Chaos prevention

Ask, and you shall learn

ICD-10: Where we are, where we’re going
Clinical evidence has demonstrated 3M™ Skin and Nasal Antiseptic is effective in reducing the risk of SSIs. Make 3M™ Skin and Nasal Antiseptic (Povidone-Iodine Solution 5% w/w [0.5% available iodine] USP) Patient Preoperative Skin Preparation part of your pre-op protocol and take control over infection prevention, helping to improve procedural outcomes and lower MRSA readmission cost. Within one hour of application, 99.5% of Staphylococcus aureus in the nares are reduced and patients are protected for at least 12 hours.

Try it for yourself. Visit 3M.com/MoreControl for a free trial.

3. 3M Study-05-011100.
Welcome to our fourth issue of Medline’s *Outpatient Outcomes* magazine.

Our goal is to deliver useful ideas and best practices to help surgery centers and surgical hospital professionals advance their careers and improve clinical, financial and operational outcomes. Based on our readers’ feedback so far, we appear to be hitting the mark.

In this issue, we received the suggestion to highlight the importance of the surgical technician. We agreed, and so with this issue, we’re devoting considerable attention to this critical role that we’re calling: the unsung hero of the OR.

Surgical technicians do more than prepare the instruments and pass them to surgeons and nurses. They’re a key cog in the staff wheel that keeps the OR running with army-like precision and efficiency. In our cover story “On the front lines,” you’ll learn about their expanding responsibilities in and out of the OR and the necessity to stay on top of the latest surgical developments.

Pressure is not new to surgical technicians. In the article “Chaos prevention,” two highly experienced former surgical technicians share their proven tips about managing instruments and high expectations.

As the importance of center efficiency also adds to the pressure on surgical technicians, we’ve also included a case study featuring Connecticut Surgery Center. You’ll discover how surgical technician Harry Bonet has cut case pick times from 10 minutes down to two and reduced inventory space by two-thirds.

We also explore the serious matter of surgical site infection prevention, addressing ideas on how to improve patient compliance with pre-op instructions and other prevention methods. Patient surveys can also be critical to improving care. In the piece, “Ask, and you shall learn,” we’ll outline some basic, proven strategies to help you solicit useful feedback.

Just as centers use patient feedback to improve operations, we encourage — and need — your continued feedback to ensure you’re getting relevant information, such as what you’ve seen in our first few issues. Please feel free to contact us at ASC@medline.com with your ideas, comments and suggestions.

Sincerely,

Josh Carter
Senior Vice President, Ambulatory Service Center Division Medline Industries Inc.
spotlight
Welcome Letter ............................... 3
Briefs ........................................... 6
Events ......................................... 8
Featured Products .......................... 10

features
Surplus aid: A destination for unused materials .... 12
Optimizing your SSI prevention program .............. 14
Case Study: Connecticut Surgery Center efficiencies .............. 16
On the front lines ................................ 18
Ask, and you shall learn ...................... 24
Chaos prevention ............................. 26
ICD-10: Where we are, where we’re going .............. 28
Changing role of surgery centers ............. 30
ASCs save Medicare billions of dollars
On average, the Medicare program and its beneficiaries share in more than $2.6 billion in savings each year from procedures performed at ASCs. That’s because the program pays significantly less to have ASCs perform these procedures instead of hospitals, according to the Ambulatory Surgery Center Association.

For example, Medicare pays hospitals $1,671 for performing an outpatient cataract surgery while paying ASCs $964 for performing the same surgery. If just half of eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional $2.5 billion a year, the ASCA reports.

Double reprocessing of duendoscopes decreases infection rate
Research presented at Digestive Disease Week 2016 in San Diego showed that double reprocessing of duendoscopes reduces the rate of duendoscope-related infections, according to a Medscape report.

The study examined double reprocessing protocol’s effect on Carbapenem-resistant Enterobacteriaceae infection associated with endoscopic retrograde cholangiopancreatography. The protocol involved two cycles of manual cleaning and automated reprocessing with a strong disinfectant. Each week over nine months, researchers cultured 10 to 20 duendoscopes that had undergone the protocol.

