Getting real about reprocessing | Maximizing supply management | The latest trends in PPIs

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When we launched *Outpatient Outcomes* 12 issues ago, we had a singular goal in mind — provide content to help you improve the financial, clinical and operational effectiveness of your facility. We’re so proud to have produced such a wealth of informative articles, so I’d like to dedicate part of this, our 12th issue, to some of our favorites.

In our very first issue, we tackled the challenge of shining light on the misunderstandings around the reprocessing of single-use devices in “Getting real about reprocessing.” In a thoughtful presentation, the article highlighted the significant savings opportunities reprocessing offers surgery centers, and detailed the myths and truths about the process, the challenges, the costs and, most importantly, safety.

Later, we took a peek inside Connecticut Surgery Center — specifically, its supply challenges. In a detailed case study on the importance of efficiency, we demonstrated how an efficiently ordered supply room can be designed in a fraction of the space while also drastically reducing case pick times and stress on surgical technicians.

In “Capturing cost,” we showed you how Surgical Care Affiliates developed a unique data management tool to determine case costs of performing specific procedures on a per-case basis — giving them a better understanding of how well they were covering their costs and data to be competitive for reimbursement. And in one of our most recent articles, “Trends in PPIs” gave us a quick snapshot of the impact of physician preference items (PPI) in outpatient settings, and how managing PPI can help with cost containment.

The perspectives of ASC patients can give us tremendous insight into why we do what we do, and how we can do it better. In “It’s better in a surgery center,” we talked with several patients and learned that convenience, efficiency and service topped their lists of decision-making benefits. We also made a deep dive into environmental cleanliness in “How clean is clean?” In it, we explored the impact of environmental cleanliness on patient satisfaction and infection control, detailing strategies and best practices.

Looking back at these articles reminds us of exactly what drives and inspires us at Medline, and that’s you. As always, we encourage your continued feedback to make sure we are meeting all your needs. Please feel free to contact us at ASC@medline.com with your ideas, comments and suggestions.

Sincerely,

Zach Pocklington
Senior Vice President, Ambulatory Surgery Center Division
Medline Industries Inc.
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New CMS grants address opioid use disorders

The Centers for Medicare & Medicaid Services (CMS) will offer $50 million in planning grants to at least 10 state Medicaid agencies as part of the CMS Roadmap to Address the Opioid Epidemic, which focuses on prevention, treatment and data. The Centers for Medicare & Medicaid Services (CMS) will offer $50 million in planning grants to at least 10 state Medicaid agencies as part of the CMS Roadmap to Address the Opioid Epidemic, which focuses on prevention, treatment and data. The CMS Roadmap to Address the Opioid Epidemic focuses on prevention, treatment and data.3

In 2017, CMS reported a 40 percent decrease in overprescribing of opioids after sending 24,000 letters to doctors who overprescribed opioids to Medicare patients, reminding them about safe prescribing practices.4

CMS also has galvanized more than 4,000 hospitals, 120,000 clinicians and 5,000 outpatient settings through national quality improvement networks to quickly produce results in reducing opioid-related events.

In related news, CMS has included a new code for non-opioid pain management drugs in its 2019 final payment rule for ASCs.5 Under the new code, these drugs are now eligible for separate payments by CMS when used in the ASC setting — but not in hospital outpatient departments.

Currently, there is only one branded drug approved by the Food and Drug Administration that falls in this category: Exparel. As of Jan. 1, 2019, Exparel is eligible for separate payment in ASCs when billed with HCPCS code C9290.

Antimicrobial stewardship requirements updated by The Joint Commission

Ambulatory health care organizations that routinely prescribe antimicrobial medications now have updated requirements for these drugs from The Joint Commission.2 The new medication management standards go into effect Jan. 1, 2020, as part of the commission’s ongoing initiative to help reduce misuse that can lead to antibiotic resistance and adverse drug events. The guidelines now call for identifying an antimicrobial stewardship leader, establishing an annual antimicrobial stewardship goal, implementing evidence-based practice guidelines, providing clinical staff with educational resources, and collecting, analyzing and reporting goal data.


REFERENCES
**INDICATIONS AND USAGE**

CLOROTEKAL® (chloroprocaine hydrochloride) is a prescription drug indicated for intrathecal injection for the production of subarachnoid block (spinal anesthesia) in adults undergoing surgical procedures. Indicated procedures include those suitable for CLOROTEKAL’s short duration of action.

**CONTRAINDICATIONS**

CLOROTEKAL is contraindicated in patients with a known hypersensitivity to the active substance, medicinal products of the PABA (para-aminobenzoic acid) ester group, other ester-type local anesthetics or to any of the excipients. General and specific contraindications to spinal anesthesia regardless of the local anesthetic used, should be taken into account (e.g., decompensated cardiac insufficiency, hypovolemic shock, coagulopathy). Intravenous regional anesthesia (the anesthetic agent is introduced into the limb and allowed to set in while tourniquets retain the agent within the desired area). Serious problems with cardiac conduction. Local infection at the site of proposed lumbar puncture and Septicemia.

Please see additional Important Safety Information and Full Prescribing Information on the reverse side of this ad. You are encouraged to report negative side effects of prescribed drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.
**Clorotekal®**  
(chloroprocaine hydrochloride) injection for intrathecal use

**INDICATIONS AND USAGE**  
**CLOROTEKAL®** (chloroprocaine hydrochloride) is indicated for intrathecal injection for the production of subarachnoid block (spinal anesthesia) in adults undergoing surgical procedures. Indicated procedures include those suitable for **Clorotekal®’s** short duration of action.

**CONTRAINDICATIONS**  
- **CLOROTEKAL®** is contraindicated in patients with a known hypersensitivity to the active substance, medicinal products of the PABA (para-aminobenzoic acid) group, other ester-type local anesthetics or to any of the excipients. (See Risk of Hypersensitivity Reactions)
- General and specific contraindications to spinal anesthesia regardless of the localization of the injection (e.g., decompen- 
sated cardiac insufficiency, hypotensive shock, coagulopathy)
- Intravenous regional anesthesia (the anesthetic is introduced into the limb and allowed to set in while burnout risk return the agent within the desired area)
- Serious problems with cardiac conduction
- Local infection at the site of proposed lumbar puncture
- Septicemia

**WARNINGS AND PRECAUTIONS**

**Risks with Neuroaxial Administration**

Local anesthetics are only administered by clinicians who are well versed in diagnosis and management of dose-related toxicity and other acute emergencies which might arise from the block to be employed, and then only after insuring the immediate availability of oxygen, other resuscitative drugs, cardopulmonary resuscitative equipment, and the personnel resources needed for proper management of toxic reactions and related emergencies (see Adverse Reaction and Overdose). Data in proper management of dose-related toxicity, underventilation from any cause and/or altered sensitivity may lead to the development of acidosis, cardiac arrest, and, possibly, death.

