PPE supply chain a continuing issue for healthcare in COVID-19 crisis

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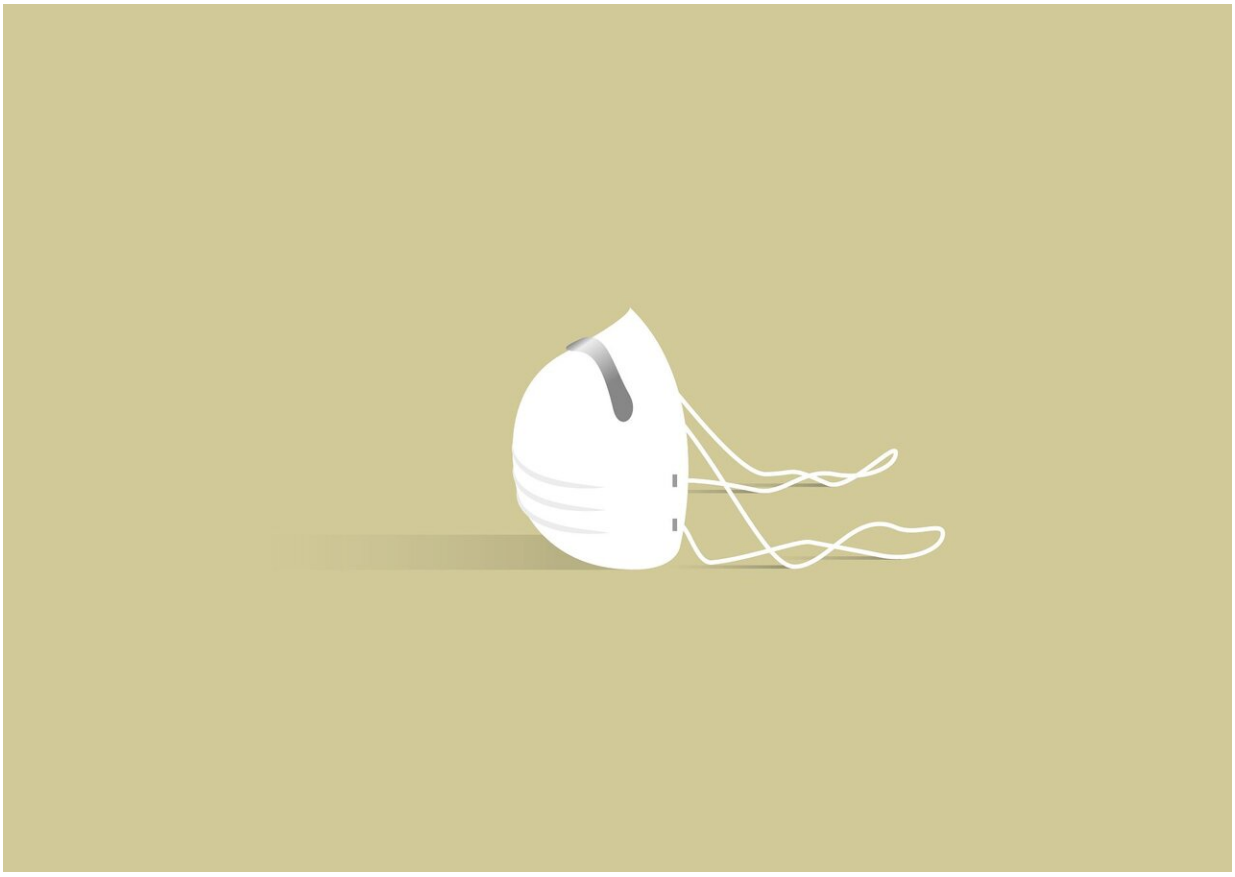

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Getting personal protective equipment to the frontlines while America fights COVID-19 has more twists and turns than it may seem, but

thinking about the supply chain from a disaster recovery perspective can help, a University of Arkansas researcher says.

