing with Cone Health
- Jennifer Browne, Corporate Director, Value Analysis with LifeBridge Health

Chemicals of concern

DEHP is LifeBridge Health's primary chemical of concern due to its well-documented health risks, Browne noted. In addition to DEHP, her health system also aims to minimize exposure to mercury, other phthalates, latex, and even anesthetic gases – especially when these pose risks to vulnerable patient populations.

She said that while some chemical effects, like latex-induced anaphylaxis, are immediate and well-known, others may have long-term or hidden impacts on the body. This uncertainty reinforces the importance of educating healthcare providers and staff to understand what chemicals are in the products they use and to make informed, cautious choices when those chemicals can't be completely avoided.

Vuilleumier shared that her health system is focused on reducing exposure to a broad range of chemicals of concern, including antimicrobials, BPA, anesthetic gases, and chemicals used in labs, cleaning, disinfection, and sterilization. Their goal is to protect patients, staff, and the environment from health risks such as cancer, reproductive harm, and respiratory issues, while also supporting sustainability efforts.

Legacy Health collaborates with Practice Greenhealth and participates in their chemical reporting programs. They also work closely with their GPO, sitting on its sustainability committee to exchange strategies with other health systems. Their GPO helps identify contracts that involve chemicals of concern, allowing Legacy to consider alternative suppliers through RFPs (Requests for Proposals).

AB 2300

Kistner, a registered nurse and policy analyst in California, shared her strong support for AB 2300, a bill addressing the use of toxic chemicals – specifically DEHP– in medical products. She explained that these chemicals, commonly found in IV and respiratory tubing, can leach into patients' bodies, posing serious health risks such as cancer, reproductive harm, and neurological issues. Most nurses are unaware of these risks, despite being directly exposed themselves.

Kistner also highlighted the environmental impact of plastic waste in healthcare, noting that incinerating medical plastics releases toxic dioxins into the environment.

"It's also in our broader environment," she said. "This is a community and population health issue. It goes beyond the bedside."

Lurie believes AB 2300 has the potential to support patient safety initiatives, but its success depends on strong partnerships with industry. She stressed the importance of transparency from manufacturers, particularly in clearly communicating their efforts to eliminate or reduce DEHP in medical products.

When suppliers clearly label products as not made with DEHP and share their action plans, it builds confidence and reduces the burden on healthcare systems to verify safety – ultimately protecting patients more effectively. Lurie concluded that holding industry partners accountable and communicative is essential for the law to truly advance patient safety across health systems.

The importance of supporting sustainability initiatives

Zado acknowledged the current challenges in supply chain – such as product shortages and tariff impacts – but emphasized that health systems with well-structured Environmentally Preferable Purchasing (EPP) programs are leading the way in sustainability. She highlighted that integrating clinical and supply chain teams can promote safer products, reduce waste, and improve ethical procurement, contributing to better patient outcomes, cost savings, and environmental health. She noted that the future lies in value-based supply strategies that align cost control with sustainability.

Kistner reinforced this by stressing that health systems can act proactively – they don't need to wait for legislation like AB 2300 to make sustainable changes. She pointed to California healthcare leaders who eliminated toxic chemicals like DEHP before being required to, achieving both better patient outcomes and financial savings. She advocated for aligning sustainability with the Quadruple Aim – improving care, outcomes, provider well-being, and cost – through collaborative, informed decision-making.

With leaders embracing transparency, sustainability, and innovation, the path forward points to a future where patient safety and environmental responsibility go hand in hand.

Commitment to safer products

Panelists praised B. Braun for its early and sustained leadership in removing DEHP and PVC from many of their IV therapy products, emphasizing the positive clinical, financial, and sustainability impacts on their health systems.

Vuilleumier said Legacy has used B. Braun's IV products not made with DEHP and PVC for years. In a recent 2024 RFP, B. Braun was again selected due to their alignment with governance priorities like environmental sustainability, patient safety, and cost-effectiveness. Zado has worked with B. Braun since 2010 and commended their long-standing commitment to safer products without added cost. Lurie said B. Braun products were successfully introduced during an IV shortage caused by a hurricane, leading to strong clinical acceptance and familiarity. Browne appreciates B. Braun's leadership in removing DEHP, noting it is a differentiator in the marketplace.

Indeed, as healthcare systems work to safeguard vulnerable patients, reduce harmful chemical exposure, and meet evolving legislative standards, collaboration across clinical, supply chain, and industry partners is more essential than ever. With leaders embracing transparency, sustainability, and innovation, the path forward points to a future where patient safety and environmental responsibility go hand in hand.

The reason our IV bags aren't made with DEHP is clear.

Over 40 years ago, B. Braun recognized the environmental and patient risks of toxic chemicals like DEHP and PVC and was the first medical device manufacturer to remove them from many products. DEHP, which is used to soften PVC, can leach into IV fluids, potentially putting patients at risk. Protect your patients and the planet with a full line of IV bags not made with DEHP or PVC.

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People to Watch

IN HEALTHCARE CONTRACTING

MELANIE BALL
Director, Strategic Sourcing and Value Analysis, Rush University System for Health

RACHEL CUNNINGHAM
Director of Operational Excellence, Piedmont Healthcare

MICHAEL F. MARTIN
Vice President, Supply Chain Operations, Trinity Health

MELANIE RICCI
VP, Supply Chain, Tower Health

ALEX BUTLER
MBA, Director of Strategic Sourcing, Supply Chain, Community Health Network

JASON LUBY
Vice President of Value Chain Management and Strategic Sourcing, BJC HealthCare

JASON MOULDING
Chief Supply Chain Officer, MultiCare

ASHLEY E. WILSON
Executive Director of Supply Chain, Children's National

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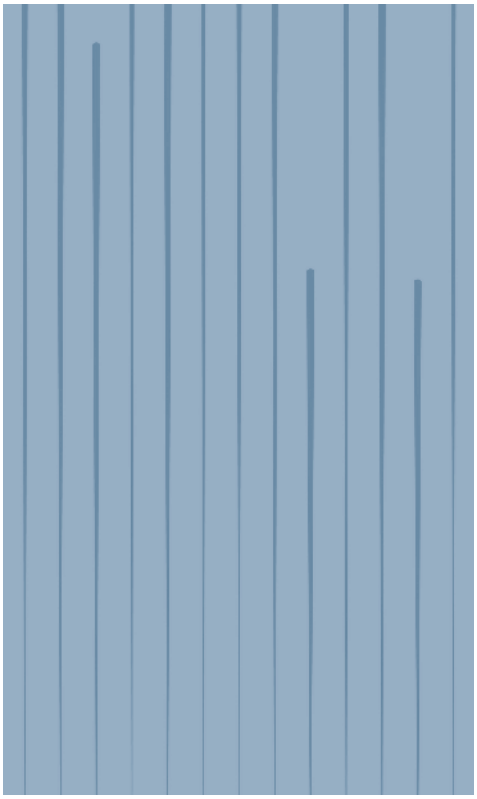
Melanie Ball

Director, Strategic Sourcing and Value Analysis, Rush University System for Health



Melanie Ball is passionate about value analysis.

"As much as we strive to be cost conscious – and that's what you think of with Sourcing (financials and driving cost savings) – but part of our job is to make sure that we're also bringing in the right products for our patient population," she said.

As an academic medical center, new technology is often a priority at Rush. "So, how can we make sure that we are able to financially – and safely – bring in all the new technology necessary for our clinicians to then also teach our residents as a teaching hospital? There's a balance we have to find with all the new technology out there – ensuring access and making sure that we're financially responsible in our decisions."

Ball serves as the Director of Strategic Sourcing and Value Analysis at Rush University System for Health.

"I have the privilege of leading a talented team that works across all areas of clinical sourcing," she said. "Together, we partner with physicians, nurses, and operational leaders to make sure we're bringing in the right products and services that balance cost, quality, and safety."

Her favorite part of the role is helping connect the dots between supply chain and patient care, and "ensuring the work we do supports our care teams in delivering exceptional outcomes."

On launching a supply chain internship program

Ball: This is something I have the privilege of being a part of, co-leading alongside two of my other peers. We're partnering with Rush University and their graduate program to provide students with hands-on experience. It's a partnership even within Rush with our university and those students to really give them an experience in supply chain.

This fall, I will be a preceptor through Rush University, supporting a first-year student as they go through our program and participate or lead real-world projects. I love internship programs; that's how I got my foot in the door during college. I know firsthand the impact they can have in workforce development and open the doors for future talent.

On 2025 and beyond

Ball: Like many healthcare organizations, we're still navigating supply disruptions, persistent back orders, and inconsistent supplier performance. We're also

managing significant cost pressures, along with uncertainty around tariffs and inflation – and the potential impact they could have on our system. A big part of our work is finding the right balance: keeping our hospitals well-supplied while managing competing cost priorities and ensuring our budgets are prepared for whatever challenges may arise.

On the need for data transparency

Ball: If I could change one thing overnight about our industry, it would be achieving true data transparency across the entire supply chain – from manufacturers all the way to the providers who use the products. While we've made progress, healthcare still lags behind in this area. The question is: how can we better leverage emerging technologies, including AI, to improve visibility into costs, supplier performance, and utilization? With better transparency, we could make faster, smarter, and more informed decisions. For me, that's the top priority.

On being seen as a partner with clinicians

Ball: While I'm not clinical, I know I can still make a meaningful impact on patient care by ensuring everything we do supports our clinicians and care teams in delivering exceptional outcomes. I think our team is increasingly being recognized as a vital partner. The pandemic really highlighted the value of supply chain – not just in getting products to the bedside, but in helping structure strategic contracts, managing supplier relationships, improving access to technology, and generating cost savings. What I'm most passionate about is value analysis – because it brings all of that together in partnership with our clinical teams.

What I'm most passionate about is value analysis – because it brings all of that together in partnership with our clinical teams.

On building sustainable sourcing

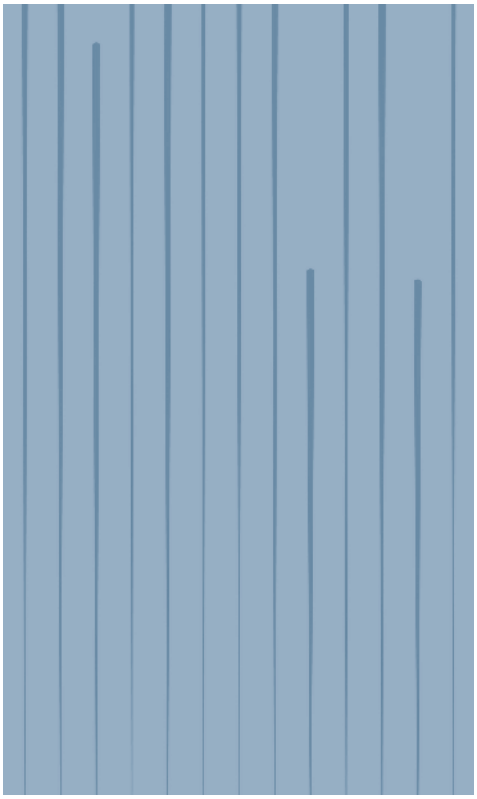
Ball: I'm really excited about the work we're doing to expand sustainable sourcing across our health system, particularly in the operating rooms. We're exploring reusable textiles, reprocessed devices, and waste reduction strategies that align with our organization's environmental and community impact goals. It's energizing to work on initiatives that connect clinical care, cost savings, and environmental responsibility

On supplier relations

Ball: We believe in treating our suppliers as true partners, not just vendors. We regularly meet with key suppliers to review performance, address challenges, and proactively plan for the future. When disruptions occur – and they will – we prioritize open, honest communication and collaborative problem-solving. Just as importantly, we stay closely aligned with our clinical and operational partners to ensure we're making informed decisions that minimize risk to patient care. At the end of the day, it's about working together to do what's best for our patients.

Alex Butler, MBA

Director of Strategic Sourcing, Supply Chain, Community Health Network



The balancing act for Community Health Network's supply chain team has certainly been interesting this year.

"There's a little thing going on with the economy these days that has everybody talking and is changing on a daily basis," joked Alex Butler, MBA, Director of Strategic Sourcing, Supply Chain, Community Health Network. "That is front and center for us. We're trying to monitor everything in the news and react to updates from our supplier community."

"But ultimately, we're still trying to remain profitable as an organization and serve our communities within our footprint," he added. "We're still building new hospitals and surgery centers, and we're continuing to expand with construction projects in virtually all our sites. With that comes trying to ensure that tariff fees, surcharges, and price increases don't completely take the legs out from under us."

