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FEATURED ESSAY

The Care Continuum Starts at the Source

Why healthcare's most important idea has been getting in the wrong place — and what changes when the supply chain becomes the first leg of patient care.

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I spent fifteen years in healthcare commercialization believing, like everyone around me, that the patient was the beginning of the story.

We built the whole industry around that belief. The *continuum of care* — follow the patient across every site, primary to acute to post-acute to home, keep them at the center. It is one of the best ideas healthcare ever had. I've spent a career inside it.

But I've come to think we drew the starting line in the wrong place.

We start the continuum at the patient's first clinical encounter. The admission. The procedure. The wound. And everything we measure, fund, and improve flows from there. But by the time a patient needs a sterile dressing, a compression system, a surgical tape, that product has already completed a long and entirely separate journey — from raw material, through a factory, onto a truck and a ship, across a border, through customs, into a distributor's warehouse, onto a purchase order, and finally into a supply room. A continuum of its own. And almost no one in clinical healthcare has ever looked at it.

That blind spot is not academic. It is where patients get hurt.

When I worked on gray-market suppression, I watched authentic product get diverted out of authorized channels and resold — overpriced, mis-specified, sometimes unsafe. When I helped build a pressure-injury prevention program that cut HAIs by 63% at a major health system, the single most important variable was not a clever protocol. It was whether the right product was physically present, in spec, at the right moment. And when I looked at a health system with 53 ICU beds and an estimated five to eight million dollars a year in preventable complications, the root cause wasn't clinical knowledge. It was a broken first mile: supply that was unavailable, diverted, or unaffordable before it ever reached a ward.

Sub-Saharan hospitals report hospital-acquired infection rates of 6 to 12 percent and pressure-injury rates of 10 to 15 percent, the overwhelming majority of them acquired in-facility. We treat these as clinical failures. Mostly, they are supply failures wearing a clinical mask. The right product wasn't there, so the protocol couldn't hold, so the patient got the infection, so the bed stayed occupied, so the next patient couldn't get in. Every one of those steps traces backward, through the wall of the hospital, into a supply chain no clinician was ever asked to see.



The continuum of care does not start at admission. It starts at the source.

Here is the reframe I'd ask the healthcare world to consider: raw material to finished good, across the border, through logistics, into the hospital, onto the purchase order. That is the true first mile of patient care — and right now it is invisible to the clinicians who depend on it and unmanaged by the system that pays for it.

This is not a call to make doctors into logisticians. It's a call to extend the continuum we

already believe in all the way back to its real beginning — and to put the same rigor, the same outcomes accountability, and the same patient-at-the-center discipline on the first mile that we put on the last one.

And there's a harder truth inside it: for the companies and health systems that serve patients to keep doing what's best for those patients, they have to survive — and survival starts with getting the right product, authentic and affordable, to the bedside. Caring for the patient and sustaining the system that serves them are not in tension. One makes the other possible.

Because the data is unforgiving and also hopeful. When the right product is reliably present — authentic, in-spec, affordable, traceable — infections fall, bed-days return, budgets recover, and protocols finally hold. That discipline has produced a documented 63% reduction in pressure injuries and a measurable return on investment. None of it started in the operating room. It started at the source.

I came to this from the commercial side, and my partner came to it from the other end entirely — he helped build the U.S. customs security program and spent years training the officers who guard exactly this first mile. We built a firm on a single conviction: that the border and the bedside are the same continuum, and that almost no one is treating them that way.

So this is the work I want to do, and the argument I want to make to anyone who will listen: stop starting the story at the patient's first encounter. Start it where it actually begins. Secure the source, and you finally put the patient at the center of a continuum that runs the whole way through.

The patient was always supposed to be the focus. We just never started at the beginning.

— *Rachel Clark*

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