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"You have to know the past to understand the present."
Dr. Carl Sagan

Expense Reduction in Wonderland?

Once upon a time, according to the book, *Alice in Wonderland*, Alice came upon the Cheshire Cat and asked for directions. "Would you tell me, please, which way I ought to go from here?" she queried. "That depends a great deal on where you want to get to", said the Cat.

Examining this dialogue can explain some of the reasons the healthcare industry has not been highly successful in its efforts to reduce non-payroll expenses effectively.

Let's assume for a moment that Alice is like a Director of Materials Management in healthcare during the mid-1970s (the period when the industrial concept of materials management began to emerge in healthcare). As well-intended as the concept was planned to be in the 1970s, introduction of the concept of materials management into the healthcare industry caused immediate push-back from departments such as pharmacy, dietary, plant operations, laboratory, etc. This push-back manifested itself by the department's refusal to abdicate responsibility for their purchases or control of their inventories. Additional resistance came from managers of clinical departments when they refused to accept input by or influence from "lay" personnel in the selection of alternative products, preparation of specifications, or even the selection of distributors. As a result of these reactions, the potential for the benefits of a materials management concept in healthcare was never fully realized.

NOTE: For the purpose of simplification, the title Director of Materials Management or DMM will be used throughout this article to signify supply chain executive or professionals with similar titles who are assumed to be responsible for managing and reducing non-payroll expenditures.

DMMs, to a fair extent, have searched for direction for several decades. Like Alice, they have had the option of selecting between two "paths." One would enable them to manage materials (limited to non-silo based supplies) and focus on maintaining the flow of merchandise throughout the organization (excluding supplies deemed "sacred" by managers of some silos). The other "path;" involving all product specifications, source selection, as well as the efforts to reduce expenditures for all supplies, capital equipment and purchased services organization-wide, would be laden with obstacles; some of which could be career threatening.

The Shift in Emphasis to "Materials"

External

Traditionally, suppliers prefer DMMs to focus on soft factors; e.g. freight, inventory control, billing systems, etc. instead of hard factors which can have a more dramatic effect on their profit margins; e.g. price reduction, generic acceptability / conversion, make - buy analysis, demand matching, conservation through reduced consumption, etc.

Over the past 8-10 years, as part of sales and marketing strategies to protect profit margins, a majority of manufacturers and distributors opted to place an emphasis on the virtues of systems and processes referred to as being critical components of "supply chain." At the same time, several major software companies resolved the problems associated with the general ledger interface through the development of comprehensive materials management information systems (MMIS) and enterprise resource planning (ERP) programs. The availability of such systems enabled providers with access to a voluminous amount of previously non-existent data.

Recognizing the opportunity to further shift emphasis of providers away from issues that could directly impact profit margins, suppliers of hospital products and services invested considerable money in the promotion of the need for providers to place a greater emphasis on optimizing the new data in order to achieve expense reductions through "supply chain" initiatives.

Do not misread these comments. It was nearly impossible for members of the Executive Team or for DMMs to overlook the fact that the healthcare industry had and still does suffer from the lack of adequate data. The question is not whether the issue warrants attention to data. Instead, the real question should be whether or not the issue deserves the near - exclusive focus and energy being devoted to it by the individual typically responsible for facilitating organization-wide initiatives to ensure change in order to maximize the value of the data.

Are precious human resources being wasted in gathering, interpreting, and regurgitating irrelevant and meaningless data? Does the shear volume of data available for analysis overwhelm many DMMs to the point where the "right" data isn't maximized? Does the workload associated with massaging data prevent the DMM from having the time to "sell" its applicability to department managers? Do they have the skills and/or credibility to "sell" it? Has the supplier side of the hospital industry guided the C - suite to place a greater emphasis on controlling inventory, the flow of merchandise, minimize shrinkage of products and the capture of revenue through patient charge mechanisms? Has the C - suite unintentionally and unknowingly shifted the focus of managing expenses to "supply chain" issues to the point where the DMMs do not have the time available to function as a leader in other critical aspects of expense reduction? Is time available and have the incumbent personnel evolved to possess the skills associated with the dynamics of change management; i.e. resource management issues?