The clinician should take the appropriate measures to avoid an intravascular injection. In addition, it is essential for the clinician to know how to recognize and treat uncontrolled effects, systemic toxicity and other complications. If signs of acute systemic toxicity or total spinal block are observed, the injection of the local anesthetic must be stopped immediately (see Overdosage).

**Cardiovascular System Reactions**

Hypotension and bradycardia are well known side effects of all local anesthetics (see Adverse Reaction and Overdose). A serious, undesired effect of spinal anesthesia is high or total spinal block, with consequent cardiovascular and respiratory depression. Cardio-vascular depression is induced by an extended block of the sympathetic nervous system, which may induce severe hypotension and bradycardia to the point of cardiac arrest. Respiratory depression is induced by the block of the respiratory musculature and the diaphragm. Careful and constant monitoring of cardiovascular and respiratory (adequacy of ventilation) vital signs and the patient’s state of consciousness should be accomplished after **Clorotekal®** injection. Patients over 65 yrs, particularly those with hypertension, may be at increased risk for experiencing the hypertensive effects of **CLOROTEKAL®**. Blood pressure should, therefore, be carefully monitored after administration of the local anesthetic. The patient’s condition and the technique of drug administration. Adverse reactions in these studies, (incidence greater than or equal to 10%) following **CLOROTEKAL®** administration were injection site reactions, (incidence greater than or equal to 10%) following **CLOROTEKAL®** administration were:

**ADVERSE REACTIONS**

The following serious adverse reactions are described, or described in greater detail, in other sections:

- **Cardiovascular System Reactions** (see Warnings and Precautions)
- **Central Nervous System Reactions** (see Warnings and Precautions)
- **Hypersensitivity Reactions** (see Warnings and Precautions)

**Clinical Trials Experience**

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

During clinical investigations, a total of 111 patients undergoing various surgical procedures received **CLOROTEKAL®**. Patients were administered a dose ranging from 30 to 50 mg of **CLOROTEKAL®**. The most common adverse reaction in these studies, (incidence greater than or equal to 10%) following **CLOROTEKAL®** administration was procedural pain. The common adverse reactions (incidence greater than or equal to 2% to less than 10%) following **CLOROTEKAL®** administration were injection site pain and hypothermia.

The less common adverse reactions (incidence less than 2%) following **CLOROTEKAL®** administration were:

**Drug Interactions**

Concurrent administration of vasopressor drugs (for the treatment of hypotension related to obstetric blocks) and ergot- or cytotoxic drugs may cause severe, persistent hypotension or cerebrovascular accidents. The para-amino-benzoic acid (PABA) group of local anesthetics is not distributed in the systemic circulation and, therefore, cannot compete for the action of sulfonamides. Therefore, avoid use in any condition in which a sulfonamide drug is being employed.

No studies have been conducted on interactions between chloroprocaine and class III antiarrhythmics (e.g., amiodarone). Carefully monitor these patients for cardiovascular effects.

The combination of various local anesthetics may result in additive effects affecting the cardiovascular system and the central nervous system. Monitor these patients for signs and symptoms of local anesthetic toxicity.

**USE IN SPECIFIC POPULATIONS**

**Pregnancy**

Risk Summary

The limited available data with chloroprocaine use in pregnant women are insufficient to inform a drug associated risk of adverse developmental out- comes. There are no animal reproduction studies for chloroprocaine. There are risks to the mother and the fetus associated with use of chloroprocaine during labor and delivery (see Clinical Considerations). The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general popula- tion, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively. Clinical Considerations

**Labor or delivery**

Local anesthetics rapidly cross the placenta, and when used for epidural, paracervical, pudendal or caudal block anesthesia, can cause various degrees of maternal, fetal and neonatal toxicity. The incidence and degree of toxicity depend upon the procedure performed, the type and amount of drug used, and the technique of drug administration. Adverse reactions in the parturient, fetus and neonate involve alterations of the central nervous system, peripheral vascular tone and cardiac function.

Spinal anesthesia for labor and delivery are through changes in uterine contractility or maternal expulsive efforts. Spinal anesthesia has also been reported to prolong the second stage of labor by removing the pariti- nent’s reflex urge to bear down or by delayed onset of the urge. The use of obstetrical anesthesia may increase the need for forceps assistance. The use of some local anesthetic drug products during labor and delivery may be followed by diminished muscle tone and strength for the first day or longer, thereby increasing the risk of maternal decompression for the newborn.

Maternal hypotension has resulted from regional anesthesia. Local anesthetics may be followed by vasodilation by blocking sympathetic nerves. The fetal heart rate also should be monitored continuously, and electronic fetal monitoring is highly advisable.

**Lactation**

There are no data on the presence of chloroprocaine in human milk, the effects on the breastfed infant, or effects on milk production.

The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for **CLOROTEKAL®** and any potential adverse effects on the breastfed infant from **CLOROTEKAL®** (see Use in Specific Populations).

**Pediatric Use**

Safety and effectiveness in pediatric patient have not been established.

**Geriatric Use**

Patients over 65 yrs, particularly those with hypertension, may be at increased risk of developing hypertension while undergoing spinal anesthesia with **CLOROTEKAL®**. Clinical studies of **CLOROTEKAL®** do not include sufficient numbers of older subjects. Other reported clinical experience has not identified differences in responses in the elderly and younger patients. In general, patients with cardiovascular disease have the potential for decreased systemic, renal, and cardiac function, and of concomitant disease or other drug therapy (see Warnings and Precautions).

**Hepatic and Renal Impairment**

Since local anesthetics are hydrolyzed by plasma cholester- 
olase produced by the liver, the risk of toxic reactions might be greater in patients with advanced hepatic disease. This drug may be known to be substantially excreted by the kidney, and the risk of toxic reactions might be greater in patients with impaired renal function.

**OVERDOSAGE**

Acute emergencies from local anesthetics are generally related to high plasma levels encountered during therapeutic use or to inadvertent sec- ondary to upward extension of spinal anesthesia. Hypotension is commonly encountered during the conduct of spinal anesthesia due to relaxation of sympathetic tone, and sometimes, contributory mechanical obstruction of venous return (see Warnings and Precautions and Adverse Reactions). In the event of accidental intravascular injection, the toxic effect occurs within 1 minute. In mice, the intravertebral LD50 of chloroprocaine HCl is 97 mg/kg and the subcutaneous LD50 of chloroprocaine HCl is 95 mg/kg. Management of Local Anesthetic Emergencies: the first consideration is prevention, best accomplished by careful and constant monitoring of cardiovascular and respiratory vital signs and the patient’s state of consciousness during each local anesthetic injection. At the first sign of change, administration of **CLOROTEKAL®** must be stopped and oxygen should be administered (see Warnings and Precautions).