On managing supplier relationships in today's marketplace

Butler: That's been a key focus of mine since I started with the Network in early 2024. We have reset some things with regards to our supplier community. We have implemented a strategic supplier partner model where we've worked very closely with our high spend, high complexity suppliers, and really brought those folks to the table. We're trying to do it in a more holistic way that would include representatives from each of those suppliers' business units, so we can break down silos.

With those strategic suppliers, we've done more to share our goals, priorities, and strategy as a supply chain team, while giving them a peek behind the curtain of upcoming strategic initiatives, ensuring that our data is well aligned, and that we have a strong foundation for transactions and day-to-day work. This allows us to build upon that foundation to be more successful with one another moving forward.

We've really tried to lean more heavily into that over the last year. We're now doing our second wave of annual strategic supplier meetings. This time around, it's more of a brainstorming session of sharing ideas back and forth. If it's something we're not doing well, and that respective supplier partner is looking for us to improve, or vice versa, we are detailing specific dates and deadlines and treating it with a project management approach to what we're going to do to solve those issues.

Beyond these strategic relationships, we've started stratifying the other suppliers within our base for those that are more critical to supporting our

needs versus those that we only use every once in a while for things less critical to patient care. We do frequent business review meetings, but we're trying to make those more valuable and impactful for everyone.

On implementing a new governance structure

Butler: We have a governance structure that we put in place about a year ago that is a true top-down approach, which is unique from what I've seen in the past. Often, the supply chain team is bringing the ideas forward, securing new pricing, and is responsible for the entire enforcement arm following implementation. In this case, we're operating with executive leadership's blessing on our initiatives, which gives us more ground to stand on as we engage clinicians and operational leaders.

We also have a layer of advisory support, allowing us to confirm our recommended sourcing strategies and to set project groups in place of those clinical experts to receive input and ultimately make decisions. That has been really impactful. We've definitely garnered a lot of savings, standardization, and penetration in those categories toward our cost savings goals as a result of this structure.

On surpassing a big goal

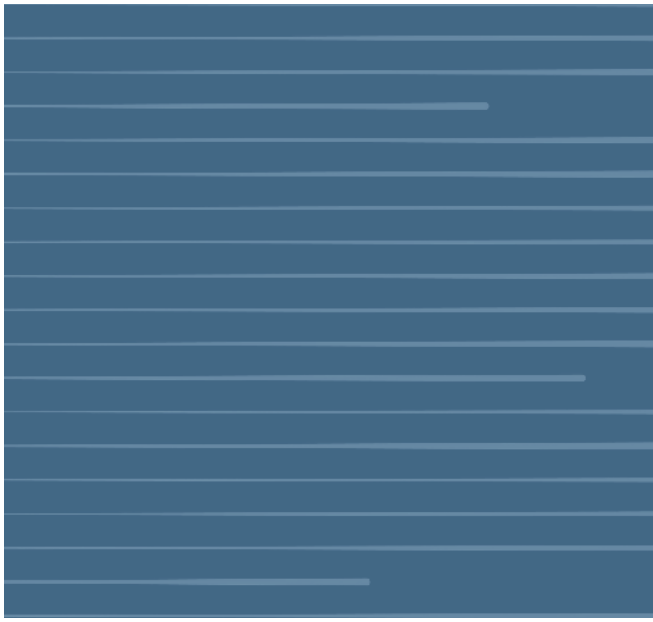
Butler: At the end of last year, we successfully implemented a new hip and knee implant initiative. We had expectations of a traditional market share-based scenario where we would award one or two suppliers within that category.

We're now doing our second wave of annual strategic supplier meetings. This time around, it's more of a brainstorming session of sharing ideas back and forth.

But as a result of a lot of input directly from the physicians, the request was made to pivot the approach completely. Rather than moving forward with executing the initial proposals, we went back to the source, rebuilt the bid and moved forward with a capitated model, with a true formulary approach to the category.

We were even more successful than we would've been under the initial approach. We received really strong input and support from the physicians throughout the rest of the project. As part of the negotiations, we were able to set new capitated price points for the different subcategories, and then we were able to land all suppliers on those price points.

Ultimately, we surpassed the goal. As of late last year, we finalized the initiative and implemented the new pricing, and we anticipate more than 10% savings. So, we're really excited about it.



Rachel Cunningham

Director of Operational Excellence, Piedmont Healthcare

Supply chain is slightly removed from patient care. Because of this, Rachel Cunningham, Director of Operational Excellence, Piedmont Healthcare, wants to connect her team to the person or people at the end of all the decisions they make.

"I came up in manufacturing, transportation, and then moved into healthcare," she said. "So that's really a big difference between supply chain in healthcare and supply chain anywhere else – there's a human being at the end of all this."

Working in the automotive industry, it was going to be annoying if supply chain didn't get an engine out on time. But no one's life was threatened in that scenario. Healthcare is different. "So, I think that's really the balance or the philosophy that my team has, is just keeping that human being at the center of everything that we do," she said. "Understanding that not only the human being that benefits from making sure that we have the right price in the system and being charged the right price, but also the human being that has to clean up after our messes when we don't do something right."

Cunningham uses the Bullwhip Effect as an example. The Bullwhip Effect states that every small decision makes a larger impact the further down the line it goes. Cunningham and her team know that the people doing the work on the ground – those seeing patients, refilling pars, etc. – will have to pay the biggest consequence when something goes wrong. "That's our philosophy around keeping the cost efficiency and quality in tandem," she said. "Don't let perfection get in the way of progress, but keep in mind that somebody else is cleaning up your mistakes."

Operational effectiveness at Piedmont Healthcare encompasses things like analytics work and new technology. Cunningham and her team are the bridge between supply chain data and action within supply chain. She leads the business/systems analytics team, which handles all of Piedmont's ERP integration and all the vendor information. She also manages continuous improvement projects and any other projects that come our way. "So, any new fun stuff we want to roll out, that tends to roll through me."

On what continuous improvement looks like for her team

Cunningham: It can mean everything from cross-functional projects with our cross-functional teams – such as finance, quality, safety – all the way to mergers and acquisitions for us. Lately it has been around dashboards and metrics. The

supply chain of now is not the same supply chain of six years ago. We are updating our metrics to be more encompassing of what our actual operation looks like.

On the most pressing challenges in supply chain

Cunningham: First, the number of stakeholders that are involved in just about every decision we make now has grown. Silos are a luxury of the past. We can't afford them anymore. Every decision must be made in tandem with our clinical teams and our finance team.

Second, we've come to understand that just judging by price isn't a fair comparison of how we are doing anymore. We're really focused on total cost of ownership, or a cost-to-serve model. Just because we have a price increase doesn't necessarily mean it's a bad thing. It may increase revenue. A big challenge has been seeing that full picture and making sure that we're encompassing everybody that needs to be in all of those discussions.

The final challenge is supply chain continuity or just making sure that we have the right products in the right place, especially around all the challenges that we've had since COVID. We're luckier than most. We self-distribute, which is a huge benefit to us. We have a distribution center where we're able to keep a lot of our commodity items so we can mitigate quite a bit of risk. But I think every health system is in the same boat of all going after the same products at the same time, and when they go on a shortage or when there's a recall, we're all still looking for the same products at the same time.

One of the mottos that we keep at Piedmont is "right product, right place, right time at the right price," because that is what supply chain is all about.

On the value of good, clean data

Cunningham: One of the big initiatives for our systems analytics team is around our data cleanup and match exceptions. We've put a lot of work in the last few years into data cleansing and data integrity. One of the mottos that we keep at Piedmont is "right product, right place, right time at the right price," because that is what supply chain is all about.

We've done a ton of work around this in the last couple of years, and we were able to improve our match exception rate. When you're going through the system, if something has to be touched by human hands because the automation didn't work, that's a key way to think about a match exception. For example, if your invoice price didn't match, or the part number didn't match. Something made it so someone had to take it out of its automated process and actually touch it.

We took our match exception rate number from 20% of our overall purchase orders to less than 3%. I'm very proud of the team for that. They've put in a lot of hard work, and we've been able to maintain that for over 18 months at this part.

That's coupled with astronomical growth. Piedmont has doubled in size twice in the time that I have worked here. So that's been a really big thing for us to be able to do that amount of data cleansing on top of day-to-day maintenance.

Jason Luby

Vice President of Value Chain Management and Strategic Sourcing, BJC HealthCare

Jason Luby, Vice President of Value Chain Management and Strategic Sourcing for BJC HealthCare, has prior experience in industries like packaged goods, food and beverage.

"Healthcare is the most important mission of any industry that I've worked in," he said. "Taking care of patients and getting patients healthy is a mission we can rally around. But when I talk to my peers [in other industries], I've noticed we're all trying to solve the same sorts of problems."

Supply chain's mission in healthcare is to take care of patients' health care needs. When Luby was working for a food company, the mission was to get food on the shelves. When he worked for CPG, it was to get products into the house.

"We still have the same problems," he said. "We're still dealing with securing the right price and the right product at the right time. So, I think that experience gave me a broad breadth approach."

Healthcare supply chain professionals have some wonderful ideas, but the industry doesn't have a patent on great ideas. "So, this gives us a good opportunity to go outside and look for other best practices to solve our problems, whether it's in the retail space or the food space and then leverage that experience," Luby said.

"When we build our teams, we look for a balance between people who are healthcare natives and people who can bring in some diversity of thought, experience or talent because of what they've seen elsewhere. The ability to leverage ideas, practices and successes from the world outside of health care has really helped with our transformation journey."

On building a better supply chain mentality

Luby: The trading partner relationship in healthcare is much more transactional-focused than the other industries. While I'm not suggesting everyone is transactional-focused, we want to extend the supply chain beyond our borders to the best of our ability into suppliers. That's an old habit from working with retailers. There is a lot of information sharing, a lot of data sharing, things like that. But health care has been slow to the table.

We want to move toward being strategically focused, find like-minded partners and continue to work through that extension of the supply chain where we're all working together trying to solve those problems.

On his experiences and education at West Point

Luby: I think that experience was incredibly formative. [Following graduation] my first roles were supply chain related. So, I guess I've been doing this since I was 20 years old.

What I learned had a lot more to do with leadership than it did supply chain fundamentals, like the ability to articulate a strategic vision or mission of where you want to go, and then to connect those dots in a way each person can find motivating

In healthcare we're incredibly fortunate because our mission is pretty straightforward and easy to conceptualize. We all have a story in our head, we can all imagine what if that was my mom, dad, sister, brother, or wife in the hospital bed, what do I do?

The same thing is true when we talk about the suppliers, where we look for organic improvement or operational improvements, we can connect the dots back in a way that helps keep the focus on what we're trying to accomplish and the needs of the people we are serving.

On building resiliency

Luby: It's definitely been a challenge. When you think about our mission, we can't be lean to the point where we impact quality patient care. However, I think the belief of methodologies like Lean and Six Sigma and continuous improvement, are not mutually exclusive with building resiliency. In fact, if anything, they actually require you to think more critically about where you have resiliency.

The more complicated a supply chain gets, the more fragile it can become. We've seen that with all sorts of recent news stories. A captain makes a wrong turn and blocks the Suez Canal and shuts down global trade for months at a time. Something relatively simple can shut down the whole system if you're not building that resiliency.

We've tried to work with our partners to figure out those fracture points. What and where are the things that can break? And then what are those critical quality measurements we have to work on together, and where do we apply extra resources to make it resilient?

Our suppliers have to be honest with us about where they're exposed and we have to be honest with them about where we're exposed, so that we can work together to provide a solution that covers each other. It's trying to avoid the Swiss cheese effect where you're just trying to put layers on top of layers on top of layers. If we can't be transparent with each other, then we won't know where we are vulnerable. None of us have the ability to try to fix everything. We all have limited resources, so we have to put the resources we do have at the point of maximum exertion or where we can get the most leverage.

When you think about our mission, we can't be lean to the point where we impact quality patient care.

Michael F. Martin

Vice President, Supply Chain Operations, Trinity Health

For Trinity Health, achieving alignment across such a large and complex (and geographically spread out) organization is a massive undertaking – but worth the effort.

"Over the past year and a half, we've put a new leadership structure in place that's helped bring clarity and consistency to how we operate," said Michael F. Martin, Vice President, Supply Chain Operations, Trinity Health.