The aforementioned questions are only a few that must be considered when the need to reduce (not merely contain) the 50+% of every hospital dollar expended becomes the critical issue. Quite simply, until the cause of a problem is identified, a cure cannot be found. In the case of the nation's insurance dilemma, until the root cause of the problem is clearly identified and efforts to "cure" the problem are initiated, the nation's reform of the insurance side of the healthcare industry will never be resolved. Money will merely be shifted from "one pocket to another." Taxation will never be the answer to resolve the

nation's healthcare crisis and further cuts in Medicare and Medicaid will only intensify cost shifting; a consequence that has contributed heavily to the problems in the healthcare industry.

Internal

Department managers and members of the medical staff have grown accustomed to having the freedom to select their own products and, in many instances, even the distributor from which it should be purchased. Simply put, it has evolved that the role of DMMs is usually viewed as being merely mechanical / functional to perform rote tasks to support customers, rather than as a critical and invaluable internal consultant / resource to provide guidance or alternative solutions to reduce expenditures.

What's in a Title?

As mentioned previously, the healthcare industry has adopted a title from the manufacturing industry—supply chain manager / director. Again, while interpreting actual duties based on a title may be too literal, the "chain" concept evokes a linear picture of this position focusing on the pulling or pushing of supplies. Shouldn't the perception of this position evolved into one of facilitating and leading critical expense reduction strategies? In his most recent book, The Agenda, Michael Hammer commented on supply chain when he wrote, "The term *supply chain*, like many other business terms, has been co-opted, debased, and reduced to a euphemism for procurement, much as *human resources*, has become a politically correct name for personnel."[1]

Over the past several decades, the shifting of the focus onto the management of supplies has not been a wasted effort. Historically, providers have been horrible at managing inventories and some still are; especially within some of the silos. Obviously, there has been a need to strengthen the management of inventories while maintaining service levels of operating departments. Unfortunately, however, limited time and the lack of adequate resources have left many DMMs with one "path" to follow.

The obvious choice of DMMs has been to refocus their efforts on providing essential customer service while devoting any remaining time to internal consulting for expense control and cost reduction. During this shift of focus onto traditional "supply chain" processes, the lack of internal resources has contributed to the increased utilization of group purchasing contracts.

Over the past decade, government guidelines relevant to group purchasing organizations (GPOs) resulted in the development of multi-source contracts by most of these organizations. Such contracts were developed for many of the most expensive products consumed by providers; most notably physician preference products such as pacemakers, hip implants, etc. Unfortunately, because internal processes to establish mechanisms for adequate input and evaluation of these expensive implantable products is so time consuming and individuals with skills in inter-disciplinary communication are basically non-existent in hospitals and health systems, most providers have opted to merely utilize multi-source GPO contracts where only token discounts are typically offered.

[1] Michael Hammer, The Agenda, Three Rivers Press, New York, NY, 2001

Are mindsets regarding the role and true potential of DMMs being misdirected? If so, what will be the long term impact?

Pitfalls to avoid

Today, the perception of the concept of materials management is drifting further away from the original vision of being a leader / facilitator for managing organization-wide non-payroll expense management initiatives. To survive in their positions, many DMMs are following the safest "path" in order to produce meaningful outcomes for their employers; thinking that this will secure their positions. While in contrast, providers are becoming enticed to outsource that position or ones associated with supporting initiatives to reduce non-payroll expenditures in an effort to obtain more meaningful results; usually attainable because the providers of these services offer configurations of infrastructures which utilize clinicians and personnel with essential skills training in various aspects of human capital (organizational change and inter-disciplinary communication).

A trend also appears to be emerging with regard to unbundling and outsourcing of various elements of the management of materials; i.e. "supply chain" (to distributors, GPOs, manufacturer's representatives, management firms, third party logistics companies (3PLs) or a combination thereof. Such segmentation dramatically dilutes the leadership cohesion essential to focus on creating a unified process to reduce all non-payroll expenses on an organization-wide basis. It also precludes the ability of large and complex providers (and systems) to readily interface knowledge and information.

At the same time, a small number of organizations are gradually making an effort restructure their operating mechanisms to divide the facilitation and leadership duties which should be assumed by the DMM throughout the executive team and middle managers. This trend is also unnerving because, due to the lack of meaningful results in the past, providers may erroneously assume the concept of centralizing expense management and reduction does not have merit (despite the fact that such shortcomings are actually due to the providers - not the practitioners).