The first step in the management of convulsions, as well as unventil- 
ation or apnea, consists of immediate attention to the maintenance of a patent airway and assisted or spontaneous ventilation. A delivery system capable of permitting immediate positive airway pressure by mask. Immediately after the institution of these ventilatory measures, the adequacy of the circulation should be evaluated, keeping in mind that drug-induced excitement may cause convulsions so that an adequate circulation is needed for adequate and effective ventilation. Convulsions persist despite adequate respiratory support, and if the status of the circulation permits, small increments of a ultra-short acting barbiturate or a benzodiazepine may be administered intravenously; the clinician should be familiar, prior to the use of sympathomimetics, with appropriate antidote drugs. Supportive treatment of circulatory depression may require administration of intravenous fluids and, when appropriate, a vasopressor dictated by the clinical situation (such as ephedrine to enhance myocardial contractile force). If not treated immedi- 
ately, both convulsions and cardiovascular depression can result in hypoxic acidosis, bradycardia, arrhythmias and cardiac arrest. Recovery has been reported after prolonged resuscitative efforts. Endotracheal intubation, employing drugs and techniques familiar to the clinician, may be indicated, after initial administration of oxygen by mask, if difficulty is encountered in the maintenance of a patient’s airway or if prolonged ventilatory support (assisted or controlled) is indicated.

**DESCRIPTION**

**CLOROTEKAL®** is a sterile non pyrogenic local anesthetic 1- m/s of solution for injection contains 10 mg of chloroprocaine hydrochloride, equivalent to 44.05 mg s, (81,891 mg/l) chloroprocaine. It also contains the following inorganic compounds: hydrochloric acid (for pH adjustment), sodium chloride, water for injection.

Rx only  
Clorotekal is a registered trademark of Sanofi S.A.

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OCTOBER 2019

BECKER’S ASC 26TH ANNUAL MEETING: THE BUSINESS AND OPERATIONS OF ASCs
Oct. 24-26
Swissotel Chicago
Chicago, Illinois
Choose from more than 100 sessions covering the latest and most important issues affecting ASC owners, surgeons and administrators, along with panel discussions featuring top industry professionals. The event’s 185 speakers include physicians, directors of nursing, administrators, owners and CEOs from outpatient surgery centers. Visit www.beckersasc.com/annual-ambulatory-surgery-centers-conference.

NOVEMBER 2019

CASA INFECTION PREVENTION SEMINAR
Nov. 7-8
The Westin South Coast Plaza
Costa Mesa, California
Learn from infection prevention experts and ASC professionals who have implemented successful IP programs nationwide at California Ambulatory Surgery Association’s 12th annual seminar. You’ll also take home a certificate of training in Infection Control and Prevention. Visit www.casurgery.org.

WASCA ANNUAL EDUCATION CONFERENCE & TRADE SHOW
Nov. 14-15
Tulalip Resort & Spa
Tulalip, Washington
The Washington Ambulatory Surgery Center Association explores state and national ASC industry issues with general sessions and separate tracks for general infection/prevention control, gastrointestinal, and administrative topics. Visit https://wasca.net.

JANUARY 2020

ASCA 2020 WINTER SEMINAR
Jan. 16-18
InterContinental New Orleans
New Orleans, Louisiana
You’ll be able to move freely between tracks to attend sessions on ASC-specific topics such as coding and billing. ASC management and infection prevention during ASCA’s three-day seminar. Visit www.ascassociation.org.

LOUISIANA ASCA ANNUAL MEETING
Jan. 17
West Baton Rouge Conference Center
Port Allen, Louisiana
Join the Louisiana Ambulatory Surgery Center Association, a statewide, professional membership organization that represents the interests of licensed surgery centers, for their annual meeting. Visit: https://lasca.wildapricot.org.

If you would like to have your event listed here, please send an email to ASC@medline.com.
MEDLINE NOW EXCLUSIVE PROVIDER OF SOUTHMEDIC’S OXYMASK

Traditional oxygen devices have been bound to specific oxygen liter flows and saturations, with the patient’s acuity level determining which oxygen device is used. Carrying multiple products can also lead to operational inefficiencies and variability in care for patients. The end result:

- Risk of clinical error leading to CO₂ rebreathing.
- Wasted time changing out products.
- Inability to communicate effectively with patients.
- Limited patient comfort.

Southmedic’s OxyMask™, an innovative open-style oxygen mask now offered exclusively by Medline, empowers clinicians to deliver safer care while providing a better experience to patients from adults to tykes. OxyMask’s patented technology keeps the flow of oxygen in front of the patient’s nose and mouth, unlike traditional oxygen masks that rely on high levels of oxygen flow to flush out CO₂.

The technology also allows for an open design that can provide a broad

TAKE THE GUESSWORK OUT OF CERVICAL SPINE SURGERIES

Poor visibility to the lower cervical spine can obscure results of intraoperative radiographic imaging and lead to wrong level surgeries. The Clear Cervical Visualizer (CCV) radiolucent device was made by and for surgeons to provide enhanced intraoperative visualization of the lower cervical spine for more accurate diagnosis and improved surgical outcomes.

The CCV gently pushes shoulders down to expose up to two or three more vertebrae for more accurate diagnosis.
TRANSFER PATIENTS SAFELY WITH COMFORT GLIDE® LT

More than one-third of back injuries among nurses have been associated with patient handling and the frequency with which nurses are required to manually move patients.¹ Nurses also suffer more back and arm injuries than just about any other occupation.²

For patients, pressure injuries due to friction, shear and moisture are a significant health issue and closely related to repeated transfers.³

With the proper tools, however, nurses can transfer patients in a manner that’s safe for both parties. Comfort Glide LT provides caregivers with a safe, easy way to laterally transfer patients of all sizes from one surface to the next by raising the patient in one smooth motion on a cushion of air, without the need for lifting. The reduced exertion helps lower the risk of injury and requires less manpower to complete a move, although perimeter and extended handles enable multiple caregivers to assist. Overall, the Comfort Glide LT helps reduce effort by 75 percent compared with standard of care.⁴

Pre-printed surface instructions on the Comfort Glide LT make the process easy. For patient comfort during transfer, the breathable fabric helps prevent shear and friction forces on the patient’s skin as the device supports the body, and the sheet can remain underneath the patient throughout the hospital stay.

Accessories – sold separately – include the drypad (CGLIDEPAD), air blower (MSC60090), air blower cart (MSC60099), hose protection sleeve (DYNJE4250) and MRI-Safe 25’ Hose (MSC600925).

For a sample or additional product information, please contact your Medline ASC sales representative or email us at ASC@medline.com.