Of the 610 duendoscopes cultured during the study period, 59 were positive. But only five of those tested positive for potentially pathogenic organisms. The double reprocessing protocols appear to prevent duendoscope-associated transmission of CRE.

New fire protection guidelines impact ASCs
The Centers for Medicare & Medicaid Services recently announced a final rule updating healthcare facilities’ fire protection guidelines. The intent is to improve protections for Medicare beneficiaries from fire.

The new guidelines apply to ambulatory surgical centers, hospitals and other healthcare facilities, and their provisions cover construction, protection and operational features designed to provide safety for Medicare beneficiaries from fire, smoke and panic.

• For ASCs, all doors to hazardous areas must be self-closing or close automatically. Additionally, alcohol-based hand rub dispensers may now be placed in corridors to allow for easier access.
• Healthcare facilities in buildings taller than 75 feet are required to install automatic sprinkler systems within 12 years after the rule’s effective date.
• Healthcare facilities are required to have a fire watch or building evacuation if their sprinkler system is out of service for more than 10 hours.
• Healthcare providers affected by this rule should be in compliance with all regulations as of July 4, 2016.

TALK TO US
Have a comment on something you’ve read in Medline’s Outpatient Outcomes magazine? Got an idea for a story in a future issue?
Please submit comments and suggestions to ASC@medline.com.
Dermabond Advanced

Skin closure for excellent outcomes

Strengthens
When used in addition to sutures, DERMABOND ADVANCED® Topical Skin Adhesive was shown ex vivo to add 75% more strength to the wound closure than sutures alone.¹

Inhibits bacteria
Demonstrated in vitro inhibition of gram-positive bacteria (MRSA and MRSE) and gram-negative bacteria (E colI).¹*

Provides a microbial barrier
Provides a flexible microbial barrier with 99% protection in vitro for 72 hours against organisms commonly responsible for surgical site infections.²†

For more information, contact your representative or call 1-877-ETHICON.

¹Clinical significance is unknown.
²Staphylococcus epidermidis, Staphylococcus aureus, Escherichia colI, Enterococcus faecium, Pseudomonas aeruginosa.
³Staphylococcus epidermidis, Staphylococcus aureus, Escherichia colI, Enterococcus faecium, Pseudomonas aeruginosa.

For complete indications, contraindications, warnings, precautions, and adverse reactions, please reference full package insert.


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TASCA FALL CONFERENCE AND TRADE SHOW  
Sept. 29-30  
Marriott Cool Springs  
Franklin, TN  
Tennessee Ambulatory Surgery Center Association’s Fall Conference and Trade Show will bring together ASC professionals with industry experts and vendors. Topics range from clinical to management to business, providing something for everyone. For more information, visit www.tnasca.org.

October 2016  
BECKER’S ASC 23RD ANNUAL MEETING: THE BUSINESS AND OPERATIONS OF ASCS  
Oct. 27-29  
Swissotel Chicago  
Chicago, IL  
This meeting provides focus on the challenges and learning opportunities specifically for ASCs. Ambulatory surgery center administrators and physicians can connect with and will benefit from the panels of industry experts. For more information, visit www.beckersasc.com/annual-ambulatory-surgery-centers-conference.

November 2016  
CASA INFECTION AND SURVEILLANCE SEMINAR  
Nov. 9-10  
Westin South Coast Plaza  
Costa Mesa, CA  
California Ambulatory Surgery Association’s critically acclaimed seminar presents the absolute experts in the infection prevention arena. It is specifically designed for ASCs, providing practical information that attendees can easily implement in their daily practices. For more information, visit www.casurgery.org.

June 2017  
AST’S SURGICAL TECHNOLOGY CONFERENCE  
June 6-10  
New Orleans Marriott  
New Orleans, LA  
The Association of Surgical Technologists’ annual conference offers a chance for surgical technicians to gain more insight into their field and connect with other surgical technicians. For more information, visit www.ast.org/AboutUs/Conference/.

BECKER’S 15TH ANNUAL SPINE, ORTHOPEDIC & PAIN MANAGEMENT-DRIVEN ASC CONFERENCE + THE FUTURE OF SPINE  
June 22-24  
Swissotel Chicago  
Chicago, IL  
This conference offers a chance for spine, orthopedic and pain management physicians to connect. For more information, visit www.beckersasc.com/conferences-and-events.html.