This past year, Trinity conducted current-state assessments across all ministries to better understand how inventory is managed, how they handle PAR locations, and where there are opportunities for efficiency and improvement. "Historically, we've had a very service-oriented culture – we're quick to respond to issues and 'put out fires' – but that meant process improvement often took a back seat," Martin said.

With the new structure, Trinity has established three regional service areas, each supporting about 30 hospitals. This model allows for more localized collaboration and support. Now, when a ministry needs help, they can lean on their regional peers instead of relying solely on the system office. "In the past, Trinity's system services team here in Livonia, including my continuous improvement team, could only deploy a handful of people to a site at a time." That limited their ability to scale improvements across 90-plus hospitals.

This new infrastructure is changing that. "Ministries are now beginning to collaborate in meaningful ways, which simply wasn't happening before. We've also established a clear baseline of where each ministry stands, allowing us to set aligned goals for the future."

"Looking ahead, we want to advance our capabilities in procedural areas – OR, cath lab, IR, and EP. Today, some ministries have supply chain fully embedded in those spaces, while others still rely on clinicians to manage supplies. Across the board, we still struggle with visibility: knowing what we have, where it is, and how to manage high-value inventory more efficiently."

On major accomplishments

Martin: Over the last five years – aside from navigating COVID, which we all hope remains a once-in-a-lifetime event – I'd highlight two major accomplishments.

First, our self-distribution center. The foundation was solid, but we optimized it based on my background in distribution. It's now highly efficient, best-in-class in how it operates, and more importantly, it's sustainable – it practically runs itself today.

Second, and more recently, is the organizational redesign we've implemented over the past year and a half to two years. This structure is already delivering significant benefits. We've created alignment around shared priorities across all 94 hospitals in our system. In the past, growth through acquisition led to a patchwork of legacy practices. While we respected those, we've reached a point where we can no longer afford inefficiencies. Now, we're focusing on learning from one another and operating as one unified system.

That alignment – getting everyone moving in the same direction – is a huge win.

On the soft skills supply chain leaders need today

Martin: While it may not be a traditional soft skill, I believe data analytics is foundational. You don't need to be a full-time analyst, but you must understand workflows and use data to drive decision-making and process improvement. You really can't separate the two.

Once that foundation is in place, soft skills like communication and leadership become critical. You need the ability to inspire and manage both your frontline and entry-level staff, as well as engage in meaningful, trust-building conversations with clinical leaders. Being able to manage both up and down the organization is essential.

In our structure, the role we call a "site manager" is focused primarily on inventory and logistics – sourcing is now handled at the system level. Similarly, value analysis used to vary by site, but we've aligned and standardized that support across all locations.

Ultimately, it's about being an effective matrix manager. While site managers no longer meet with vendors as much as they might have in the past, their ability to communicate clearly across roles and levels remains essential. But again, it all starts with a strong grasp of data.

If I had clear insight into where our high-value items are – whether they're in use, sitting in excess, or could be moved across facilities – it would unlock enormous value.

On one change he believes would improve the U.S. healthcare supply chain

Martin: For me, it's product visibility – specifically, visibility into high-value inventory through standardized G10 scanning. If I had clear insight into where our high-value items are – whether they're in use, sitting in excess, or could be moved across facilities – it would unlock enormous value. As a large system, our collective inventory should be a strength, but currently, I don't know what others have or where it is.

The focus shouldn't be on meticulously tracking every single item clinicians touch; that adds cost without much benefit. Instead, we need tools that highlight what matters most – those high-value, chargeable items in procedural areas like the OR, cath lab, and IR suite. These are the products that truly impact the financials.

Historically, too much attention has been on distributors – what came in, shipping errors, etc. – but those are often low-dollar issues. The real financial drivers are physician preference items and devices. Yet we rely on clinicians to manage them without proper support.

Another challenge is the lack of clarity around whether certain items are reimbursable. Each hospital seems to figure it out on their own. We need better guidance. If something isn't reimbursable, just include it in a bundled charge and move on.

So, if I could fix one thing, it would be enabling better visibility and management of high-value inventory. That's where we can make the biggest impact.

Jason Moulding

Chief Supply Chain Officer, MultiCare

Jason Moulding's journey into healthcare supply chain was shaped by his family's background – his father, a military dentist, and his mother, a nurse. While attending college, he needed a job and chose a position in medical records at a nearby hospital. This initial step kept him in the field, eventually leading to a role in the operating room at Overlake Hospital in Bellevue, Washington.

His strong negotiation skills soon caught the attention of the director of materials management, earning him a new role in contract management, a pivotal shift that uncovered his passion for analytics. Moulding continued advancing through positions at Overlake, Providence Health & Services, and later MultiCare Health System, where he has spent nearly nine years.

Although he considered other industries after earning his MBA, he remained in healthcare supply chain, saying, "I felt that healthcare was my calling."

On what he's keeping an eye on as a supply chain leader

Moulding: Supply Chain post-COVID is so much more complex. The biggest challenge I would say is there is no single overriding challenge. Tariffs are obviously an issue for now, and then the downstream effects not just from a pricing perspective, but what is that going to do to the global supply chain? Will there be shifts in manufacturing? Shifts in manufacturing countries? Will manufacturers exit the market?

A supply chain leader of today needs to have visibility a lot further upstream than ever before. Risk and resiliency are at the forefront, and it has been that way since COVID. We haven't let our foot off the gas. Each year brings increasing complexity, with more factors that supply chain professionals must stay fluent in and closely monitor.

The impacts of global supply disruptions are happening more often every year – whether through natural disasters, geopolitical events, shifts in manufacturing, etc. Having a macro lens and then discerning how disruptions or opportunities impact your organization will keep Supply Chain relevant and essential.

On the skills and intangibles needed from supply chain teams

Moulding: Analytics/insights is a crucial skill, and I really like the business background versus maybe the purely healthcare-focused one. Having accounting knowledge and a finance background is part of that new language or skill set for today's Supply Chain landscape.

Beyond technical expertise, I value intellectual curiosity and a drive to be curious. Our CEO talks about three key components a leader or individual contributor needs to have: critical thinking, integrative thinking, and situational awareness. Integrative thinking involves connecting Supply Chain operations with clinical, financial, and operational stakeholders across both acute and non-acute sites. Situational awareness means understanding global trends and identifying what's most relevant. Critical thinking, meanwhile, focuses on pinpointing priorities and addressing the most pressing challenges. These intangible qualities are always top of mind for me.

On how MultiCare wins with people

Moulding: Our people are the cornerstone of our strategic plan. We take pride in maintaining one of the lowest turnover rates in the organization's support services – less than 5%, which including our frontline teams.

A major factor behind this success is our dedication to professional development. We actively support employees in advancing their education, whether through bachelor's or master's degrees, as well as industry certifications like the CMRP. Some team members have even pursued fellowships with the American College of Healthcare Executives.

Leadership development is another priority, with 14 internal promotions into leadership roles – without a single external leadership hire. This commitment to growing talent from within reinforces a culture of career advancement and long-term success.

On being a go-to source for support and help

Moulding: Our Supply Chain vision statement is: *Partnering to deliver the highest value to support the vision of MultiCare.* One of the achievements I'm most proud of in support of this vision is the transformation of our analytics division within MHS.

Since assuming responsibility for the platform in 2022, we've made significant progress. Initially, each MHS division preferred to manage its own analytics. However, through collaboration and by embedding our experts within business units, we've built strong partnerships. Since then, we have successfully insourced majority of analytics under our platform. Today, stakeholders actively seek our support, recognizing the value we bring.

We overlay cost data with reimbursement figures, payer mix, and essential quality metrics – readmission rates, surgical site infections, and more.

Our analytics platform has evolved into a powerful, trusted tool across the health system. As owners and managers of the enterprise data warehouse (EDW), we integrate disparate data sources – including Epic, Workday, and various clinical programs – into dynamic Power BI dashboards. These dashboards, coupled with our analysts, serve decision-makers at every level, from the boardroom to individual leaders running daily operations.

Our dashboards operate at multiple levels, offering a macro view of system-wide procedures while diving deep into encounter-level insights. We overlay cost data with reimbursement figures, payer mix, and essential quality metrics – readmission rates, surgical site infections, and more. This allows us to pinpoint key relationships: Does a particular intervention reduce length of stay? Does it accelerate patient transition to home?

With four to five years of data-driven decision-making behind us, we continue to refine our approach. The next phase is ensuring we engage the right stakeholders, helping them navigate trade-offs while integrating more clinical insights. The platform is a critical tool – one among many – that drive smarter healthcare strategies that ultimately improve the patient care to the communities we serve.

Melanie Ricci

VP, Supply Chain, Tower Health

Melanie Ricci, VP, Supply Chain, Tower Health believes you must come into supply chain with a flexible mind. "One minute you could be focusing on something EVS related, then the next you are shifting to something lab related, followed by a construction meeting."

But the only way a person can be successful in a role that's so varied is if you have a great team.

"And the team that I work with is just phenomenal."

They are content experts in what they lead, she said. For example, the system director for contracting has 30 years of experience. He's done GPO transitions, insourcing and outsourcing. "Not only that, but he's a great person," Ricci said. "He's kind and he cares about his team."

Flip over to construction management and a Navy veteran leads that department. She did builds as part of Navy contracts and now she does that for Tower Health's hospitals. She's an expert in FGI guidelines, and is also a kind person.

"They're kind, and they're there for the right reasons," Ricci said. "The commonality amongst everyone on my team is their expertise. These are mission-driven people. They are not money-driven people. And I think that makes a difference. When your team is pointed in the same direction for the best for your organization, you can do some pretty cool stuff. I have been incredibly blessed and fortunate to not have a single person on my team be only out for themselves. They are all incredibly inclusive."

Tower Health has three hospitals and a joint venture with a children's hospital. Ricci's role is not just everything Supply Chain, supply and distribution through purchasing and contracting and value analysis but also fulfilling the role of support services. This includes construction management, facilities, food and nutrition, EVS, security and laboratory. Those other service lines all come through the department she leads.

On tackling a GPO conversion

Ricci: We have just completed a GPO conversion. This is a unique situation that may come along every five years. Those contracts are pretty stable, but if you do a GPO conversion, you're looking across the board: value analysis, data, purchasing, supplier engagement, all those things. So, to get that aligned and ensure that there are no drops in pricing is a pretty magnificent undertaking.

Our team did this work in the middle of a restructuring. Prior to me joining the organization, Tower Health had a highly analytical supply chain. When I came on board, our core business was a little bit lacking, not in the sense that we didn't have great people, but we had focused so much on analytics that we kind of lost what the core business looked like. We put some resources into coach-up skills in contracting and in purchasing, and we worked with our IT colleagues to develop different analytical platforms; some that would rest with Supply Chain, others that would rest within IT. We were able to tackle the GPO conversion to use those systems and processes in a unique way so that we didn't have a single miss.

Supply Chain took out about $7 million in cost in just about nine months. That was related to a couple of big contracts that they had been working on. We've actually lowered the amount on shelf – not of the class A or class B type supplies, but those things that are not used a whole lot or have very slow turns. We were able to reduce by about 4% what we kept in-house, which was a huge savings for the organization.

On looking at total cost of care

Ricci: We're on boarding a new value analysis platform. Value analysis needs to be reworked, not because the process is wrong, but because we have kind of watered it down with cups and plates and commodity type items. We need to start looking at the total cost of care and partnering with our clinicians. That's what the new value analysis is, and this I think is new for Tower Health, but probably not for most hospitals where supply chain and clinical partner differently, which is bringing over the physicians to your side of the negotiating table, even against suppliers that they typically have enjoyed the partnership with but have not performed favorably in the financials. It's establishing credibility.

Value analysis needs to be reworked, not because the process is wrong, but because we have kind of watered it down with cups and plates and commodity type items.

The supply chain folks are going to be tasked with upping their soft skills of presentation and engagement and then bringing with them what they have already, which is that really hard skill of contract negotiations and dealing with suppliers. Because of COVID and being in a remote environment, I think that supply chain contracting folks have kind of lost that connection, so we have to reestablish that with our clinicians.

It's a different thing to say, "I'm here for you" versus "I'm here with you." I can be here for you and be remote. But what if I'm here with you? Then you have a partner, because I'm beside you while you're having conversations with the doctors and then having the conversations with the supplier. So bringing that full triad together is going to be important in our success.

I'm also excited about the fact that in the distribution world, some of the lessons learned from Covid were about what does pandemic supply look like as far as a self-distribution operation? And especially with Baxter, the recent fluid shortage, how do we look at that situation differently and do some self-distribution where it makes sense to not risk clinical care?