REFERENCES


Is it safe? Does it save? Can you get your doctors and staff on board? Let’s take a deeper dive.

Doctors are diligent about making sure nothing jeopardizes the health and safety of their patients, either through the risk of infection or the failure of a surgical tool, possibly unnecessarily increasing expenses and waste. Surgical tools, crafted to exact specifications and made out of durable materials such as metals and plastics, are taken out of the packaging, used once and thrown away. Purchasing new items can cost hundreds of dollars at a time, which adds up to thousands upon thousands of dollars over a year — an expense that takes a massive bite out of the budgets of surgery centers.

The cost has led administrators to seek a new solution — which they’ve found, in increasing numbers, in the reprocessing of surgical tools.
“The way it works is, you collect items after they’re used in a procedure, you send them away to a facility, and they’re reconditioned, repackaged and sold again,” says Nancy Larson, the administrator at Mary Immaculate Ambulatory Surgery Center in Newport News, Virginia. “Generally, you can buy reprocessed instruments for about half of what you’d pay for a new instrument.”

It’s a polarizing topic among health care providers, and administrators who have successfully implemented the use of reprocessed tools often have had to overcome waves of resistance to make it happen.

Facing the pushback

When the administration of an ambulatory surgical center first broaches the topic of utilizing reprocessed surgical tools, they can expect the strongest initial resistance to come from surgeons.

“When we first tried introducing reprocessed tools, our physicians simply wouldn’t use any of them,” says Stephanie Marquez, the administrator and CEO of Old Tesson Surgery Center in St. Louis. “What we had to do, in the end, was work with our reprocessor, Medline, to implement a blind study, where doctors didn’t know if they were using new or reprocessed. Once they found out that they couldn’t tell the difference between the performance of new and reprocessed, that’s what got them on board with it.”

Original equipment manufacturers (OEMs) have posed another hurdle to reprocessing. Although many OEMs of surgical equipment have now entered the reprocessing space themselves, they initially were an area of staunch resistance.

“It got to the point where I would send manufacturer representatives out of the room if they pushed back,” Marquez says. “I had to put my foot down — it’s my product, I bought it, and I’m not harming patients.”

Larson says some of the OEMs that remain resistant to reprocessing are developing products that can’t be reprocessed.

“Some OEMs are even putting chips in their instruments that won’t allow them to be reprocessed,” she says. “If you try to reprocess the instruments, they’ll fail.”

Because of internal and external resistance, the process of winning...
over the physicians at Old Tesson was a long one — about three years of statistical confirmation that infection rates were not increasing, tool failure rates were not increasing and the savings was worth it.

“If I had physicians come to me and tell me an instrument failed to perform, or there was some other problem, I had to tell them to show me facts,” Marquez says. “It took a lot of standing firm on the use of reprocessed instruments, positive reinforcement and reminders of how it can benefit everyone.”

In addition, Marquez and her staff engaged the instrument tech at Old Tesson. As the person who oversees all of the on-site inspection and quality control of surgical instruments, the instrument tech needed to be properly trained and on board with the use of reprocessed tools, Marquez knew.

“Medline took the extra time to make sure our instrument tech was on board, which I think helped quiet some of the concerns our physicians had,” she says.

It’s also critical to cultivate champions for reprocessing among a center’s ranks.

“It really helps if you can find champions, particularly on the physician side,” Marquez says. “If you can find a physician who believes in the cost benefits of using reprocessed, and understands that reprocessed instruments aren’t inferior, that’s a big win. Beyond that, you’ll need to work with your staff, too. They also have to understand that using reprocessed isn’t going to cause harm to patients.”

**Reprocessing in action**
The sequence of reprocessing surgical devices is designed to minimize the inconvenience for the surgical staff as much as possible. New surgical tools are taken out of their packaging and inspected by the instrument tech. From there, they go to the operating room for a procedure. After the devices are used, they’re placed in a special collection bin provided by an off-site reprocessing company.

The reprocessing company disassembles, decontaminates, disinfects, sharpens, remanufactures, tests, inspects and sterilizes all devices. It isn’t a matter of simply cleaning and returning the reprocessed devices. Reprocessed devices receive FDA clearance, specifying that the devices are substantially equivalent to OEM devices — meeting the exact same form, fit and function. The reprocessing company also assumes all liability for the devices it sells, becoming the manufacturer on record.

“When you consider that we might pay between $200 and $300 for a new drill bit that would normally be used once and thrown away, the financial case for reprocessing becomes very clear,” Larson says. “By the time reprocessed instruments have arrived here, they’ve been sterilized and packaged and are ready to use. They’ve passed a quality control inspection at the reprocessing plant. So I feel comfortable being open about the fact that we reprocess. New healthcare providers who come aboard are always informed that we reprocess, and why.”

Ambulatory surgical centers can reprocess a wide variety of surgical tools, depending on the specialization areas of the center. The savings depends on what can be purchased from a reprocessing vendor.

At Mary Immaculate, which specializes in orthopedic surgery, Larson’s staff collects and ships out postsurgical items including drill bits, saw blades, burs and trocars. Old Tesson reprocesses used electrodes and ports, among other items.

What is reprocessed, and how many times an item is reprocessed, are at the discretion of both the care providers and the reprocessing company. Items the reprocessing company deems ill-suited for further use are discarded. In some cases, and for a variety of reasons, surgery centers will opt to discard an item that potentially could be reprocessed.
For instance, we don’t reprocess shavers due to our contract, which includes a supply of disposables,” Marquez says. At the Surgical Institute of Reading, Pennsylvania, which specializes in ear, nose and throat surgeries, as well as orthopedics and general surgery, the staff reprocesses items including coblators.

“Our ENT surgeons were the first to accept the idea of reprocessing,” says Ron Goff, the institute’s materials manager. “Some of the other general surgeons and orthopedic surgeons weren’t as receptive. It’s the same reasons for just about all of them — are the items safe, will they perform, and do we have to worry about increased risk of infection?”

As was the case at Mary Immaculate and Old Tesson, the staff at the Surgical Institute of Reading started to warm to the idea of reprocessing as the data in favor of it began to accumulate. Once administrators were able to share data that demonstrated no increase in infection rate or instrument failure rate, and after the staffs became comfortable with the idea that the FDA has approved the practice of reprocessing, the reservations regarding the practices started to evaporate.

“Now, we only have two surgeons who are 100 percent against reprocessing,” Goff says. “Our program has expanded, and we now also reprocess nonsterile items that are not placed in or near an incision during surgery, such as compression sleeves that are used to prevent blood clots during surgery. They’re multiple-use products, but they need to be cleaned and repackaged for the next use.”