If you would like to have your event listed here, please send an e-mail to ASC@medline.com.
Fast, effective results in one step

Prevail-FX® solution

One-step patient preoperative prep

0.83% available iodine and 72.5% isopropyl alcohol

“For preoperative skin prep, Prevail-FX solution is an efficient, effective way to help reduce bacteria that potentially can cause skin infection. The patented applicator is easy to use and ensures controlled coverage and generous volume for a variety of procedures. Prevail-FX solution also meets the FDA’s TFM testing standards for a preoperative skin preparation.”

References
Fürst surgical instruments: Savings through sourcing

Need increased cost efficiency? Medline has established a new line of surgical instrumentation — Fürst. This standard surgical-grade offering complements the König® premium line by using the same grade of stainless steel as German products, but at a much lower cost.

Here are a few key takeaways:
- Fürst surgical instruments are comprised of the 200 most commonly used patterns — scissors, forceps and towel clamps.
- The value to the customer comes from leveraging Medline’s manufacturing relationships, where the steel is transformed into a finished product on the same lines as products being finished for the König line and other leading manufacturers.

That results in the same grade steel being made by the same hands and machines at a much lower cost. Thus far, cost savings per item have varied from 30 to 50 percent, which can really make a significant difference over the course of a year for Medline customers and their budgets.

Fürst instruments are really taking root in accounts across the country. Request more information from your Medline representative and ask for a quote to see the savings for yourself.
PICO®: Canister-Free Negative Pressure Wound Therapy

PICO®: what is it?
- A single-use negative pressure wound therapy. Unlike its competitors, PICO® is canister-free which means it’s discrete and portable for the patient to wear, even after being discharged. Most important, PICO® is easy to use and maintain. The therapy can last as long as 7 days with minimal dressing changes.

The purpose of PICO®
- Help prevent surgical site infections and readmissions for high-risk patients
- Improve healing process and appearance of scarring

When to use PICO®
- In surgery centers, PICO® is used after surgery on closed incisions or skin grafts on patients who are either high risk or concerned about scarring. (Plastic surgery centers are generally a good opportunity for PICO®.) What qualifies a patient to be high risk? Typically any of the following: obese, smoker or diabetic.

Procedures Pining for PICO®
- Orthopedic
- Breast Reconstruction
- Colorectal
- Vascular
- OBGYN

CS Pro™ nitrile gloves
For clinicians, technicians and staff who clean, decontaminate, sterilize, disinfect, or, in general, work with chemicals, CS Pro™ nitrile gloves provide exceptional protection, fit and performance.

Here are some of their superior features:
- Longer, 16-inch cuffs provide extra protection between the cuff and sleeve
- Fully textured for better grip, the gloves enhance tactile sensitivity and perform well in both wet and dry situations
- Thicker for superb protection. Our thickest and most durable nitrile gloves are tested to withstand harsh chemicals and offer excellent resistance to holes, tears and abrasions
- Complementing other PPE gear when worn with appropriate personal protective equipment, CS Pro™ helps provide comprehensive protection for the entire body
The healthcare needs of those in many developing nations can seem overwhelming, and meeting them can be a challenge. But Project C.U.R.E. (Commission on Urgent Relief and Equipment), the largest provider of donated medical supplies and equipment in the world, is working to meet that challenge by delivering donated equipment and supplies to parts of the world that need them most.

Partnering with the organization to get supplies to medically underserved areas is Medline. “In some developing countries, deaths from preventable diseases are rising and life expectancy is dropping,” says Kathryn Cummings, vice president of corporate communications at Medline. “Public hospitals can’t afford disinfectants and exam gloves; patients spend days lined up outside the facilities for treatment. In response to these critical needs, Medline developed a unique system for redistributing unused medical supplies to global relief efforts. These life-saving medical supplies otherwise would have been landfilled.”

Project C.U.R.E. collects donated equipment and supplies and distributes them to parts of the world where AIDS, tuberculosis, malaria and other diseases run rampant, public hospitals are often insufficiently staffed and common medical items are in short supply.