It seems like a different shift. I think a few years ago, a lot of folks wanted to get back to LUM so they had less on the shelf and just-in-time inventory. What we've learned in certain situations, like tubes and IV fluids, was if you can for high turn bulk items, maybe self-distribution is not a bad thing.

Ashley E. Wilson

Executive Director of Supply Chain at Children's National

By necessity, Supply Chain wears many hats. "Even though we operate in the supply chain department, everyone on the Supply Chain team is deeply integrated into all organizational operations and initiatives because we partner with other areas, both clinical and non-clinical," said Ashley E. Wilson, Executive Director of Supply Chain at Children's National.

Wilson's team is not just negotiating syringes, implants or custom packs. They're starting to get involved in negotiations of indirect spend and purchased services contracts which include services like interpretive services, reference lab, nitric oxide, cleaning and janitorial services that expand across both clinical and non-clinical areas. And that requires supply chain executives to better understand the operational pieces of those areas.

"How does the EVS department provide cleaning services to our extended campus locations?" Wilson said. "How does our lab team understand which labs they want to send out versus conduct in-house? How do we expand access of our interpreters at the fingertips for our clinical teams should we need to provide interpretive services at the bedside for families and patients?"

As Supply Chain teams delve more into the realm of purchased services and indirect spend, which is the greatest non-labor expense of a healthcare organization, even above supplies, they have to consider the wraparound business processes to help departments better think through how services are consumed. "Indirect spend negotiations are not just about a lower rate or price," Wilson said. "How can we be more efficient about how we consume and operationalize this service to drive the most value, efficiency and benefit for the organization? As a result, Supply Chain is uniquely positioned to facilitate these opportunities – not merely as negotiators, but as objective partners who collaborate with both clinical and non-clinical stakeholders. They can bring a multi-disciplinary perspective, who can understand, dive into the details, but also see the bigger picture and help these teams develop strategy around what levers we're going to pull with those suppliers beyond just price."

Clinical and operational teams may not jump at the chance to change a supplier or competitively bid a category they have never opened up to the market; they may not see that anything is broken, or that current state appears efficient and the incumbent supplier is delivering value. "But Supply Chain professionals who can see across the organization, who can see trends in expenses and market changes, and see an opportunity to challenge the status quo, will always yield more value that initially expected."

On the passion for the job

Wilson: I am by nature an operationally driven person. I like to fix things. I like to improve things, and Supply Chain gives me the opportunity to do that within our own operations or by working with other departments to influence opportunity in theirs. We touch and interact with every single department across the hospital; we work with EVS, IT, respiratory, clinical departments, physicians. It's eye-opening to understand other areas and help them drive opportunities that will yield not just financial rewards, but improved operations and efficiency.

I'm also an extrovert, so I'm a very social person. And being able to develop the networks and the inner working relationships with those other leaders beyond supply chain is something I really enjoy about this job and drives me to continue to learn more about the organization and how Supply Chain can have their touch in every element of it.

On the push from acute to subacute

Wilson: One of the big challenges that organizations are going to have to solve for today is a shift from acute into the subacute ambulatory market, trying to meet patients and families where they're at as opposed to having everyone come to the main campus, which could be two hours away.

It's a major shift. As organizations shift more into ambulatory care to drive access for patients, extending into a community outside the primary hospital into a specialty clinic or ambulatory surgery center or primary care practice, Supply Chain has to develop a strategy to ensure supply operations are delivered in same efficiency and outcome.

As health systems start to change what needs to be on a main campus, you're starting to see supply chains move to more of a central service distribution center.

That makes it really hard for Supply Chain because instead of just thinking about a small concentrated geographical area to provide supplies and distribution, now I'm starting to cover a lot more geographical area to be able to create an effective, efficient and price conscious way to get supplies to those areas.

Ten years ago, Children's reach was 30 miles or so outside of our main campus. Now we're 200 miles. We've got areas and clinics down in Salisbury, Maryland and Richmond, Virginia, which are two to three hours away from us. This creates a very unique challenge. How do I still give that same customer service and satisfaction to the cardiology clinic in Salisbury, Maryland that I do to the cardiology clinic here on the main campus? You don't want our clinicians or patients to have a different experience just because they're located in Salisbury versus the one here on the main campus. So, I think that distribution model is going to be a challenge for us.

Space is also challenge for Supply Chain. As health systems start to change what needs to be on a main campus, you're starting to see supply chains move to more of a central service distribution center. You're having more of your functions offsite. And again, that brings in transportation challenges and new strategies that we have to do because you're not receiving everything at your main campus anymore. Maybe you have to cross-dock and do different things. Especially as you build out new hospitals, nobody thinks about wanting to give that real estate to a supply room. They want to maximize it for patient rooms or a clinic room. But we have to create a balance to be able to support the other elements. You need space to be able to maintain supplies and other equipment. ■

Meeting the Moment

Navigating the complexities of supplying non-acute facilities.

Supplying non-acute healthcare facilities presents a unique set of challenges. In a recent podcast with *The Journal of Healthcare Contracting*, Travis Miller, Vice President of Supply Chain Management Operations at Advocate Health (Midwest region), discussed the logistical and strategic nuances involved in supporting a growing network of non-acute care sites.

A fundamental difference lies in the sheer diversity and distribution of non-acute facilities. Unlike hospitals, which tend to be centralized and more uniform, non-acute sites range from outpatient clinics to specialty centers scattered across wide geographic regions. Each has unique demands and limited storage capacity. "Storage is lean," Miller said, emphasizing how crucial unit-of-measure flexibility becomes. Ordering in bulk isn't viable if there's no storage space or if items expire before use.

This constraint demands precision—both in forecasting needs and delivering the right quantities at the right time. It also shifts the burden of ordering to individuals who often juggle multiple responsibilities. "At non-acute sites, we're working with whoever is available—whether it's a clinical lead or an admin assistant. Ordering isn't their day job," Miller explained. To help, Advocate Health has implemented templates within its ERP system and established a customer service-like point of contact for questions or assistance.

Standardization poses another layer of complexity. Hospitals can rely on internal value analysis teams to drive product standardization and efficiency. But in non-acute settings, product variability

and decentralized decision-making can hinder that process. Miller stressed the importance of integrating ERP data with distributor information to identify opportunities for standardization. This coordination, combined with sourcing and operations teams, helps streamline SKUs and supports warehouse efficiency.

"It's part of our job to analyze purchasing patterns, identify site-level variation, and uncover opportunities to standardize products and workflows," said Tami Cates, Director, Strategic Accounts, Henry Schein Medical. "Standardization isn't one-size-fits-all—it's about building a smarter foundation for consistency, predictability, and cost control."

Distribution strategy plays a central role. Advocate Health utilizes its Heil distribution center in Wisconsin as a primary hub that supports Illinois and Wisconsin, carefully selecting which products to stock based on usage, shipping costs, and packaging sizes. "If we can minimize shipping fees and order in smaller units, that's a win for everyone," Miller said. Other items are shipped direct to the non-acute sites. Advocate Health utilizes Henry Schein in the Southeast.

Miller identified three key qualities of a good distribution partner that help reduce a health system's cost to serve non-acute:

- **Flexibility –** The ability to adapt in terms of order timing, delivery schedules, and logistics to meet the system's needs.
- **Ease of Use –** Making it simple for end users by providing clear packing/shipping labels and visibility into purchase orders, especially for non-supply chain staff at the receiving end.
- **Shared Goals –** Being a true partner focused on efficiency, cost reduction, and aligning with the health system's operational objectives.

Ultimately, success in non-acute supply chain operations depends on adaptability, visibility, and strategic partnerships. As Miller put it, "It's all about maximizing the people and space we already have, while staying agile enough to grow with the system."

"A non-acute distribution strategy ensures scalable, efficient, and consistent care delivery. The right partner reduces cost to serve, adapts locally, aligns system-wide, and enhances staff efficiency across sites," said Cates. ■

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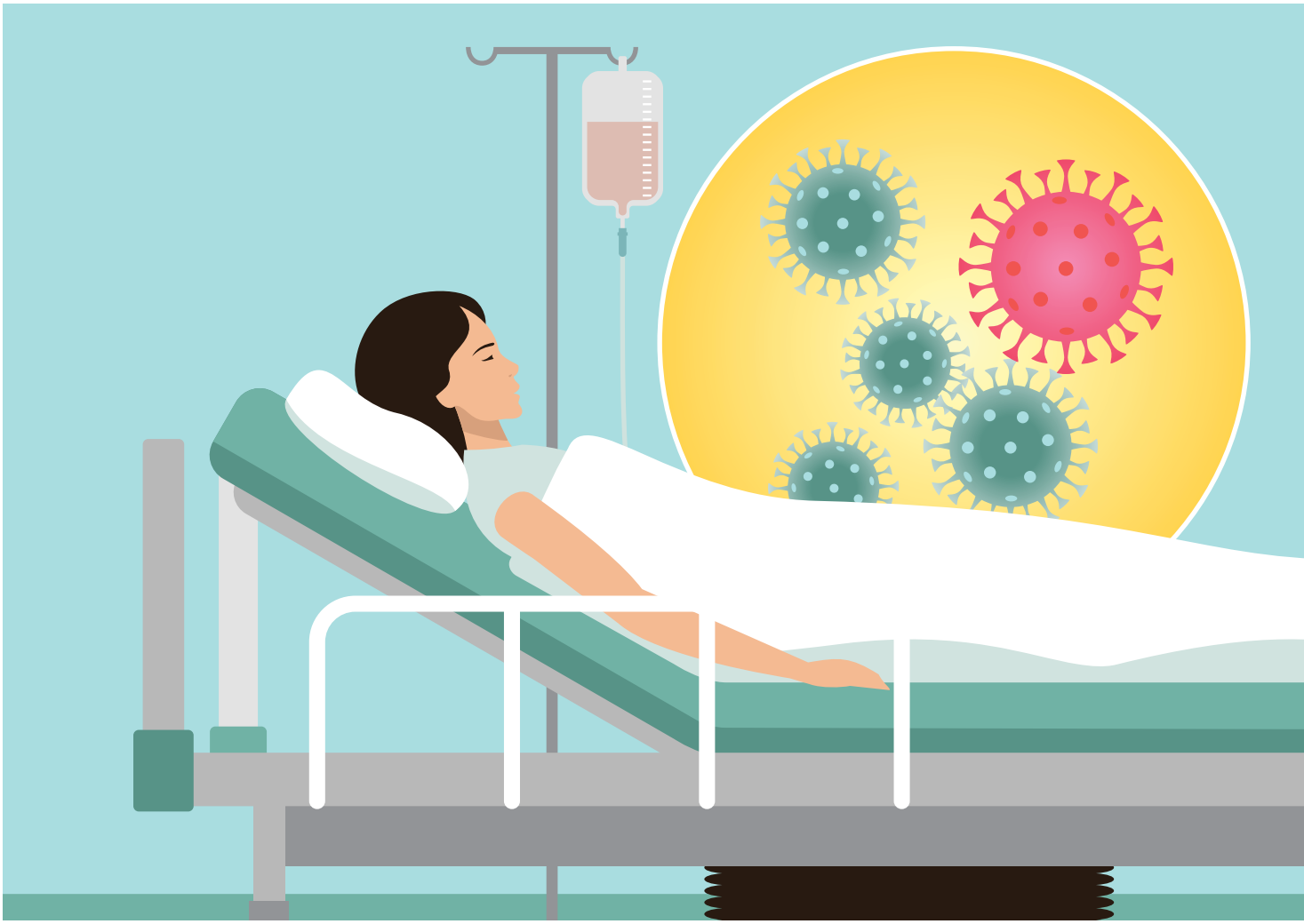
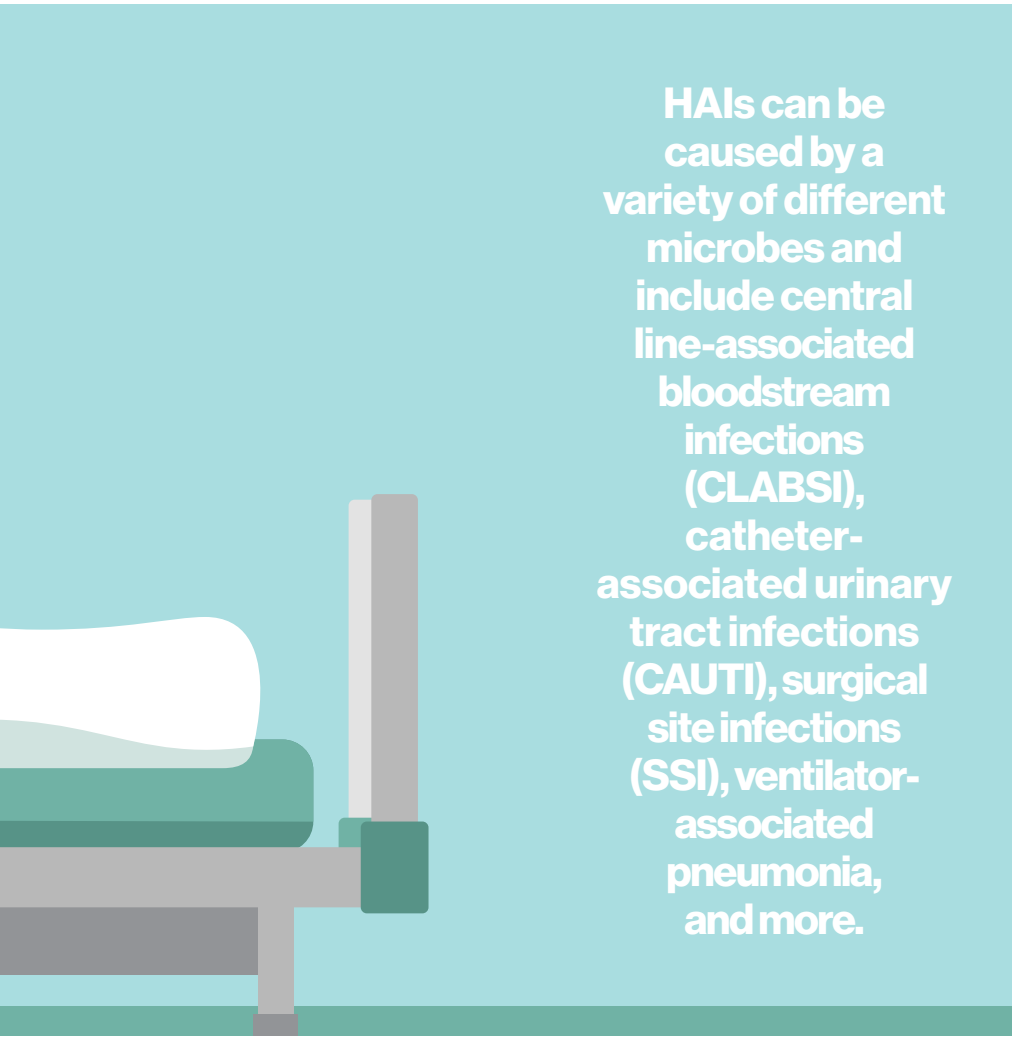