Dollars, cents and sense
The financial case in favor of reprocessing is a strong one. In the four years since the introduction of reprocessing, Goff estimates his surgical center has saved about $270,000 — nearly $70,000 a year. The story is similar at Mary Immaculate and Old Tesson. Larson estimates a savings of $59,000 last year, and Marquez estimates an annual savings of about $35,000.

But financial reasoning will get a center’s administrators only so far with surgeons. If you want to introduce reprocessing at your center, you’ll need data and facts, and answers to all the questions you will face. Here are some basic ideas to communicate for starters.

- Reprocessing is now a widely accepted practice. “Hospitals, ambulatory care — just about everyone uses reprocessed now,” Larson says. “It’s all due to the cost. If you’re looking for ways to keep costs down and not pass the cost on to consumers, you have to look at this.”

- Infection and instrument failure rates aren’t affected — and in some cases, reprocessed tools’ performance exceeds the performance of new tools. “We’ve tracked product complaints of reprocessed versus OEM, and in some cases, we’ve had more complaints about OEM,” Goff says.

- If you work with a reputable reprocessing company, it will assume insurance liability for the devices it reprocesses. “Work with a company that will, in effect, put their name on the products they resell,” Goff says. “Companies like Medline assume liability because they inspect and test every device before shipping it out. There are rigorous quality control standards in place.”

Go behind the scenes — check out the video at medline.com/renewal.
Capturing cost

Surgical Care Affiliates uses case costing tools to improve financial transparency — and its bottom line

Do you know the true cost of performing procedures at your surgery center on a per case basis? Having a firm grasp on cost is a universal best practice in business. Yet ambulatory surgery centers are known for struggling in this area, especially when it comes to case costing, explains Amanda Frith, vice president of supply chain operations for Birmingham, Alabama-based Surgical Care Affiliates (SCA).

“For most surgery centers, costing at the case level is not part of the overall management process,” Frith says. Some centers don’t even know if they are covering their costs, she notes. That’s changing, however, and SCA is at the forefront of the trend. “We’re finding that the demand for data and the tools for capturing data are growing,” Frith says. “These developments are important because, as concern around the escalating costs of healthcare grows, facilities have the opportunity to understand the exact costs to perform a case and leverage that data to identify opportunities to reduce costs.”

The power of data

With 200 surgery centers nationwide, SCA is one of the largest providers of outpatient surgery in the United States. About 30 of its facilities are now actively capturing cost per case (CPC) data, Frith says.

“Facilities have the opportunity to understand the exact costs to perform a case and leverage that data to identify opportunities to reduce costs.”

— Amanda Frith, vice president of supply chain operations, Surgical Care Affiliates
The organization’s costing efforts gained traction in 2013 when it developed its ECO (Every Case Optimized) enterprise tool, which combines procurement, inventory management and case costing with its reporting tool.

“ECO is the mechanism that allows us to capture supplies and labor associated with each surgical case, and our reporting tool is a business intelligence solution that enables us to build impactful, easy-to-use reports with the ECO-captured data,” Frith explains.

The reports are housed in a company portal, where all SCA surgery centers can retrieve them.

“Facilities can determine savings opportunities by accessing the portal for data on cost per case, margins and supply-cost differences by physicians,” Frith explains.

Such tools didn’t exist when SCA first developed ECO — but they do now. ENVY™ by IOS Corp. and the Hybrent platform by Hybrent Inc. are two enterprise solutions currently being marketed to surgery centers. Both cite lower costs and improved efficiency in the supply chain as part of the value they bring to ASCs.

Still, the value of CPC data will vary for different centers, Frith says. Case costing efforts that make sense for large multispecialty centers with different cases and a large physician population may not add the same value for a single-specialty center or smaller facilities that aren’t at capacity, she explains.

Uncovering efficiencies

To what extent do physicians want to get involved with costing?

“They crave this data,” says Frith.

“Surgeons are often sold implants, supplies and equipment in the operating room, and cost is not part of the conversation. In my experience, most surgeons are very interested in understanding their case costing. They also love to see their costs relative to other surgeons.”

When data are put to good use, the results are significant. For SCA, successes include the following:

• A multispecialty center achieved $100,000 in annual savings after having all its top spine procedures evaluated and costed out using ECO, Frith says. “We worked with the center’s suppliers to cap them at an even price point, and we also added a direct vendor to achieve the savings.”

• An SCA center achieved $50,000 in annual savings by partnering with the company’s administrative staff to manually gather case costing data. The center used the data to evaluate the costs of the its total joint replacements versus the CPC benchmark in the SCA network.

• Foot and ankle surgeons at a multispecialty center selected four vendor partners after data revealed that technique and vendor selections can cause huge swings in CPC — “sometimes up to $6,000 for the same procedure,” Frith says.

• A large orthopedics center eliminated an expensive bone-graft substitute after attaining and analyzing implant CPC per doctor in the center’s sports medicine area. “Data allowed physicians to drive conversations that resulted in evaluating techniques by other doctors, alternate tissue vendors and supplies,” Frith says.

3 TIPS FOR SUCCESSFUL CASE COSTING

From Amanda Frith, vice president of supply chain operations, Surgical Care Affiliates

1) Share data with physician partners. “They have the power to change many of the cost inputs to their cases.” Present data during partnership meetings with the goal of identifying strategies for reducing costs.

2) Start with a few changes. Whether it’s implants, supplies or staffing, Frith says, “If you can boil the opportunities down to a couple of things, it will lead to more pointed and data-centric conversations, and your chances of success will be greater.”

3) Commit to use the data. “Unless your ASC is committed to using the data, it’s likely not worth all the hard work necessary for capturing the information.”
Case study

How to improve efficiency and maximize storage space while managing rapid procedure volume growth

Illustrating the power of a comprehensive supply management program

Who
- Connecticut Surgery Center (CTSC), Hartford, Connecticut
- Three operating room suites
- Specialties: orthopedic and spine, oculoplastic, cataract, gynecology and podiatry

Challenge
The patient care volume had quadrupled in a short time to more than 2,640 procedures per year. This increase in volume prompted the facility to look at its overall supply management processes, including storage space needs and labor efficiencies to keep up with the increased volume.

Goals
- Reduce storage room square footage
- Reduce case pick time to less than 10 minutes per case
- Decrease individual items ordered, from more than 1,000
- Decrease supply touch points from 250,800 (annually)
- Improve labor efficiency
- Improve staff morale

Solution
Partner with Medline to optimize supply and clinical processes with the company’s Perioperative Supply Management Consulting Services. The program reviewed CTSC’s situation, identified data-driven solutions and constructed an implementation plan.