Since September 2015, Medline has donated bed linens, towels, bed pans, feeding tubes, examination gloves, surgical gowns, wound care, cleaning products, thermometers, mattresses, wheelchairs, crutches and much more.

“It is exciting to see unused products go to 130 countries that are in the greatest need,” says Cummings.

With 40 distribution centers in North America and a fleet of more than 450 trucks, Medline collects surplus medical supplies from across the country and is proud to be in a position to help. Project C.U.R.E. makes it possible for the company to get these supplies into the hands of volunteer doctors and nurses so they can deliver quality care to people in desperate need.

To find out more about Project C.U.R.E. and how you can help with much-needed medical products and equipment or financial donations, visit ProjectCURE.org.
“As I drifted off to sleep, I was thinking I was lying in the sun.”

—Cindy C.

Another 3M™ Bair Paws™ flex gown love story
With the Bair Paws flex system, patients can bask in warmth and comfort throughout the surgical journey. And it transforms patient satisfaction and quality of care while maintaining normothermia to help prevent surgical site infections. See more patient stories at ILoveBairPaws.com.
Surgical site infections (SSIs) are a serious concern for healthcare providers due to the significant clinical and financial burdens associated with them. Although infection control practices have advanced in recent years, including improved operating room ventilation, sterilization methods, barriers, surgical technique and availability of antimicrobial prophylaxis, SSIs remain a substantial cause of morbidity, prolonged hospitalization and death. SSIs are associated with a mortality rate of 3 percent, and 75 percent of SSI-associated deaths are directly attributable to the SSI.1

Even though most operations in the United States are now performed in outpatient settings, SSI rates and morbidity and mortality statistics come from the acute care hospital setting. Very little is known about infection rates following these outpatient procedures or how best to monitor for these complications. Recent reports of serious lapses in infection control practices at ambulatory surgery centers 2,3 — combined with the continued growth of procedures in outpatient settings — show the importance of preventing SSI.

The guidelines and the bundle recommendations are the same for the ambulatory surgery center (ASC) and the acute care hospital, but there are also unique differences between the two. Where the acute care hospital, for the most part, has oversight of the surgical process from pre-op through post-op, the ASC generally only has oversight from the time the patient walks in the door to the time he or she is released. Even the strongest ASC infection prevention program can be thwarted by inadequate preparation and monitoring of the patient pre- and post-operatively.

Traditional post-op surgical site infection surveillance methods, which focus on inpatient hospitalization and readmission at the facility where the procedure was performed, have proven to be inadequate for monitoring complications following ambulatory surgery. The same can be stated...
for SSI pre-op prevention strategies.

In the pre-operative phase, physician pre-op instructions are rarely standardized, and patient compliance is difficult to track and monitor. Lack of standardization and variance in practice can be detrimental to any infection prevention program, while consistent execution of best practices drives optimal outcomes. It may be difficult, but collaborating with your physician groups to develop a standardized, evidence-based approach will be rewarding in the end. Without a program intentionally designed to standardize practices, you likely won’t achieve your clinical goals.

Patient compliance with pre-op instructions may be the more difficult issue to tackle. Both the ASC and acute care settings are struggling in this area. The key is to develop standardized practices that are easy for a patient to understand and use. There are four key components that can help drive patient compliance:

- Bundling supplies into a kit that can be given or easily obtained by the patient
- Providing an explanation of why it is important for the patient to comply
- Providing instructions that use simple, everyday words or pictures
- Using technology to remind patients when they need to perform a procedure and to document compliance

This must be a collaborative effort with buy-in from the management team, physicians, nurses, techs and, most important, the patient. This type of effort, if implemented correctly, can enhance the patient’s pre-op experience.

Tracking complications

As surgical procedures increasingly shift to ambulatory settings, tracking postoperative complications will become critical, not only from a patient safety perspective but also from a reimbursement and financial perspective. Hospital-based surveillance methods can be inadequate because SSIs following ambulatory surgery often do not require hospitalization. Many SSIs acquired via a surgical procedure in an ASC are managed in an outpatient setting such as a primary care physician’s office or the surgeon’s office. Furthermore, if hospitalized, patients who underwent surgery at a freestanding ambulatory surgery center will likely be treated at a different facility. Currently, surveillance requires self-reporting from the surgeon or primary care physician’s office. This is not ideal, and a more robust and manageable method must be developed.  