Post-Acute Care Infection Prevention

How healthcare providers can implement practices that address HAIs in post-acute care.

One of the major challenges faced by post-acute care providers is the prevention and management of infections acquired in healthcare settings.

Healthcare associated infections (HAIs) are a substantial issue across the healthcare industry that delay patient recovery, reduce favorable patient outcomes and pose risks to healthcare staff. In long-term care (LTC) facilities, including long-term acute care hospitals, inpatient rehabilitation facilities and skilled nursing facilities, where individuals are being treated or work in proximity, the risk of spreading HAIs increases significantly.



HAIs can be caused by a variety of different microbes and include central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), ventilator-associated pneumonia, and more.

On any given day, about one in 31 hospital patients has at least one HAI, according to the Centers for Disease Control and Prevention (CDC), with 1 in 43 nursing home residents contracting at least one infection associated with their healthcare.

"HAIs are infections that develop during the receipt of medical care," said Dr. David P. Calfee, director of the Healthcare-Associated Infections Division, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality (AHRQ). "HAIs that are among the most common in long-term care facilities include urinary tract infections, respiratory tract infections such as pneumonia, bronchitis, influenza and other respiratory virus infections, and skin and soft tissue infections."

HAIs can spread through person-to-person contact, hand transmission, contaminated medical equipment and treatment environments, and more. Effective infection prevention practices are critical to protecting vulnerable patient populations in post-acute care settings.

"Infection prevention is important in all healthcare settings," said Dr. Calfee. "Residents and patients in long-term care and other post-acute care facilities frequently have medical conditions that place them at higher risk of infection and of poor outcomes from any infection that develops."

HAIs in post-acute care settings

HAIs are a serious threat to the safety of patients, residents, and LTC physicians and staff. Patients can become infected with HAIs while receiving or soon after treatment, according to the CDC. Certain healthcare procedures can expose a patient to bacteria and viruses that cause HAIs that can then spread between patients, providers, staff and visitors through unclean hands or improper use (or reuse) of medical equipment.

AHRQ has compiled a resource and a review of standard precautions for LTC physicians in "A Unit Guide to Infection Prevention for Long-Term Care Staff," calling healthcare providers to be aware of the signs and symptoms of infection, consistently ask patients how they are feeling, become familiar with what is and isn't normal for a patient, and report any symptoms of infection immediately.

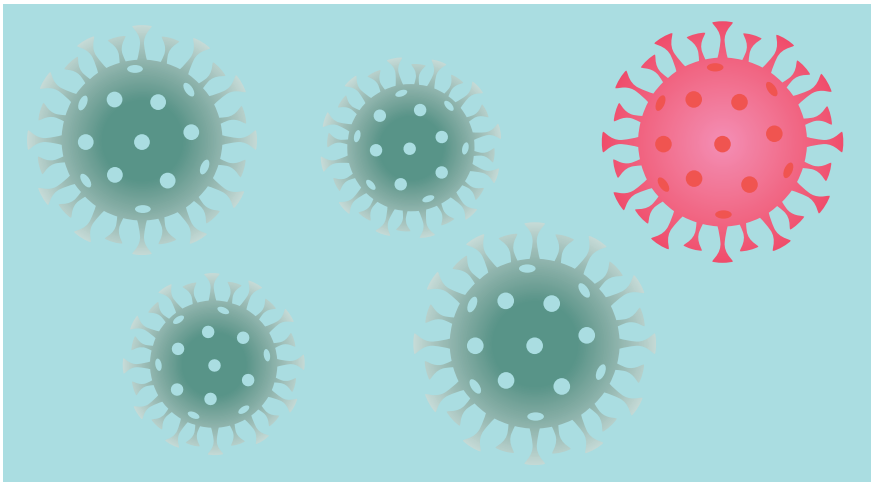
"Symptoms and signs at the site of infection are often present in patients," said Dr. Calfee. "These include symptoms such as dysuria in residents with urinary tract infections; cough, shortness of breath, sore throat, and/or nasal congestion in respiratory tract infections; and pain, redness, swelling, and/or drainage in skin and soft tissue infections."

HAIs can be caused by a variety of different microbes and include central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), ventilator-associated pneumonia, and more. Other types of common infections in LTC include

respiratory infections such as pneumonia and COVID-19, gastrointestinal infections, and skin infections such as bedsores.

"Non-localizing symptoms and signs, such as fever, hypothermia, hypotension (low blood pressure), hyperglycemia, and delirium, may be present in residents with infections, but these findings can also be due to non-infectious processes," said Dr. Calfee. "Thus, when these are identified, evaluation for both infectious and non-infectious causes is warranted."

According to the AHRQ guide, physicians should break the chain of infections by detecting, diagnosing and treating infections quickly, not rushing to use antibiotics, as they could cause antibiotic-resistant infections, and carefully following facility policies on infection prevention.



The Comprehensive Unit-based Safety Program (CUSP) is a method that can help clinical teams make care safer by combining improved teamwork, clinical best practices, and the science of safety.

Prevention of HAIs in LTC

Healthcare staff can reduce the risk of infection to themselves and other patients by practicing proper hand hygiene, wearing gloves and other personal protective equipment, keeping the healthcare environment clean, properly disinfecting surfaces and medical equipment and handling waste safely.

"Strategies that may be helpful in implementing and sustaining effective infection prevention practices include periodic education and training, observations of infection prevention-related practices when indicated, and environmental cleaning and disinfection with feedback to frontline staff, and identification and resolution of barriers to implementation of recommended practices," said Dr. Calfee.

Patients and visitors should also be involved in the prevention of infections, according to the AHRQ guide. Patients and visitors play a role in increasing the safety of the entire facility by practicing infection prevention themselves, and in supporting healthcare teams in prevention practices.

"Efforts to build a strong culture of safety and to optimize communication among staff, residents, and residents' family and visitors can strengthen a hospital or health system's infection prevention program," said Dr. Calfee.

AHRQ's Comprehensive Unit-Based Safety Program (CUSP) and Team Strategies & Tools to Enhance Performance & Patient Safety (TeamSTEPPS) program can help facilities pursue such improvements, says Dr. Calfee.

The Comprehensive Unit-based Safety Program (CUSP) is a method that can help clinical teams make care safer by combining improved teamwork, clinical best practices, and the science of safety. The Core CUSP toolkit gives clinical teams the training resources and tools to apply the CUSP method and build their capacity to address safety issues.

TeamSTEPPS is an evidence-based set of teamwork tools, aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare teams, including patients and family caregivers.

Ultimately, reducing the incidence of HAIs depends on the commitment of post-acute care providers implementing a variety of strategies and procedures across the facility.

"Improving teamwork, communication, and safety culture may help to improve infection prevention, other aspects of care, staff engagement, and staff satisfaction in post-acute care facilities," said Dr. Calfee. ■

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Navigating Tariffs Together

By Wyeth Ruthven, Director of Congressional and Public Relations, Health Industry Distributors Association

Across the continuum of care, tariffs remain a concern. From the factory floor to the hospital bedside, every link in the medical supply chain is impacted when tariffs are imposed on healthcare products. Each segment of the chain faces unique challenges, and we all face constraints on resources.

Manufacturers

The impact of tariffs on overseas manufacturing is readily apparent. But even domestic manufacturers will be impacted by increased tariffs, because they rely on globally sourced inputs such as resins for syringes or metals for surgical tools. Tariffs increase the cost of these materials, squeezing margins and limiting capital available for innovation and quality improvement. A recent survey of medical equipment manufacturers found that 81% predict longer lead times and supply shortages as the result of tariffs.

Distributors

Distributors have scant margin to absorb the cost of tariffs on behalf of the entire medical supply chain. Most contracts for medical products are locked in years in advance with group purchasing organizations on behalf of providers. When tariffs unexpectedly alter cost calculation of medical products, there is little leeway to revise an existing agreement.

Providers

Hospitals, nursing homes and other healthcare providers operate within tightly managed budgets, many of them tied to government reimbursement rates that do not adjust for rising input costs. When tariffs drive up prices for basic medical products, providers have little recourse. Some may cut back on stockpiling safety reserves, limit investments in advanced care tools, or shift purchasing toward lower-cost alternatives. When surveyed about the impact of tariffs on their health systems, 94% of healthcare administrators said they foresee buying less equipment or delaying upgrades to mitigate financial strain.

Patients

Ultimately, patients will feel the cumulative effects of these pressures on the medical supply chain. Tariff-inspired shortages of critical medical products can translate into delayed procedures, limited access to care, and increased out-of-pocket costs. Approximately 84% of payer executives expect to see higher claims costs due to increased pricing on medical treatments and drugs, and 48% of payer executives believe that insurance premiums will rise within the next 12 months as a direct consequence of increased supply chain expenses.

The challenge

Our healthcare system depends on a reliable, affordable, and diverse flow of medical goods. Tariffs threaten to disrupt that flow at every point along the continuum of care. No single segment of the medical supply chain can carry the weight of tariffs on its own. Because we are navigating this together, we all have a role to play: to ensure that tariffs do not compromise the resilience, efficiency, or equity of our healthcare system. ■

Shifting Culture for Better Hand Hygiene

Determination, resilience and leadership support

During the COVID-19 pandemic, Dr. Emily Landon, hospital epidemiologist at the University of Chicago Medicine, observed a striking shift in hand hygiene compliance across her hospital. Hand hygiene compliance rates soared to nearly 100%. This wasn't due to new mandates or surveillance, but rather because healthcare workers, motivated by self-preservation and patient safety, instinctively changed their behavior. They batched tasks, minimized room entries, and stayed vigilant.

However, once the perceived threat of COVID waned, hygiene compliance dropped rapidly back to pre-pandemic levels. During the GOJO Symposium at the Association for Professionals in Infection Control and Epidemiology (APIC) 2025 Annual Conference, Dr. Landon noted that this pattern reveals how situational and perception-based hand hygiene really is. "We know people are capable," she said. "When they're motivated and focused on providing care safely—both for others and themselves—they find a way to make it work."