1. Reviewed situation
- Performed a Lean Assessment
- Assessed clinical, logistical and financial issues
- Collected current practice data, including surgical volume reports and preference cards
- Analyzed case cart and supply flow to observe staff productivity and interactions between OR and case cart set-up
- Documented physical measurements and observed how staff picked and set up cases

2. Identified data-driven solutions
- Present a re-engineered supply management program with Complete Delivery System (CDS)*
- Outlined opportunities to improve staff productivity through space planning, redesign and process flow

3. Constructed an implementation plan

4. Implemented a new Perioperative Supply Management Program

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*CDS is composed of disposable and procedural-specific items for a single case and puts them in one convenient module. Medline assembles the products, provides them to the facility as one SKU and delivers it directly to the facility.
Outcomes
Supply handling by a surgical technician
- Reduction in case picking and setup time, now picking 80 percent fewer individual items per case
- Achieved a 94.7 percent reduction in supply touch points, going from 250,800 touch points annually to 13,200, drastically improving overall supply management and clinical productivity.

Clinical
- Improved turnover rates. With staff opening fewer items, there is a quicker setup time. One surgeon’s case takes only seven minutes to turn over, as everything he uses is contained in a CDS.
- Improved case standardization and maintenance of surgeon preference items. By ensuring the preference cards are reflective of what is in the CDS module, case set-up can be replicated more easily and efficiently.
- Increased staff and surgeon satisfaction. Improved processes, standardized cases and reduced turnover times make for happier team members.

Materials management
- Two-thirds reduction in storage square footage. Each CDS contains 80 percent of supplies needed for each case, reducing the amount of shelf space needed for individual supplies.
- 50 percent reduction in individual items stored on shelves, down from 1,000 to 500
- Reduced inventory and cost. Before, the facility stored up to six months of supplies. Now, it orders two weeks of CDS modules at a time.

Through this service, CTSC has gained improved visibility to its cost per case and increased efficiencies. Both of these improvements help the center by giving nurses more time for patient care and providing the administrator with an improved picture for employee satisfaction and management.

“Before, picking instruments for one case took more than 10 minutes. Now, with a CDS, it takes two minutes. With a hand case, we’d pick all the instruments individually — 20 items or more. Now, we pick a CDS module and just four or five additional items.”

- Harry Bonet, surgical technician, Connecticut Surgery Center
Jim Mathers manages materials for Mercer County Surgery Center.
The past couple of years have been good to Mercer County Surgery Center (MCSC), an outpatient ambulatory surgery center (ASC) in Lawrence Township, New Jersey. In 2018, the ASC moved into a new 15,000-square-foot facility, double the space of its former location. The move coincided with the addition of spine surgery services and allowed MCSC to expand its total joint replacement program.

The increase in services and patient volume, however, meant an increase in medical-surgical supply costs. A strong partnership with Medline has helped MCSC accommodate both physician and patient needs while keeping costs under control.

Al Rodrigues, Mercer County Surgery Center vice president of clinical operations, and his team meet regularly with their Medline representative, Stephanie Tremblay, to discuss materials management goals, products and pricing. Over the years, the conversation has changed, but the relationship remains robust. Here’s what makes their prime vendor partnership work.
Reinventing a business model
When MCSC restructured from 49 percent physician owned to 100 percent physician owned about five years ago, it re-evaluated many aspects of the business, including vendor relationships. “We developed an action plan to identify opportunities for improvement and how to best deliver the highest quality care to our patients,” says Rodrigues, who studied MCSC’s medical and surgical supply costs to see if the facility could make its supplier relationship work better.

Rodrigues and staff decided to start fresh with a new supplier in 2016. Medline earned their trust not only by offering competitive pricing but also by making a commitment to ongoing communication and transparency.

Controlling costs
In its new location, MCSC now offers two GI procedure rooms, a pain procedure room, two operating rooms, pre-op and post-op areas and private recovery rooms. In addition to outpatient total joint replacement and spine surgery programs, the ASC offers gastroenterology, orthopedics, pain intervention and podiatry services.

With a larger facility and expanded services, MCSC saw a corresponding increase in its supply costs — a primary budget item for ASCs nationwide. According to VMG Health’s 2018 Multi-Specialty ASC Benchmarking Study, drugs and medical supplies make up a median 24.4 percent of total operating expenses, more than employee salaries and wages.¹ Focusing on controlling costs while maintaining quality is a constant goal for ASCs and

“‘We’re always seeking to provide the highest quality care at a reasonable cost.’”
– Al Rodrigues, vice president of clinical operations, Mercer County Surgery Center

¹Focusing on controlling costs while maintaining quality is a constant goal for ASCs and
their suppliers, both feeling the impact of the changing healthcare industry.

“We’re always seeking to provide the highest quality care at a reasonable cost,” Rodrigues says. “Medline provides cost saving opportunities with its branded items while maintaining a high degree of quality.”

Reprocessing also helps shave costs. MCSC participates in the Medline ReNewal medical reprocessing program. Reprocessed instruments receive FDA clearance, and reduce the amount of waste sent to the landfill each month. (See related story on page 12.)

**Staying flexible**

When MCSC launched its Outpatient Total Joint Replacement Program in 2015, it worked with Tremblay to develop custom trays for those cases. The custom trays have met the needs of MCSC’s providers, who have successfully performed hundreds of outpatient total joint replacement procedures.

“We worked consistently with Stephanie and her team on what we wanted to see in those trays,” says Rodrigues. “A supply partner that demonstrates flexibility and delivers a top-notch product is critical to the center’s operations. It’s equally important that a supply partner has the ability to change seamlessly and without hesitation.

“You don’t want your vendors to say they have to bring it to a committee or be slow to respond,” he says.

**MERcer County Surgery Center’s Total Joint Replacement Program**

Mercer County Surgery Center began offering outpatient total joint replacement in 2015. The program started at a modest pace, performing a few procedures with the same nurse, physical therapist and staff. This consistency ensured quality and allowed the team to work on efficiency.

Since then, MCSC has performed hundreds of total joint replacements. Now settled into its new 15,000-square-foot facility, the ASC has the space to handle a high volume of cases.

Efficiency is key when performing outpatient surgical procedures, because time spent searching for and assembling supplies is time not spent with patients. Medline partners with MCSC to provide custom surgical packs and procedure trays for its total joint replacement program. “These trays are very important to patient care and the quality of care,” says Al Rodrigues, MCSC vice president of clinical operations. “The ability to customize our trays to the provider’s liking is very important.”

Custom trays and packs can also change as physicians’ needs change. This level of flexibility helps provide better service to the physicians as well as improving operational efficiency.

“We work with Stephanie [our Medline representative] to make sure our packs are optimized for each procedure, and engage in dialogue to update them as needed. That’s the relationship that exists,” says Rodrigues.

Rodrigues says MCSC performs over 4,000 procedures overall annually, of which hundreds are successfully performed total joint replacement and spine procedures. As the ASC grows, its supply partner will be ready to grow and adapt with it.