David Dobrzykowski, an associate professor of supply chain management at the Sam M. Walton College of Business, was the founding director of the Master of Science program in Healthcare Services Management at Rutgers University and had a 13-year career as an executive, serving as chief executive officer and vice president in the healthcare sector, working for organizations such as BIDON Companies, Corporate One Benefits, Bon Secours Mercy Health and UnitedHealthcare

He said the healthcare sector faces a Catch-22.

"With the traditional supply chain unable to fill the gap between production and consumption, many hospitals have had to source personal protective equipment, or PPE, directly," Dobrzykowski said. "Direct sourcing is a new approach to most hospitals because they have historically relied on distributors and group purchasing organizations to manage many aspects of the sourcing process.

"The challenge is exacerbated by the fact that many of these new sources are overseas and U.S. hospitals generally do not have experience with international business transactions, which involve an entirely new set of intermediaries to wire and accept funds, certify products that meet FDA standards, and confirm accurate shipments, facilitate global logistics, etc."

This produces a steep learning curve for hospitals already stressed financially.

"This is not only financially risky given the inherent international transaction risks, but many hospitals simply do not have the cash on hand

to facilitate these purchases," Dobrzykowski said. "About 33% of U.S. hospitals already report negative operating margins and about 25% report negative total margins. Recently, poor financial performance has caused some rural hospitals to close, which also creates access-to-care challenges for COVID-19 patients."

The suspension of elective procedures, which cuts into revenues, coupled with the new costs of setting up off-site testing facilities for COVID-19 and switching to telemedicine for clinic services have piled on more economic and budget concerns.

"These structural investments have further reduced hospitals' financial positions, adding to their burdens as they attempt to source and pay for PPE," Dobrzykowski said.

The federal stimulus package allocated billions to hospitals, but it is unclear exactly how that will be shared and whether or not that will cover all the costs associated with COVID-19 preparations, Dobrzykowski said. "Furthermore, many of these programs come in the form of unattractive, relatively high interest, loans to hospitals."

"This represents a Catch-22: COVID-19 has not uniformly spread across the country, yet hospitals are essentially forced to prepare as though it has," Dobrzykowski said.

"Think of it like this: The peak is more of a plateau that is expected to hit in waves across the country. At the peak, demand will not decrease overnight. Also, just because you reach the peak of the outbreak in one area doesn't mean the need or consumption for this equipment will go down for everyone. With the 'plateau' mindset, some hospitals have made substantial outlays for resources and staff, yet they have not experienced a surge of patients.

"For example, Mayo Clinic is now operating at 35% capacity, with surgery capacity even lower at 25%. It will experience severe financial challenges due to this lost revenue. As a form of damage control, hospitals are laying off staff until COVID-19 patients start to increase in their facility, but they are fearful that when or if these surges come, they will not have the supplies needed to treat patients."

Hospital leaders are concerned that they will soon be forced to close if financial performance does not improve. Other hospitals are worried about how they will manage the pent-up demand for elective procedures when COVID-19 is over.

Dobrzykowski said, though, that now is not the time to be critical of traditional supply chains. "We are living through a disaster that's unprecedented and bigger than anything we've experienced in the last 100 years," he said.

"My overarching recommendation moving forward is that we think about and treat this like the global disaster that it is," he said. "While time for preparation on a national level is largely behind us for this wave of COVID-19, efforts aimed at mitigation, response and recovery can serve us well."

He said mitigation includes social distancing and other policies that are helping reduce the spread of the disease and the need for additional personal protective equipment. Response must focus on expanding current supply sources and developing new ones, he said.

"In terms of recovery, it is critical that we are thoughtful about not only when but, more importantly, how we reopen the country," Dobrzykowski said. "Recalling that the peak is really more of a plateau, it is critical that we don't flip the sign on the door overnight." He said phased reopenings by region and modified operational models provide the highest

probability of success. These include soft starts that move from "take-out only" to "50% capacity dine-in services" and so forth.

"While these indeed are unprecedented times and significant factors are changing daily, it's also a time to learn and to prove our big picture thinking, creativity and resilience," he said.

Provided by University of Arkansas