Different hospital units reflect this variability. For instance, the burn unit consistently maintains high compliance, particularly in winter months when they treat patients with visible skin injuries. However, during summer when trauma cases rise, handwashing rates dip—perhaps because the infection risk in trauma patients isn't as visually apparent. On the other hand, some ICUs hover around 70%; yet one struggled to surpass 50%—until a *Candida auris* outbreak. Then, hand hygiene compliance jumped to 85%, proving once again that urgency drives behavior change. Still, once the crisis passed, rates declined.

Dr. Landon highlights that hand hygiene is a "tricky beast" because it's one of the first safety practices to be sidelined when staff face competing priorities. And changing behavior isn't simple—it's complex, individual, and often emotional. Like quitting smoking or losing weight, improving hand hygiene requires internal motivation, sustained effort, and personal commitment.

What makes the challenge even harder is that one strategy doesn't fit all. What works on one unit—like using the unit secretary to page reminders—might fail on another. That's why Dr. Landon stresses the importance of culture and peer influence: when more people consistently wash their hands, others are more likely to follow.

Behavior change also mirrors the psychological stages of grief—denial, anger, bargaining, depression, and acceptance. Managers must go through these stages themselves before guiding their teams through them. Progress is slow, nonlinear, and often frustrating.

Ultimately, Dr. Landon reminds us that hand hygiene isn't just about compliance—it's about shifting culture. And in the chaos of modern hospitals, where clinicians are overwhelmed with alerts, documentation demands, and critically ill patients, the simple act of handwashing becomes a complex human challenge—one that must be addressed with empathy, persistence, and creativity.

Road to Fiscal Perdition

Might tariffs have ignited the newest global pandemic?

BY R. DANA BARLOW

Time to tip your ball cap to Yogi Berra because it seems like déjà vu all over again.

After all, it appears that the tariff-driven trade wars dominating media coverage around the world (save for the Chicago metropolitan area that can't seem to get enough of Windy City-area-born-and-bred Pope Leo XIV) may indeed qualify to be elevated to pandemic status. Such a fiscally infectious malady likely would have been called by now if the Department of Government Efficiency hadn't cut the budgets, labor and payroll of the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH).

But seriously, we may have to call it yet another systemwide failure of imagination. [*See "Might supply chain press for the impossible?" June 2024 JHC, pp. 56-57*]

Who would have thought that encouraging the globalization of supply chains to lower production costs during the last few decades or so (for lower raw materials and labor costs balanced to a degree by increased shipping and transportation costs) might backfire if someone lit the wick of a trade war by yo-yoing tariff bluster to appear strong and in control?

Why did companies move manufacturing plants overseas anyway or source components outside of the U.S.? By and large, labor and production processes were cheaper. Further, it made the C-suite and shareholders happy when they looked at profit statements, retirement funds and stock prices, respectively. They didn't have to absorb the higher cost of labor in the U.S. and then pass those costs on to the consumers to protect their profit statements, retirement funds and stock prices. Fair or not (and not a cop-out), that's business, which is driven by the volleying refrains of "show me the money" and "follow the money."

Unfortunately, encouraging through fiscal (and arguably legal) coercion that companies return their manufacturing and sourcing operations domestically likely will force these companies to deal with the higher cost of labor in the U.S. as well as the higher cost of building or repurposing factories, plants and other real estate. Few suspect "newly domesticated" corporations won't pass those costs on to the consumers to protect their profit statements, retirement funds and stock prices.

During a recent Berkshire Hathaway shareholder meeting, revered corporate chairman Warren Buffett not only surprised the crowd by detonating the announcement of his retirement at year's end (after previously stating he would not retire so Greg Abels would succeed him after his death, but, you know, things change), Buffett also took aim at the topsy-turvy trade war launched by the U.S. that seems more like a tete-a-tete with China and other "secondary" world powers than anything else. Buffett chastised Washington that "trade should not be a weapon" and that "there's no question that trade can be an act of war." He further criticized the global instability of the supply chain brought about by the tariff lobs.

Buffett also uttered a time-worn cliché that some in the healthcare supply chain industry historically applied to managing CSCs vs. letting distributors do it because that function, for the most part, is their core competency. "We should be looking to trade with the rest of the world. We should do what we do best, and they should do what they do best."

What can lead you to speculate about the tariff-driven, tumultuous and turbulent trade war may be found in a familiar-sounding description of a Supply Chain USA 2025 keynote panel discussion held by Reuters Events in Chicago in early June. The keynote panel highlighted "a new era of uncertainty and opportunity: How to adapt to tariffs and trade policy." As one of five similar-themed sessions, it listed three deliverables for attendees. They are:

- Develop alternative sourcing options and proactively manage supplier relationships to minimize vulnerability to tariff fluctuations and geopolitical instability.
- Leverage automation, AI, and data analytics to streamline trade processes, improve accuracy in tariff classification, and identify opportunities for duty optimization.
- Collaborate with industry peers, participate in policy discussions to communicate your business needs and enhance resilient strategies.

Been there, done that much?

During the pandemic, consumers, providers and suppliers grappled with depleting products, empty shelves and federal, state and local orders restricting conveniences, freedoms and self-sufficiency in attitude, behavior and consideration and service to others. The response was all about finding actual (terminally on backorder) and alternative products from alternative suppliers and then stockpiling what you could for as long as possible.

These days, it's all about finding actual and alternative resources to absorb the anticipated price hikes for tariffed products and ease the budgetary pressure valve. It doesn't help matters when this latest American revolutionary cry, "The tariffs are coming! The tariffs are coming!" seems to be emanating from Chicken Little.

Supply chain is designed to move with constant – if not consistent – motion in mind and prepped accordingly.

Comparing the tariffs to the pandemic

How might tariffs be like COVID-19 as part of a global pandemic?

1. **COVID-19** was believed to have originated from a people's market in China. The tariffs originated from the people's house in Washington.

2. **COVID-19** was transmitted through airborne particles and unsanitary surfaces and quickly spread worldwide. The tariffs were transmitted through bully diplomacy and spread through media and political reactions, some of which were infected with disinformation and misinformation both on accident and on purpose.

3. **COVID-19** led to calls for wearing masks, sheltering-in-place and closing down businesses and regular publicly accessible areas. The tariffs led to calls for buying a lot of stuff right away before prices spiked, complaining at work and in media and worrying about closing businesses and public places.

4. **COVID-19** motivated some to embrace herd immunity through broad exposure to the virus rather than suppressed conveniences and service access. The tariffs motivated some to embrace blurred impunity to the economic consequences of brash, firehose-driven fiscal diplomacy.

All satirizing aside, the bottom line remains that we should have learned something from healthcare reform in the 1990s, from the 9/11 terrorist attacks and economic unrest in the 2000s, from the struggling economic rebounding in the 2010s to the pandemic of the early 2020s. There's always going to be something to keep supply chain alert, focused, on its toes and ready to act (vs. react). Supply chain is designed to move with constant – if not consistent – motion in mind and prepped accordingly.

Perhaps Peter Brereton, Tecsys President and CEO, said it best in his blog, "Tariffs and the Urgency of Supply Chain Resilience," from April 7, 2025: "The real question isn't what changes when new policies roll out – it's whether your systems are built to absorb that change without grinding to a halt." ■

R. Dana Barlow serves as a senior writer and columnist for *The Journal of Healthcare Contracting*. Barlow has nearly four decades of journalistic experience and has covered healthcare supply chain issues for more than 30 years. He can be reached at rickdanabarlow@wingfootmedia.biz.

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Driving Excellence in Ambulatory Surgery Centers

A Conversation with ASCQC Executive Director Nina Goins.

As the healthcare landscape continues to evolve, ambulatory surgery centers (ASCs) are playing an increasingly vital role in delivering high-quality, cost-effective care across the country. At the forefront of championing safety and performance in this sector is the ASC Quality Collaboration (ASCQC), a leading organization committed to developing and advancing quality measures tailored specifically for ASCs, collaborating with industry stakeholders, and serving as a quality and safety resource center.

Nina Goins, the newly appointed Executive Director of ASCQC, discussed the organization's 2025 priorities, including the launch of the ASC Safety & Quality Assessment and its ongoing efforts to empower surgery centers through benchmarking, education, and practical tools for improvement. With a strong background in ASC leadership and a passion for quality care, Goins shares insights on how the Collaboration supports centers in addressing key challenges.

Another goal was the transition to a new executive director. "I was honored to step into this role in March, succeeding Kathy Wilson, who served as ASCQC's executive director since 2021," Goins said. "Having previously served as the chairperson of ASCQC's Board of Directors, I am deeply familiar with the organization and its mission. I am excited to take on this expanded role and responsibility."

Through ASCQC's mission to advance safe, high-quality care in ASCs, surgery centers, Goins said it's helpful to know the history of the Collaboration. It was established in 2006 to create and promote standardized quality measures tailored to ASCs, with measures designed to be within an ASC's control and meaningful to key stakeholders. The initial efforts focused on universally applicable aspects of care, but over time, the approach has expanded to address gaps identified by national policy organizations.

Advancing safe, high-quality care

One of the ASCQC's top priorities for 2025 is the rollout of their new ASC Safety & Quality Assessment. This initiative invites ASCs to submit data on critical areas such as patient safety, patient experience, admissions and transfers, infection prevention and control, medication management and governance. The goal is to help ASCs benchmark themselves against essential attributes that define a safe, high-quality ambulatory surgical care environment, Goins said.

The assessment period ran from early February through mid-March, with more than 400 surgery centers participating. "We are now in the process of developing benchmarking reports for participants," Goins said. Each center will receive a personalized report featuring both individual results and aggregate findings from all participating ASCs.

These insights can help centers demonstrate their quality to patients, payers, prospective physicians, employers and their communities. Additionally, the reports serve as a tool for continuous improvement, reinforce a center's commitment to safe, high-quality care, and support the broader ASC industry's value narrative.

"We currently collect and analyze safety- and quality-related care data from more than 2,000 ASCs nationwide through our benchmarking and assessment resources. Our clinical quality benchmarking assesses more than 2 million ASC encounters per quarter submitted through our members."

they are building additional resources for improvement such as toolkits (e.g., fall prevention, wrong-site surgery prevention) and raising awareness through speaking engagements, media interviews (like this one) and growing the audience for their LinkedIn page www.linkedin.com/company/asc-quality-collaboration. "Additionally, we are working to expand our new Supporter program, which enables suppliers and vendors serving the ASC community to engage with and show their support for ASCQC's mission."

Standardized quality measures

To understand how the ASCQC defines and measures quality in ambulatory

Once the first set of measures was finalized through a diligent development process, ASCQC members began submitting data, leading to the development of publicly available quarterly benchmarking reports and now the new ASC Safety & Quality Assessment.

"We currently collect and analyze safety- and quality-related care data from more than 2,000 ASCs nationwide through our benchmarking and assessment resources," said Goins. "Our clinical quality benchmarking assesses more than 2 million ASC encounters per quarter submitted through our members."

"We also provide input and work collaboratively with the Centers for Medicare & Medicaid Services (CMS) and other federal agencies on the ASC Quality Reporting Program."

For the benchmarking reports, ASCQC collects performance data for the following ASC facility-level quality measures developed by the organization:

- Patient Fall in the ASC
- Patient Burn
- All Cause Hospital Transfer/Admission
- Wrong Site, Side, Patient, Procedure, Implant
- Prophylactic IV Antibiotic Timing
- Appropriate Surgical Site Hair Removal
- Normothermia
- Unplanned Anterior Vitrectomy
- Toxic Anterior Segment Syndrome (TASS)
- All Cause Emergency Department Visit Within One Day of Discharge
- All Cause Unplanned Hospital Admission Within One Day of Discharge

"Questions in our ASC Safety & Quality Assessment were related to patient experience, patient safety, hospital visits, admissions and transfers, culture of safety, infection control and prevention, medication management, quality and performance improvement, governance and human resources," Goins said.

Participating ASCs can leverage benchmarking data in several valuable ways. First, they gain insight into how their performance compares to similar facilities as well as to their own historical trends. This helps identify areas of strength to build upon and celebrate while flagging operational aspects that may benefit from targeted improvement.

Over time, benchmarking enables ASCs to track the impact of their improvement initiatives, validating whether efforts are delivering the desired results. Additionally, benchmarking can serve as an early warning system, revealing potential downward trends and developments before they escalate into more serious quality and safety issues.