“Medline has been an excellent partner in terms of their flexibility, their transparency and their consistency,” says Rodrigues. “These are proven qualities when identifying business partners.”
Exceeding expectations
ASCs can streamline their operations by partnering with medical products distributors that offer products and services across the continuum of care. Ordering from one supplier instead of two or more leads to supply chain efficiency, reducing the amount of touchpoints and improving overall logistics for the team.

With a strong supply chain partner in place, Rodrigues also worked with Medline to acquire medical equipment and other distributed products from such suppliers as 3M and Ethicon. This made it easy for Rodrigues and staff to outfit a growing surgical practice.

Bringing new ideas has also helped increase time savings. Medline introduced MCSC to Hybrent healthcare supply chain management software. By using Hybrent, the ASC reduces time spent managing supplies and has an efficient way to handle supplies from ordering to payment. Medline and other vendor products, pricing and availability are aggregated in a portal customized to the ASC.

“Medline provides additional service lines aside from the traditional medical-surgical supply area,” says Rodrigues. “I think it’s important to partner with a company that offers multiple areas of support.”

Regular business reviews
Whether an ASC works with a supply partner for med-surg only or for other products, it’s important for that supply partner to conduct business reviews to determine other cost savings that may be possible. Tremblay provides a business review to Rodrigues twice a year. “The real-time data presented allows us to quickly adapt to the changing market,” says Rodrigues.

The review gives Rodrigues a detailed view of total sales, total acquisition costs, landed costs and central supply costs, among other data. Tremblay also reviews other potential opportunities Medline can provide, such as OR turnover kits or medical devices.

“A supply partner that demonstrates flexibility and delivers a top-notch product is critical to [our] operations.”

– Al Rodrigues, vice president of clinical operations, Mercer County Surgery Center
Why strong partnerships matter
As the Centers for Medicare & Medicaid Services (CMS) and private payers become hyper-focused on lowering costs, ASCs feel the pinch. Rodrigues says he’s seen an increase in claim denials and late reimbursements. However, he’s also seen an increase in total joint procedures, as more hospitals move these to outpatient facilities.

Looking ahead, Rodrigues says MCSC plans to add cardiology to its suite of services. Like the total joint replacement and spine programs, it will start small and grow over time.

As the business continues to grow, a smooth supplier relationship is key to achieving both efficiency and cost control. “The more automation you can create between the partner and the surgery center inventory, the better,” says Rodrigues.

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MCSC works with Medline to acquire medical equipment and other distributed products.

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With the rise of consumerism in healthcare, patients have a choice of where they receive their outpatient surgical procedure — an ambulatory surgery center or a hospital outpatient facility. The benefits of ASCs are clear: less cost (lower co-pays) [Fig. 1], transparent pricing, reduced wait and procedure times, and a more personal and convenient experience due to their smaller size. It’s no surprise that patients have a 92 percent satisfaction rate with the care they receive in ASCs.1

What do patients think ASCs do to provide a superior experience? To find out, we spoke with several patients who recently chose surgery centers for their procedures. Here’s what they had to say about their experiences.

**COST COMPARISON:**
ASC v. Hospital Outpatient Department

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ASC Co-pay</th>
<th>HOPD Co-pay</th>
<th>Total Procedure Cost ASC</th>
<th>Total Procedure Cost HOPD</th>
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</thead>
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<td>$490</td>
<td>$964</td>
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<td>Upper GI Endoscopy</td>
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<tr>
<td>Colonoscopy</td>
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<td>$186</td>
<td>$378</td>
<td>$655</td>
</tr>
</tbody>
</table>

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

**STEVE – MUNDELEIN, ILLINOIS**
*Issue/Procedure:* Repair torn meniscus
*Why did you choose this facility?* My surgeon did his procedures at this facility.
*Overall experience:* It was a seamless experience from start to finish. There was very little paperwork when I checked in because I had completed most of it beforehand. Within 10 minutes, I was taken to the prep area. The staff answered all my questions, and the surgeon clearly told me exactly what he was going to do and what I should expect. The entire staff was very nice and attentive, and the facility was just a few minutes from my house.
*What was unexpected:* When I woke up from the procedure, the surgeon was right there to tell me how it went and what I should expect from the recovery. They even gave me a DVD of the surgery.

**TAMMY – DALLAS, GEORGIA**
*Issue/Procedure:* Repair broken leg
*Why did you choose this facility?* The date and time they offered me were sooner than other facilities.
*Overall experience:* Everyone was very warm and caring, but they also did their work with military-like precision. They were right on schedule. I went in at 10 a.m. and was out by 4 p.m. The admission process was very quick, and then I was taken straight back to the prep area. There were no complications, and I felt no pain. The fact that I could get this procedure
done in one day and get to go home with the best care made the surgery center a great experience. I don’t think a hospital outpatient facility would have given me the same experience.

**What was unexpected:** The attention to detail was amazing. During the pre-surgery process, the facility made sure the person accompanying me (my husband) knew to bring a jacket because the waiting room can be chilly, and that they provided snacks if he got hungry.

**MICHAEL – SAFETY HARBOR, FLORIDA**

**Issue/Procedure:** Repair detached retina

**Why did you choose this facility?** It was in the same building as my doctor’s office.

**Overall experience:** There was very little paperwork for me to do when I was admitted because I completed it the day before. They took me back almost immediately after I checked in, so everything moved along quickly. After the pre-op, when they explained exactly what was going to happen, the last thing I remember is being wheeled in the operating room suite. I woke up about an hour later feeling a little groggy but with little pain. After I recovered, I went right to my doctor’s office conveniently located in the same building so that he could examine my retina. My doctor gave me post-op care instructions and products in a nice branded package. In all, it was a really nice experience, and the staff was very polite and attentive.

**What was unexpected:** The whole process was super quick. They gave me a general anesthetic, and before I knew it, the procedure was over — and successful.

**TRACY – LINDENHURST, ILLINOIS**

**Issue/Procedure:** Two procedures within two months – cyst removed from thumb and bone spurs removed from both feet

**Why did you choose this facility?** It was where my doctor practiced, and it was near my house.

**Overall experience:** For both procedures, the staff was incredibly attentive. They called me about a week before the surgery to give me instructions, answer my questions, take my insurance and ask if I had a ride to and from the procedure. I felt like I had everything covered and was confident before I walked in the door of the facility. When I did check in, the staff was really nice and did everything to keep me comfortable and reduce my anxiety level. The surgeon even marked the thumb with the cyst to make sure he was operating on the right one. The facility was very updated and modern, but much smaller in size than a hospital so it felt more intimate and personable.