Utilizing a bundled approach to the prevention of SSIs (and other healthcare-associated infections) is gaining acceptance. Maureen Spencer, RN, M.Ed, infection preventionist consultant, has developed the 7 S Bundle for the prevention of SSI, based on current guidelines from the CDC/HICPAC and the recommendations of national societies such as AORN and SHEA. The results obtained by Spencer and her colleagues showed that better outcomes were obtained when the bundle was used as a whole, instead of only using individual components of the bundle.

The seven steps of this bundle are:

- Safe operating room practices
- Screen for risk factors

SSI prevention strategies should encompass the entire continuum of the surgical procedure — the pre-operative, intra-operative, and post-operative periods. Improvement processes to prevent SSI should be driven by leadership with a commitment to provide adequate resources and attention to the initiative. In the ASC setting, commitment from all parties that touch the surgical process and procedure is imperative for success.

References:
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 touchpoints 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
- Presented 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

*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
Danny Dillard, purchasing and SPD manager, and former practicing surgical tech, Andrews Institute ASC, Gulf Breeze, Florida
Think about everything that happens during a surgical procedure, from start to finish.

Think about the scores of puzzle pieces that have to fit into place, one after the other, in perfect sequence, to reach the desired outcomes. And think of the people, instruments and equipment that all have to be in the right place at the right time, dancing to the same rhythm from the time the case is scheduled to the time the patient is wheeled into recovery.

Surgical technicians are the unsung heroes of the operating room. Here’s how they make sure every case reaches a successful outcome.
Coordinating it all is a very large task requiring a great deal of behind-the-scenes work, and surgical technicians carry out much of that work. Depending on the type of procedure, every operating room is staffed by one or more surgical techs, performing in sterile glove-and-gown roles at the operating table, and in nonsterile circulating roles, retrieving items for the surgeon as needed.

Particularly in the ambulatory surgery field, driven by elective procedures, OR time is money. Centers aren’t generating revenue when their operating rooms sit idle or if they are mired in a lengthy turnover process between cases. That means efficiency is paramount, and surgical techs are a critical cog in the efficiency machine — ensuring that the right equipment and instruments are in the OR, laid out and operational before the surgeon arrives.

Surgical techs are expected to anticipate which equipment a given procedure will require and to work with a center’s supply department to make sure the proper inventory is on hand for each day’s cases.

In short, surgical techs have a simply stated objective to stay organized and keep everyone around them organized. It’s that simple — and that difficult — particularly as technology continues to change the practice of modern surgery.

**Changes in the field**
Of all the forces that have exerted transformational pressure on the surgical field in recent years, technology is perhaps the biggest. Advancements in technology have made procedures quicker and less invasive, in many cases reducing the recovery time for patients. But these advancements have also required surgical techs to adapt, as the OR has evolved into an arena where the tools are far more advanced than scalpels and clamps.

“I’ve been doing this for 21 years, and in that time, we’ve seen a lot of changes,” says Alicia Wagner, the materials manager and a scrub tech at Lakeside ASC, an affiliate of Surgical Care Affiliates (SCA), in Omaha. “For instance, ACL repairs used to be open-incision procedures, lasting three to four hours. Now, most ACL procedures can be completed arthroscopically with small incisions. Gallbladder surgeries can now be done with scopes, and rotator cuff repairs can all be done through scopes in many cases.”

The advancement of technology has made surgery prep easier for a wide variety of cases. Even as recently as the 1990s, surgical techs might have had to prepare five or six pans’ worth of instruments for a single procedure. Now, the number of instruments for most procedures fits in one or two pans.

Technology has, however, made the care of surgical equipment between procedures more challenging. “When you’re dealing with laproscopic/arthroscopic procedures, the instruments are going to be more delicate, with lenses and other small parts that can be damaged easily,” Wagner says. “The care instructions are more specific, and you have to be a lot more careful about the methods you use to sterilize them for the next procedure.”

Delicate instruments are usually sterilized via a low-temperature hydrogen peroxide gas system such
FEATURE

“It would benefit patient care if surgical techs were accredited with a set of uniform standards. The increased necessity of education requires more oversight of standards.”