Key challenges in maintaining high-quality standards

As ASCQC's benchmarking data reveals, ASCs generally do an excellent job of delivering safe, high-quality care and maintaining high-quality standards, Goins said. But there are certainly challenges surgery centers must be aware of to help ensure they continue their success in these areas.

"Challenges facing ASCs today include staff turnover and burnout as well as the introduction of new, more complex procedures and rising patient acuity," she said. Quality-specific challenges could include complacency in low-adverse event environments, inconsistent data capture and reporting, and gaps in staff training and engagement.

ASCQC provides ASCs with quality improvement tools and resources aligned with the measures and benchmarking data, empowering surgery centers to identify areas for improvement. "We regularly speak at conferences and engage with the media to share guidance and best practices," Goins said. "We also host meetings and conference calls that foster collaboration and create valuable networking opportunities to support ongoing quality improvement efforts."

Thinking long-term

ASCQC envisions continuing to serve as a trusted partner and resource dedicated to advancing quality and patient safety in ASCs, Goins said. "Through the development, maintenance and public reporting of standardized quality measures tailored to ASCs, we will continue to shine a spotlight on safety and quality, highlight the exceptional work surgery centers perform in ensuring excellence, and identify areas ASCs must prioritize to achieve optimal patient outcomes.

"In addition, our ongoing commitment to fostering collaboration among ASC industry stakeholders – including associations like ASCA and AORN, state associations, management companies, accrediting bodies, technology vendors and other product and service providers – will further support the adoption of best practices and drive continuous improvement efforts and initiatives across the ASC community." ■

Toolkits

In addition to the newest toolkit on preventing wrong-site surgery, ASCQC offers toolkits on important quality and safety areas like endoscope reprocessing, hand hygiene, patient falls, safe injection practices, and sterilization and high-level disinfection. These toolkits include ASC-focused resources, such as guidelines, assessment tools, training materials and monitoring tools. For more information, visit ascquality.org/toolkits.

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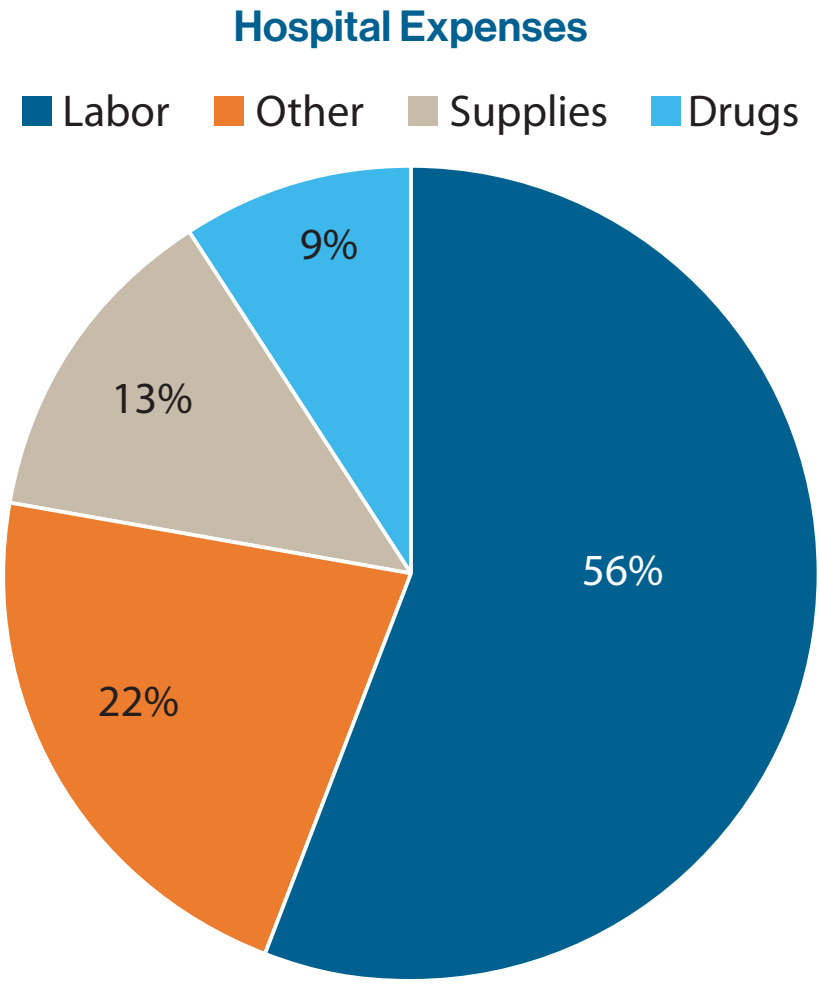
Supply Chain By the Numbers

BY JOHN STRONG, CO-FOUNDER AND CHIEF CONSULTING OFFICER, ACCESS STRATEGY PARTNERS INC

Supply Chain is a strategy – not a tactic

In my almost 50 years of healthcare supply chain experience, I've seen a lot. The most recent words from the healthcare C-Suite about SC are the handwringing over tariffs, and the need for lower prices. This seems to happen each time hospital budgets are threatened, and the supply chain is often asked "to get better prices." With President Trump's proposed changes to Medicaid, Medicare and other services, the voices grow louder. Price is just one part of the equation, however.

If supply expense is reported in three verticals (supplies, drugs, purchased services) these expenses generally represent *the second largest expense* in a hospital after labor costs[1]. Why then do so many C-Suites (often the CFO) look at the supply chain only through the lens of prices paid? This laser focus on price demonstrates too narrow focus on what should be a complete annual supply chain strategy.

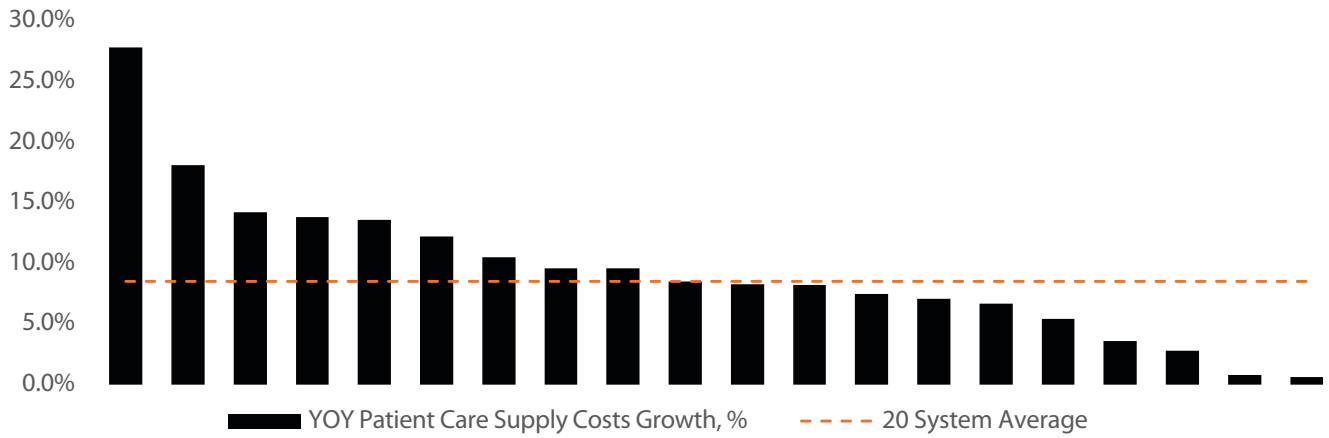


Source: American Hospital Association, © 2025

A recent article in Becker's Hospital Review[2] demonstrates the case in point. It examined supply cost increases from March 2024 to March 2025, and illustrated how supply expenses had increased at 20 health systems. Unfortunately, what is included in the increases could include purchased services and other costs, but the range of increases spans **a high of 27.8% to a low 0.6%**, with an average year-over-year increase of about **8.5%**.

All three national group purchasing organizations (Vizient, Premier and HealthTrust) are represented in the sample of 20, roughly equivalent to their national market shares. This implies that healthcare providers need to do significantly more than just belong to "the right" GPO. The graphic on page 49 shows the amount of supply cost increase across the 20 health systems cited in Becker's article. I've left off the system names because there are a wide range of factors that suggest we are not comparing apples to apples here[3].

Supply Cost Growth at 20 Health Systems
March 2024-March 2025



Source: Data from Becker's Hospital Review, Analysis by ASPI.

The dashed orange line indicates the average increase for the 20 health systems: **8.5%**.

Clearly, what is included in the data may be different among systems, and it is certainly not about which GPO these 20 health systems belong to. Variations in patient volume, levels of acuity, addition or deletion of facilities and other factors play a role.

Interestingly though, this average roughly compares to the "Supply Expense per Adjusted Discharge" reported by KaufmanHall[4] of **8%** from March 2024 to March 2025. During this period, drug and purchased service expenses both increased **6%** according to the same report[4].

Beyond price, what should a good supply chain strategy look like? Here are a few ideas that go beyond the price paid for goods and services. If you are looking at price only, you are assuming that all these ideas are equal across health systems. They are not.

Control of purchase authority. Generally, the control of purchases should be under one central authority anchored by pharmacy and supply purchasing. If you are allowing the undesirable practice of ad hoc purchases or signing of invoices without centralized control it allows for leakage of dollars.

Centralized Control of Expenditures

Control Gateways-Usual Products

- **Drugs:** Pharmacy
- **All Supplies:** SC Purchasing
- **Capital Equipment:** SC Purchasing and Clinical Engineering
- **Service Contracts:** SC Purchasing and Clinical Engineering
- **Everything Else:** SC Purchasing

Other Supply Chain Control Points

- Value Analysis
- Central Processing
- Reprocessing
- Surgical Supplies
- Disposables vs. Reusables
- Printing and Printers
- IT Purchases (With IT)
- Outsources Services

Strategy vs. "integration" of new facilities. Many health systems are growing rapidly and hospital consolidation continues. As you add (and integrate) new organizations into your fold, can you do it without a clear written strategy for supply chain that can be shared with those you are integrating? A one-page strategy focusing on key elements, and a one-page set of overarching (team) goals and objectives is all that is needed. Don't write a book!

Solid information technology that serves supply chain. Too frequently, information technology decisions are still made today without input from supply chain. Not all IT systems are good at everything, and as the complexity of the healthcare supply chain grows, they need IT that serves them, not the other way around. The same IT system must work for all the functions listed in the table on the previous page.

Using your GPO resources correctly. Each of the three national GPOs have their own strategies, including high compliance programs, value-added services and information technology. Aligning your strategy with your GPO is critical, and it can allow you to utilize rebates, credits and free programs in meaningful ways. Looking only at the prices GPO's contract for is often missing the point, although good pricing is certainly important. Can you manage rebates and fee "share backs"?

Meaningful, real value analysis. Is your Value Analysis Committee engaging in meaningful value analysis or is it a glorified New Products Committee designed to keep new or improved products out of your health system? If you run every new products request through "the Value Analysis Committee" you may not be doing VA correctly.

Supply chain goals and objectives that go beyond dollars saved. The old saying "if you can't count it…" is still valid today, but it should be one piece of SC's goals and objectives. Internal customer service and satisfaction, inventory management, supplier management and other factors play key roles. In the past year I witnessed one large supply chain pushing service requirements back on physicians. It takes a team.

Do outsourcing services actually cost more in terms of revenues and expenses?

During challenging times, many hospitals have sought financial relief by outsourcing services. Often these are "overhead" departments such as foodservice, clinical engineering and housekeeping. Taking a long view, such as five years, is necessary to really evaluate the true value of outsourcing.

Revenue producing departments

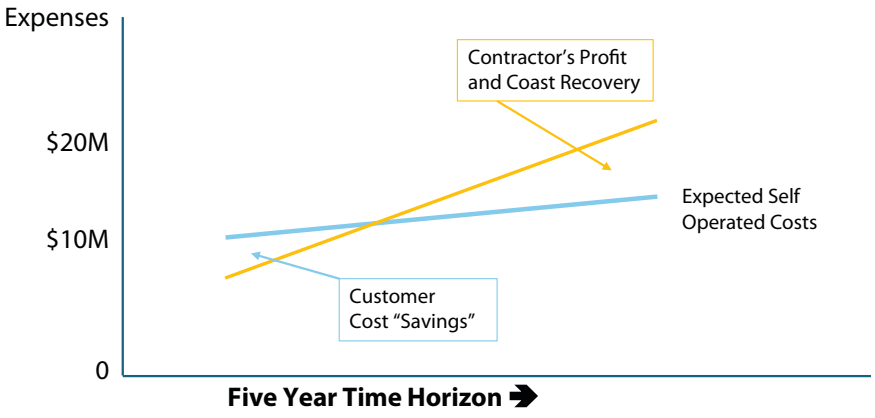
In a recent report, Mayo Clinical Laboratories maintained that "Hospitals that retained control of their lab service line grew net patient revenue (NPR) at a higher compound annual growth rate (CAGR) than hospitals that relinquished control, which realized **1.4%** lower rate of growth."[5] [in NPR.] For an $8B system, retaining the lab services yielded **$1.8B** in additional revenue vs. outsourcing over five years!