**What was unexpected:** The nurse was very helpful in advising me on the medications I received as part of my post-op care. They were strong prescriptions, and she wanted to make sure I understood what they were for and when I should use them.

Consumers are placing increasing demands on the healthcare system. They want care that is affordable, convenient and patient-centered, and that delivers quality outcomes. As these patients attest, surgery centers are more than delivering on all of these requirements.

**REFERENCES**

Utilizing patient satisfaction surveys to monitor the cleanliness of a patient room can help measure a job well done. However, just because a room looks and smells clean, does not mean it has been properly disinfected. The healthcare environment must be both clean and disinfected to reduce the risk of microbial cross-contamination.

Environmental cleaning is an important component of a complex infection control strategy. Yet outpatient facilities have traditionally lacked infrastructure and proper resources to effectively implement a standardized environmental cleaning program. Recent government pressure, however, has motivated facilities to change their way of thinking.

Though the implementation of a robust environmental cleaning strategy may be daunting, these tips can help you develop an effective plan for your facility.

**Get everyone involved.**
All clinical staff must have a stake in implementing the plan. As part of your infection prevention program, the infection preventionist (IP) will help drive participation and motivate staff. That includes encouraging procurement of appropriate EAP-registered supplies and products to support best practices as well as collaborating with leadership and staff to ensure compliance. Clinical education for anyone with environmental cleaning responsibilities
is a crucial component of an effective environmental services (EVS) program. Training can be accomplished in numerous ways, but competency testing that involves direct observation must be part of the program. Direct observation is the most important part of the training process, because it allows for immediate feedback and coaching. Just because staff have been trained does not mean they can demonstrate competency in performing a particular procedure.

**Establish written policies and procedures**

To avoid confusion around cleaning responsibilities, there must be clear, written expectations on cleaning tasks for all staff members. Try developing a chart that highlights pictures of each surface and device and identifies who is responsible for keeping them clean. Is it an EVS or nursing responsibility? Make sure this tool is easily accessible, not locked away in an office.

Document set procedures for cleaning and disinfecting spills of blood, body fluids and other infectious substances. Procedures should be detailed and easy to understand. Displaying posters or laminated cards can help keep the policies top of mind for staff.

**Audit products**

An effective environmental cleaning plan requires high-quality products. Most cleaning cloths and mops are made from either cotton or microfiber. Make sure that the material of the cloth or mop is compatible with both the chemical and the cleaning method. In addition, the disinfectants and detergent/disinfectants must be registered by the Environmental Protection Agency and labeled for healthcare use. The microorganisms that will be killed by the chemical or germicidal wipe should be listed on the side of the container.

It is important to know which types of microorganisms the product will kill as well as its contact/kill time — the amount of time the surface being cleaned needs to remain wet with the disinfectant to effectively kill microorganisms. When evaluating cleaning and disinfecting product, look for a product that will kill the largest number of microorganisms in the shortest time. Train staff on the use of each product, especially the kill times.

As always, ensure compliance with manufacturer instructions. Failure to do so could result in inadequate cleaning and disinfection of surfaces and devices.

**Monitor efforts**

An EVS program should include at least two monitoring methods. Here are several options to consider.

**Direct observation:** Observing the cleaning process as it is being performed allows you to evaluate adherence to the procedure and provide real-time feedback.

**Fluorescent markers:** Fluorescent gel is the most popular marker. The gel is applied to high-touch surfaces before the area is cleaned, dries transparent and resists abrasion, allowing you to evaluate cleaning practices objectively and quantify the impact of educational interventions.

**ATP (adenosine triphosphate) bioluminescence:** ATP testing measures the organic ATP on surfaces using a luciferase assay and luminometer, enabling facilities to quickly assess the efficacy of their cleaning methods. The food industry has used this method for more than 30 years to evaluate the cleanliness of food preparation areas.

While outpatient facilities vary greatly in the number of resources dedicated to infection prevention and environmental cleaning, it is crucial for all healthcare providers to create a tangible plan. With everyone’s participation and commitment to enhancing disinfection practices, you can develop a strong culture that facilitates both a safe environment and better patient outcomes.

**3 TECHNOLOGIES TO ENHANCE YOUR EVS PROGRAM**

If you feel like your manual EVS process needs some extra reinforcement, you might consider these novel no-touch decontamination technologies currently on the market:

- Aerosol and vaporized hydrogen peroxide
- Mobile devices that emit continuous ultraviolet (UV-C) light
- Pulsed xenon UV light systems

With growing evidence that they can improve terminal cleaning, these technologies are finding their way into cleaning protocols for ORs and in areas where C. diff or multidrug resistant organism (MDRO) contamination has occurred.
Trends in PPIs

From the most popular devices to common cost concerns, here’s how physician preference items (PPIs) play a role in the outpatient setting.

**POPULAR OUTPATIENT PPIs**

Common devices include stents, pacemakers, defibrillators, and spinal and orthopedic implants.

Some of the high-volume outpatient procedures that require the use of PPIs include:

- Hip/knee replacement procedures
- Cardiac pacemaker implants
- Spinal fusions and other spinal procedures
- Cardiac defibrillator implants
- Back and neck procedures
- Stent placements
- Cervical spinal fusions.¹

**KNEE AND HIP IMPLANTS**

- Knee and hip arthroplasty surgeries equate to nearly

24% of OR procedures

utilizing PPIs in the form of implants.²

A survey of hip and knee surgeons identified four main reasons for changing implant brands:

1. Quality (clinical results)
2. Cost
3. Improved material technology
4. Ease of use²

**FACTORS AFFECTING PHYSICIAN PREFERENCE INDUSTRY**

Studies suggest that decisions about PPIs are driven by these areas:

- Product technology
- Longevity
- Instrumentation
- Ease of use
- Product innovation
- Manufacturer reputation
- Service considerations
- Sales representatives
- Training programs
- Existing relationships with other surgeons in the practice.²

In a recent online survey of 13,000 healthcare leaders, OVER 70 PERCENT said they would trial a non-branded PPI if the clinical outcomes were similar to or better than those they use traditionally.¹

**COST CONSIDERATIONS**

- In most orthopedic and/or cardiac-related surgeries, a single PPI can account for 40-80 percent of the total procedure cost.³
- A lack of standardized items creates more work and greater room for error for both materials managers and inventory management systems, equating to an estimated $5 billion per year wasted on surplus product.⁴
- It is much more difficult for facilities to get wholesale rates if each physician requires specialized tools. Lower ordering volume equals higher cost.²

**REFERENCES**

3M Surgical Solutions for Ambulatory Surgery Centers

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- 3M™ Ioban™ Antimicrobial Incise Drapes
- 3M™ Surgical Clippers
- 3M™ Red Dot™ Electrodes

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- Steam and VH2O2

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