— Michael Homs, certified surgical tech, Wisconsin Specialty Surgery Center, Kenosha, Wisconsin

as STERRAD. But, Wagner says, the preferred method for sterilization is going to depend on the manufacturer’s recommendations.

That is one of the main reasons that the working relationship among surgical techs, materials managers and surgical equipment vendors is critical to the success of a modern OR.

The vendor relationship
The role of a surgical tech is all about anticipation. A surgical tech needs to know, in advance, what a doctor will need for a given procedure, and make sure it arrives when it’s supposed to arrive. As technology continues to create surgical instruments that are more expensive, more specialized and more complicated, a tech’s foresight is becoming of increasing importance. More than ever, it requires teamwork from forward-thinkers on multiple fronts.

“In the ambulatory surgery field, we’re doing all elective cases, so we do have the benefit of being able to look two or three weeks down the road and know what cases are coming,” says Danny Dillard, the purchasing and SPD manager and a former surgical tech at Andrews Institute ASC in Gulf Breeze, Florida. “But that also means that we’re not going to have everything on hand at all times, like a trauma unit at a big hospital that has to be ready for anything at any time. So we’re constantly ordering materials, and if it has to be here the next day, that’s when we need it. That’s what makes the vendor relationship so important.”

The surgical tech has the knowledge of how instruments are utilized. The materials department knows how they’re ordered and stocked. The vendor knows how each instrument is produced, shipped, operated and maintained. Those three perspectives create a complete view of the entire materials supply chain, which is why maintaining open lines of communication — often on a daily basis — is so important to the successful completion of cases, and subsequently, the long-term success of the ASC itself.

“The patient never sees all the work that goes into getting equipment from the manufacturer to the OR, but they live with the results for the rest of their lives — and for everybody’s sake, they had better be positive results,” Dillard says. “That’s why we, as surgical techs and materials department managers, really value vendors that are going to be there for us and that view themselves as cogs in a larger machine, as opposed to just salespeople trying to make a quota.”

The future
As the job of surgical techs becomes more intertwined with technology and the business of surgical supply, more education will be required to enter the field and to stay current once established. For that reason, certified surgical tech Michael Homs sees a future in which standard licensure is required of all surgical techs.

“It would benefit patient care if surgical techs were accredited with a
set of uniform standards,” says Homs, of Wisconsin Specialty Surgery Center in Kenosha. “The increased necessity of education requires more oversight of standards.”

As of now, any required licensure or accreditation is mandated by the employing facility, according to what each facility or governing health system mandates as essential qualifications for their surgical techs. Most techs are required to have graduated from at least a two-year training program, but beyond that, the criteria is subjective according to which facility is doing the hiring. Surgical techs often will take on additional responsibilities depending on the circumstances, increasing their versatility in both the OR and the office, but also furthering the need for a universal definition of the essential qualifications for the position.

“People know what a surgical tech is now, whereas maybe they might not have known 15 or 20 years ago,” Wagner says. “But even as the general public has gotten a basic understanding of the job, it has continued to evolve. We’re stepping out of the OR, out of the scrub-tech role.”

– Alicia Wagner, materials manager and scrub tech, Lakeside ASC, an affiliate of Surgical Care Affiliates (SCA), Omaha, Nebraska

In more ways than ever, surgical techs have to anticipate the needs of those around them and will have to continue doing so. The future of surgical techs is one in which they’ll have to be sponges, absorbing new knowledge in many different forms.

Although ASCs, hospitals and educational institutions have worked to increase opportunities for formal continuing education, many techs have augmented that by taking training into their own hands. In that regard, the internet has become a useful training forum.

In an era in which anyone can type their symptoms into an internet search and come up with scores of potential diagnoses, there is a perception that medicine and the internet are oil and water. Medical professionals caution their patients against self-diagnosing via the internet, but there is another side to the medical-internet relationship, and it’s been a very positive development.

“Honestly, the internet has really helped, even though it’s in an informal sort of way,” Homs says. “Sometimes I’ll come across a procedure I’m unfamiliar with, and I can easily go online and see video of how it’s performed. Even though the doctor is the one doing the surgery itself, it helps me to understand what I need to do in my role.