This same study maintains that in 2022, the average length of stay (LOS) for hospitals that relinquished control of their lab between 2013 and 2018 was **5.25 days**, compared to **4.85 days** for hospitals that maintained control. That 1% difference in LOS translates to **$303M** in additional discharge costs for a 15-hospital system with 4,500 beds.

Overhead expense departments

Offloading full-time staff (FTEs) to an outsourced services provider is often tempting, because there is usually savings offered to the facility in the first year. Sometimes, the company will also offer capital (such as $1 million to improve the dining room) as an up-front inducement to sign a contract. Saving costs and gaining capital looks like a great deal. Taking the long view over five years, those cost savings and capital investments must come from somewhere in the contract.

Outsourcing Overhead Departments



While there can be distinct benefits to using a service provider, such as increased quality of service, gaining expertise and other factors, there is also a distinct cost generally associated with outsourcing. This may include reductions in staff without corresponding gains in efficiency, leading to lower levels of department overall services.

While outsourcing is convenient, may bring in "experts" and relieves certain administrative burden, it is not necessarily a cost-savings measure without careful attention to the facts in the contract, and what your long-term budget strategy is. Taking the long view may be the best option.

Study shows the need for supply chain expertise in ASCs

An L.E.K. 2024 ASC (Ambulatory Surgery Center) Insight Study of 150 physicians, medical directors, administrators and nurses revealed that **58%** of respondents already partner with hospitals or are planning (or considering) partnering with hospitals[6]. This result may be partially because of the financial challenges faced by ASCs across the U.S. Approximately **31.3%** of ASCs surveyed in 2025 report rising operational costs as their greatest challenge, at a rate of about **9%** annually[7].

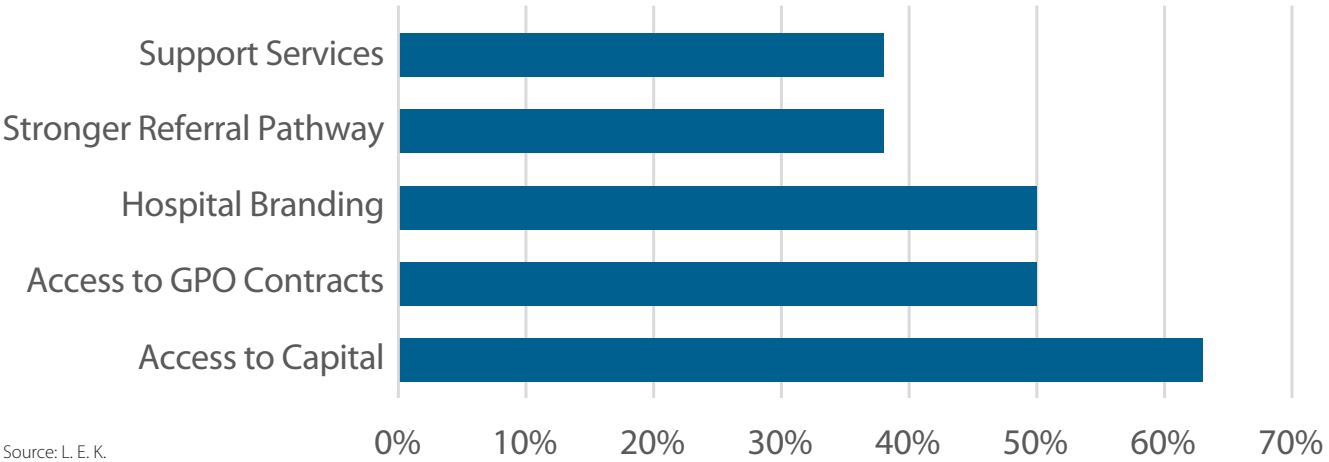
Interestingly, the L.E.K. report showed that **50%** of their respondents want "Access to GPO Contracts." While lower prices can solve certain problems, better purchasing is just one element for better control of expenses, logistics and inventory in ASCs.

As more procedures move from acute care to ASCs, is your supply chain supporting your health system's ASCs, or can they in the future? Bringing forth GPO pricing to them can be just one of many services that today's supply chains can offer to improve the financial outlook of ASCs around the country.

Looking at orthopedic products and the prices paid based on your GPO may be a good start and comparing them with what your ASC(s) are paying. In 2023, approximately **31-34%** of outpatient orthopedic procedures in the U.S. were performed in ASCs. Orthopedics now accounts for about **27-31%** of all ASC procedures. By 2030, projections indicate that over **50%** of joint replacement surgeries, a large subset of orthopedic procedures, will be performed in ASCs. A rough estimate is that **50-60% of all orthopedic procedures could occur in ASCs by 2030**[8].

Is it time to see what's happening in your ASCs? ■

Why ASCs Consider Hospital Partnerships



Source: L. E. K.

1 The Cost of Caring: Challenges Facing America's Hospitals in 2025, © The American Hospital Association, April 2025.
2 www.beckershospitalreview.com/supply-chain/how-supply-costs-have-grown-at-20health-systems.
3 ASPI analysis of Becker's data.
4 KaufmanHall, "Hospital Flash Report", accessed July 1, 2025, at page 8.
5 Mayo Clinic Laboratories, "5 data-driven reasons executives should retain their lab service line", accessed June 24, 2025.
6 L.E.K., "2024 ASC Insight Study", Accessed July 2, 2025, © 2024 by L.E.K.
7 Holly, Robert, "From Budget to Burnout: The Top ASC Challenges Defining 2025", Ambulatory Surgery Center News, March 25, 2025, accessed July 3, 2025.
8 Grandview Research, accessed July 1, 2025.

Contracting News

Amazon, Hackensack Meridian Health plan 20-plus clinics

Amazon One Medical and Edison, N.J.-based Hackensack Meridian Health continue to open clinics across New Jersey to expand access to primary care. The two organizations joined forces in 2023 to co-open the offices and make Hackensack a specialty care referral partner of Amazon One Medical. So far, the organizations have One Medical offices in Edgewater, N.J., with plans for Jersey City next month, Englewood in 2026 and Hoboken in the future, according to NJBiz.com Amazon One Medical has about 20 health system partners across the U.S.

Intermountain Hospital begins construction on 'once-in-a-generation' replacement hospital project

Intermountain St. Vincent Regional Hospital has celebrated the start of construction of the new Intermountain St. Vincent Regional Hospital – a "once in a generation" investment in the health of the Billings community and region.

The new hospital will be a 14-floor, 737,000 square-foot facility located at 27th Street and 12th Avenue North just east of the current hospital building.

This will be a full-replacement hospital, meaning the current Intermountain St. Vincent facility will be replaced, and upon opening, all current services offered at Intermountain St. Vincent will transfer to the new facility.

BayCare expands nurse well-being program systemwide, cuts new hire turnover to zero

BayCare Health System's successful effort to address nurses' stress is expanding across all 16 of its acute-care hospitals in 2025, according to a press release. With this program, Nurse Well-Being, BayCare has reduced nurse burnout by 34% and cut its new hire turnover rate to zero in the first year. The nurse well-being program will spread to more than 160 inpatient units, following a successful three-year pilot that significantly improved staff retention, communication and workplace culture.

CMS estimates U.S. health spending grew 8.2% in 2024

The Centers for Medicare & Medicaid Services estimated national health spending grew 8.2% in 2024 and expects a 7.1% increase in 2025, the agency reported June 25 in Health Affairs. CMS projects national health spending will average 5.8% per year through 2033, led by a 7.8% increase annually in Medicare spending. ■

AdventHealth acquires physician group

Altamonte Springs, Fla.-based AdventHealth has acquired Bond Clinic of Winter Haven, Fla., a 90-provider physician group that comprises 28 specialties. AdventHealth purchased the group's multi-specialty assets and care sites across Polk County, Florida. The acquisition brings the group under AdventHealth, which comprises more than 4,000 employed physicians and advanced practice providers.

The integration of Bond Clinic brings hundreds of team members and providers into the AdventHealth family, further expanding consumer access to whole-person care across Florida.

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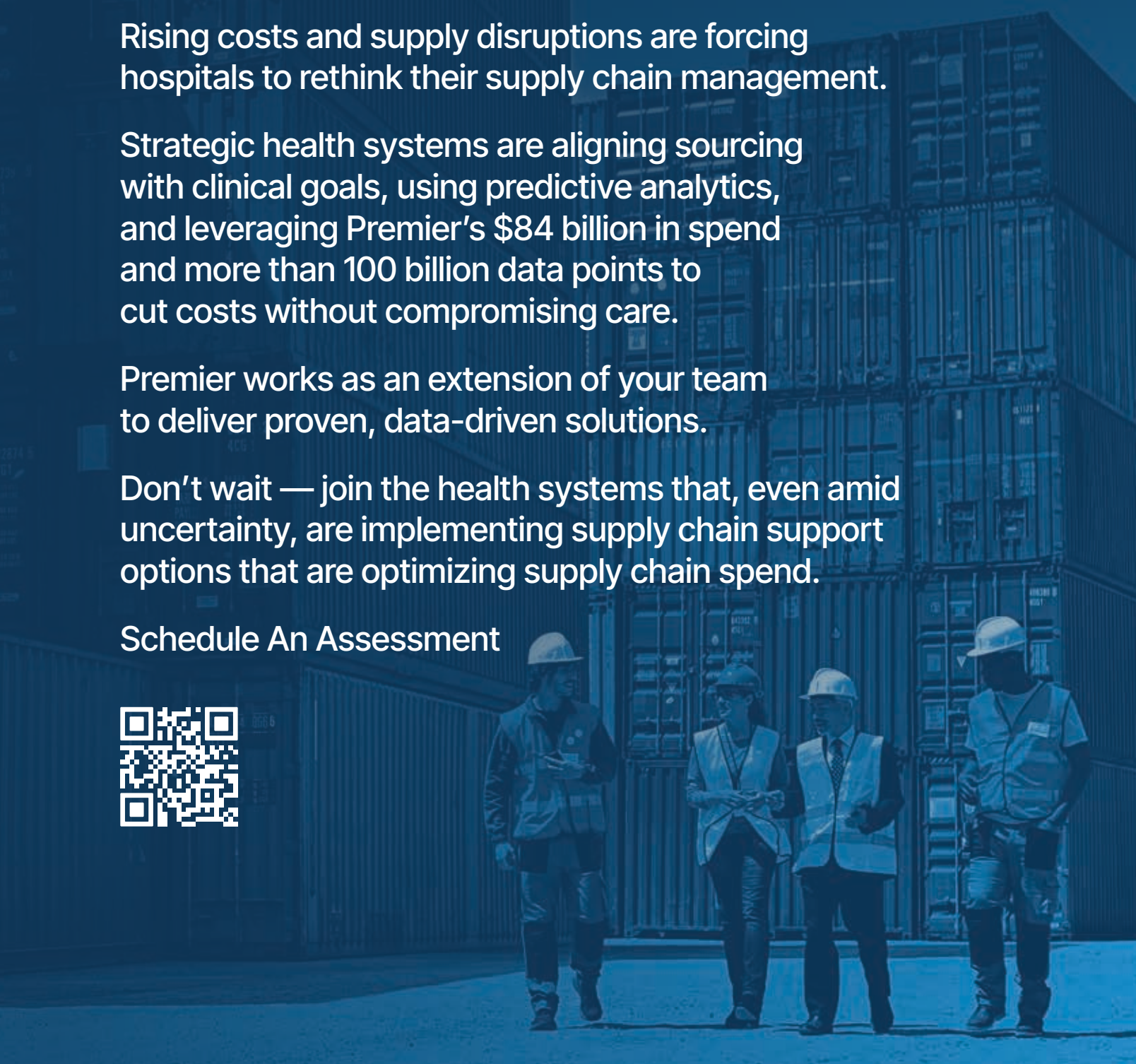
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