As we move into an environment which will demand the conservation of every available dollar, providers would be wise to re-examine all previous decisions regarding inventory management and internal distribution practices. Tough questions will have to be answered sooner or later on issues such as whether or not dispensing cabinetry is truly cost-effective, what is the real, net cost to operate in a J.I.T environment in comparison to other options, etc.? Are measures taken to control lost charges truly necessary and cost effective?

The issue of a selecting a "path" brings to mind one of the laws of systems thinking addressed by Peter Senge in his bestselling book, The Fifth Discipline. His tenth law is, "Dividing an elephant in half does not produce two small elephants."[2] Are some DMMs cutting the elephant in half out of necessity due to inadequate staff, lack of direction, or the lack of support? If the real issue is attempting to address the big picture of non-payroll expense reduction (the elephant), it will not be solved by splitting the issue into two pieces; one to address today (supply chain) and one to worry about in the future (leadership for expense reduction).

[2] Peter Senge, The Fifth Discipline, Currency Doubleday, New York, NY, 1990

This issue is particularly relevant because the future of expense reduction in the hospital industry will depend upon the recognition by executive teams and the boards of providers that two separate and distinct processes must be active simultaneously; i.e. availability of staff devoted to focus on the reduction of all non-payroll expenses as well as individuals capable of maintaining high levels of customer service ("supply chain" duties).

Because customer service is critical, maximum efforts to maintain excellent levels of customer service must be maintained. Any decrease in service levels would kill the credibility of efforts to create the essential foundation from which a culture of change acceptability can be created; the cornerstone for expense reduction processes. So, the commitment must be made to address the full, broad based needs of the organization; making the investment and relying on ROI. On the other hand, if the Executive Team decides or has decided (perhaps with the insistence/guidance from the Board) to limit their view of the objectives they expect from personnel allocated for resource management to focusing on customer service, this issue is a moot point and the elephant will die.

Finding an Expense Reduction Leader

Expense management within healthcare provider organizations has changed dramatically over the past decade or two.

The mindset must shift from management and control onto reduction; a process that will require the creation of the "right" processes and operating mechanisms, having access to the "right" tools, selecting the "right" personnel to execute the strategies and provide the "right" tools to educate and train these individuals in the array of skills essential to lead inter-disciplinary processes.

Unfortunately, the majority of the hospital industry is unable to identify operating mechanisms that will enable substantial reversal of current trends. To complicate the problem, the perception of the role of DMMs has prevented these individuals from obtaining the essential skills to transition themselves into the role of an executive capable of leading the organization to create processes that overcome change inertia. In fact, few training and educational programs (other than one to two hour presentations offered at the professional society's annual meeting) provide opportunities for skill set enhancement. Instead, most offerings address the "supply chain" aspects of the profession.

We have dubbed the problem of the regression of expense reduction leadership in healthcare the Paul Principle. Unlike the Peter Principle (i.e. individuals are often promoted to the point where they reach their level of incompetence), the Paul Principle does not address individuals reaching a point of being incapable of meeting the demands of the job. Instead, the concept focuses on the process of expecting an individual (regardless of their education, experience or capabilities) to meet the demands of a position that has evolved to require such diverse skills and adequate time that no one person is capable of meeting the organization's demands.

In some instances, the Paul Principle has applied when people are promoted into positions which are beyond their abilities and that of nearly everyone else to perform. Historically, this phenomenon occurred when people were assigned to previously nonexistent positions

which incorporated their existing job description as well as increased duties and responsibilities; without enhancing the supporting infrastructure. In nearly every instance, these individuals were incapable of achieving the anticipated level of performance or producing the desired outcomes because the scope of the job had become so demanding. Over time, the problem such problems have intensified because the needs of provider organizations have grown substantially year after year.

Unfortunately, since the constraints of traditional budgetary methodologies have not adequately emphasized ROI, providers have not configured processes to effectively reduce expenses, to hire the "right" individuals to manage these processes, to identify the necessary tools to optimize outcomes and to develop a pipeline for training and education of these key personnel to maintain their viability.

Today, the pitfalls of the Paul Principle continue to plaque the healthcare industry as providers seek to replace individuals who leave their jobs for whatever reason.

When did the position of DMM become disrupted?

As it pertains to expense management in healthcare, the management glitch that initiated the Paul Principle initially occurred when the fee for service era was transformed, by regulation, into a system based on a ratio of cost to charges (Medicare/Medicaid). Until that change took place, providers had no reason to challenge procurement and expense reduction practices. They were simply unnecessary. When the change did take place, however, many departments became "revenue centers" for other payers and were allowed to function quasi-autonomously (as silos within the organization) provided they generated targeted profit. As the aforementioned changes occurred, the demands placed on the DMMs to facilitate change within the organization when its silos had been strengthened as a result of "survival-driven" behaviors, doomed many of these professionals to failure due to the lack of support (authority) and the skills to function in such an inter-disciplinary quagmire.

Despite the introduction of capitated reimbursement for Medicare and Medicaid, due primarily to the ability to cost-shift between payers, the silo mentality continued to thrive within healthcare. Today, despite changes in reimbursement and intensifying pressure to manage expenses more effectively, not much has changed to dismantle the silo cities which comprise healthcare organizations.

As hospitals evolved into today's conglomerates of silos, most organizations were slow to react as incremental changes began to force the need for substantial reduction of non-payroll expenses. It was during this period (early 1980s) that many hospitals decided to mimic manufacturers by creating the position of Materials Manager. Most did so without understanding the true purpose and potential benefits of a trained Materials Manager. So, in a majority of instances, these positions were merely filled by the Purchasing Manager (Paul Principle). When these positions were created, the Directors of Materials Management did not know that they were about to enter a battlefield, one littered with "mine" fields.

Upon attempting to assume responsibility for organization-wide processes relating to all products and services, they quickly learned that it could not include "all" departments. Many physicians as well as clinical and technical department managers resisted passively

or rebelled en masse by saying "those decisions are mine to make", "the patients are mine and only I can decide what will be used on them," etc. Unfortunately, the careers of many committed professions were killed during those battles; others were maimed so badly that it was impossible for them to perform the necessary duties to meet the needs of the organization. These unfortunate circumstances figuratively altered the genes of these professionals for several decades.

Training and education deterioration

As mentioned previously, starting in the early 1980s, the essential management and leadership skill set training and education of DMMs deteriorated rapidly to the point where it is nearly non-existent. This deterioration started as when local or state hospital associations began to eliminate education and training programs to support the professional growth of within their member organizations. These changes were, unfortunately, an outcome of changes in reimbursement that eliminated the money to support such services provided by hospital associations for their membership.

At the same time, revenue shortfalls required these organizations to raise revenue in order to survive. As one means of generating revenue, most hospital associations adopted the use of contract administration fees from group purchasing contracts. They also developed other shared services as a means of generating income; including conducting educational conferences with fees competitive with commercial companies. These revenue sources worked well until the national organizations, such as VHA and later Premier, became competitors as their services were more widely utilized. Once again, hospital associations found their revenue base shrinking dramatically. Without the availability of many options, within a five to eight year period, nearly all of these organizations were forced to develop fee-splitting relationships with national GPOs to maintain adequate cash flow. While those relationships allowed the local and state associations to operate other shared services in order to generate additional income; the variety of the services diminished over the next several years when the national GPOs also began to provide some of these same higher volume/more profitable services.

Throughout the 1980s, changes in reimbursement methodologies challenged providers to find new ways to reduce operating expenses. As one way to reduce expenses, money allocated to educational conferences, including travel expenses, was reduced even further by providers. With clinicians receiving the highest priority, little or no money was left for educational opportunities for personnel associated with non-payroll expense reduction opportunities. Within only a few years, the emergence of annual national meetings of the newly formed GPOs/shared service alliances became the primary source for expense reduction information. While the large annual meetings of these national organizations incorporated educational sessions for many key managers specific to their specialty, time constraints limited the topics for expense management professionals to practice benchmarking (i.e. best practice examples which promote incremental enhancements to current practices). At the same time the evolution of annual meetings and conferences was taking place, the emergence of "materials managers" as the perceived front-line response of providers to deal with the need to reduce non-payroll expenses was beginning to take shape.

To offset the decreasing number and quality of educational offerings at a time when the need was increasing, the professional materials management societies expanded and enhanced their national and regional meetings. Over the past decade, in order to compensate for dwindling allocation of money for these meetings by providers, societies such as the Association of Healthcare Resource and Materials Management (AHRMM) were forced to utilize supplier-based processes such as sponsorships and product fairs to generate revenue. Since many materials management professionals believed suppliers were unlikely to spend money that is not in their best interest, this dependency on sponsorship lead some professionals to believe the educational content was biased. Accordingly, some individuals gradually drifted away from even these offerings.

Clearly, while the need for intense training and education of personnel responsible for the management and reduction of non-payroll expenses in hospitals has increased dramatically, money allocated to this need has decreased proportionately. At the same time, the educational forums and trade journals are nearly limited exclusively to practice benchmarking; much of which is slanted toward the management of materials ("supply chain" issues) rather than the skills necessary to enhance their human relations needs. Where can these people obtain the critical skills set training they need? Aren't the skills required for optimal performance of the duties relative to assuming a leadership role in expense reduction processes dramatically different than those of managers of clinical/technical departments?

The lack of adequate processes to address non-payroll expenses are obviously the result of errors of omission brought about by the evolution of healthcare over the past 35-40 years rather than commission by incumbent executives. Regardless of the reasons, however, it is obvious that the healthcare industry must now act to correct past errors. Accordingly, to fully understand the problems resulting from the evolution and to be able to reconfigure processes appropriately, it is essential to view the organization as a whole.

In the book, Unstuck, Yamashita and Spataro offered an excellent suggestion when they wrote "…we find that moving forward often requires zooming out so you can see the big picture."[3] They further explained how to observe the full impact of operations riddled with silos when added, "…viewing one's company not as a set of functional silos, but as a family of interrelated processes-processes that must be synchronized and aligned to support business goals."[4]

Today, because healthcare organizations have failed to fund infrastructures to neutralize the onslaught of professional marketing and sales tactics used by suppliers, these tactics have knowingly and intentionally fueled the growth of silo processes to the point where they are thoroughly embedded into nearly every organization; controlled by department managers as well as physicians.

The results of the Paul Principle are a classic example of a cause and effect scenario. Very few healthcare organizations have established organization-wide expense reduction strategies and their Director of Materials Management or their functional equivalent is rarely "allowed" to even meddle into the expense management/control protocols within silos. Administrative personnel have evolved into being reluctant to deal with the fallout

[3] Keith Yamashita and Sandra Spataro, Unstuck, The Penguin Group, New York, NY, 2004, p.16
[4] Ibid, p.47

caused by mandating control of or authority over expenses attributable to the various silos, despite the crucial negative financial impact. Today, only a small number of progressive healthcare organizations are instituting effective measures to dismantle silo mentalities. These proactive organizations have identified the need to reconfigure their expense management practices into dynamic processes to create meaningful reductions in non-payroll expenditures.

Low urgency causes high complacency

Another dangerous error many healthcare organizations have made in the past is to model their business practices after patient care protocols; i.e. addressing problems step-by-step as opposed to simultaneously starting multiple initiatives. One example would be the process for converting to an organization-wide IT platform. While the actual kick-off to start-up process can easily span more than 15-18 months, many providers prefer to wait for certain milestones to be completed prior to initiating critical processes necessary to "clean" data and standardize input practices (eliminate variation in order to eliminate errors). This practice is prevalent during implementation of materials management information systems (MMIS) and enterprise resource planning systems (ERP) despite the fact that it is known that product standardization is a necessity for optimal results. Whether the decision to delay the initiation of standardization processes is attributable to the lack of manpower, the sheer magnitude of the project, the lack of cooperation from essential participants, or some other excuse, waiting 15-18 months to initiate a process which is critical to the outcome of the initial phase adds another 12-15 months onto the project; exclusive of the time necessary to de-junk the system. Depending upon the size and complexity, such improper planning can waste tens of millions of lost opportunity dollars.

Clearly, healthcare organizations can no longer avoid the development of processes to deal with the reduction of all aspects of non-payroll expense management. Aggressively pursuing the creation and development of such processes and assigning the task of leading and maintaining them to the "right" individuals is not merely an operational necessity; it is a financial imperative in today's environment.

The problems associated with the Paul Principle are becoming critical (i.e. can the designated individuals really meet the demands the organization has in order to ensure fiscal stability).

DMMs are now expected to be able to lead the organization's expense reduction initiatives but the department managers and physicians perceive them as being in a support role as opposed to one of leadership. Exacerbating the problem for DMMs and their employers is the fact that today's generation of DMMs has not had access to the skill set training and education necessary to prepare them to succeed in the role they are being expected to perform. They are victims of the Paul Principle.

In his book, Leading Change, John Kotter addresses the need for change by explaining that environmental changes requires organizational change and structural change is needed to

produce behavioral change.[5] Providers that have been the most successful at making critical results become a reality with regard to reducing their non-payroll expenses effectively are those organizations that have reconfigured their structures and processes. Failing to make the necessary changes will result in the "Old Bob/New Bob" scenario. (Where a new DMM merely replaces another DMM; regardless of what the new/revised job description says).

Summary

The Future

With just a bit of scenario planning, (futurecasting[6]) providers should be able to recognize the need for the development and leadership of organization-wide efforts to reduce all non-payroll expenditures. Also, except in relatively small organizations, there is an obvious need for someone to oversee the management of materials but that individual may not have the time or skills to focus on resource management and the facilitative leadership (i.e. leadership without authority) necessary to ensure dramatic reductions in non-payroll expenditures.

Obviously, even after MMIS / ERP systems are fully operational, someone will have to serve as the systems operator / administrator. Will that person have the skills, time, and credibility to convince "users" to make the necessary changes indicated by the data?

Minimally, provider executives need to closely consider that question as well as the following issues:

- What the "real" role of a DMM is in today's environment? Also, is the need changing? What will it be in the future?

- If the incumbent DMM does not lead efforts to reduce non-payroll expenses on an organization-wide basis, who does?

- Is the DMM devoting the adequate time to truly enhance their leadership, facilitation, and communication skills to the level necessary to meet the needs of the organization? Do they have adequate time available for change management skills training?

- Where a decision has not been made for the organization to develop a MMIS/ERP platform on an organization-wide basis, will the planning process be initiated soon? Since the organization's need for such a system is inevitable, further delays could compromise the ability of personnel to meet the management and leadership needs as they evolve – simply because their time and energy is consumed by the implementation of the critical infrastructure.

- If the decision has been made to proceed with a MMIS/ERP platform, the task of implementation should not be allowed to "drag out" over a protracted period. If plans do not call for high priority / urgency on the installation of the system, the ROI from outsourcing that task should be carefully considered. Wouldn't such

[5] John P. Kotter, Leading Change, Harvard Business School Press, Boston, MA, 1996
[6] Keith Yamashita and Sandra Spataro, Unstuck, Penguin Group, New York, NY, 2004, p.60

action provide expense management personnel with the necessary data to enable someone within the organization to focus on **reducing** non-payroll expenses while others focus on the management of materials?

- What comes after the task of establishing inventory and data control processes? Are DMMs being typecast into a particular role based on the perception of what their position is thought to be? Does the incumbent DMM and their staff have the skills to reshaping opinions and attitudes regarding non-payroll expenses?

The DMM need not become an "Alice"! Without adequate planning and direction (i.e. a clearly defined purpose and detailed objectives), many DMMs could be following the wrong path rather than being recognized and utilized as one of a part of the organization's most valuable assets; a team of individual who collectively have the skills, tools, recognition and support to lead an organization-wide process to reduce non-payroll expenditures.

Taking path A or B may provide a short term solution but the problem will not be resolved. The big picture resolution may require simultaneous approaches to address the various issues; none of which would require having the DMM assume control of or authority over silo-based practices.

The real potential for optimal outcomes in expense reduction will be realized by avoiding the Paul Principle (i.e. not dooming the individual to fail because the task far exceeds the skill set, available time or acceptance of the position as being one of leadership as opposed to support).

If current trends continue, maximizing the real potential from DMMs may not be a dead issue but it is conceivable that today's atrophy will continue to the point where the concept may make the endangered species list in the not too distant future.

The future of effective non-payroll expense reduction will be in the creation of a innovative team of individuals focused on leading the organization through the creation of an organization of change acceptability; one that ensures department directors and physicians collaborate and have input into decision making processes.