“When you’re looking for any extra bit of information that can help a case run more smoothly, there really is no substitute for video, and I’d expect that it will become an even bigger part of our training in the future,” Homs says. “Training is to the point now where it really needs to go beyond just reading text on a page.”
Ask, and you shall learn

How to use patient surveys to identify weaknesses, improve care and boost patient satisfaction

Patient feedback is critical to the success of any ASC, making patient surveys a critical component of long-term success. But how can you encourage patient feedback and turn the results into meaningful improvements?

The first step is creating a patient survey that inspires response and honesty, then using the feedback to make meaningful improvements at your ASC. As such, a simple, well-written patient survey, and taking steps to motivate high rates of response, can go a long way toward upholding standards of care.

Here are some things to keep in mind when implementing your patient survey program to maximize its potential for success.

Simplify the process
However well-intentioned the survey, and however well the resulting improvements would help, you’re asking patients for a donation of their time. To make it easy, don’t intimidate responders with a survey that is too long or too complex in structure or language. Make it as easy and nonthreatening as possible with a few basic strategies.

• Think about the means of transmission. Will it be via email or postcard with a return mailer? Some facilities conduct phone surveys, although it is becoming more difficult to reach people this way.

• Offer more than one option for response — via paper or email. After all, some patients have never touched a computer or sent an email, while others communicate in no other way. Ask beforehand the means that works best for patients and get their contact information up front.

AHRQ survey
Through its Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, the federal Agency for Healthcare Research and Quality (AHRQ) also surveys ASC patients about their experiences. It restricts the questions to four general areas that solely concern pre-procedure, the procedure itself, after-care and contact with appropriate parties along the way.

• Communication with healthcare professionals
• Access to care and information
• Customer service
• Coordination of care
• Keep surveys brief and to the point. Ask as few questions as possible to get the answers you need, and ask them so it is easy to respond. Consider a five-point scale that patients can check off with responses that range from “strongly agree” to “strongly disagree,” or from “excellent” to “poor.”

• Remember that your patients may be at varying levels of comfort with written English, so keep the language to a sixth-grade reading level. Consider your patient population and look at a translated version if the need is high enough.

• Invite respondents to include written or typed open-ended responses for in-depth comments. Most will leave that section blank, but you could gain valuable input from those who choose to respond this way.

Nudge, nudge, nudge
You’ll get a better response rate if your patients think of themselves as your partners in maintaining high standards of medical care. Take a few minutes before their medical procedures to explain the purpose of the survey and their important part in ensuring quality care. That’s the moment to get their preferred contact information and ask them to respond within a stated time after the procedure. Encourage their questions and make sure they understand that the survey will be anonymous and that you seek their honest assessment — whether the news is good or bad.

If they choose to fill out the survey on paper, don’t just include it in the pile of paperwork they receive before their procedure. Instead, provide a brightly colored envelope, or one that will otherwise stand out. Most centers provide follow-up phone calls after the surgery to check on patients, so use this as another opportunity to encourage them to respond. Sending a text as a reminder is also a quick way to help increase engagement.

Learn and apply
It makes no sense to go through the effort to survey patients if you don’t carefully scrutinize what they have to say and, if necessary, institute real changes to address oft-mentioned complaints.

Make sure your questions are uniform and consistent so that surveys can be easily and reliably compared. Consistently changing or rewording questions makes it difficult to compare responses and to understand whether critiques are part of a noteworthy trend or one-offs.

If negative feedback is rare or unique, set it aside but be on the lookout for patterns of response that can indicate real operational or medical weaknesses. And even the one-offs should be addressed, perhaps with a phone call or other form of contact to get a fuller understanding of the nature of the complaint. Remember: nothing helps — or hurts — a business faster than word of mouth.

Post-operative patient surveys can be real and effective agents of change. After all, who knows better the real quality of care than those who have experienced it?
Chaos prevention

10 tips for managing instruments when the pressure is on

Surgical technologists have an incredible amount of responsibility during a procedure, including the management of instruments, supplies and equipment. In such a fluid environment, it is critical that they exercise extreme care and precaution. But as with so many important jobs, there are a lot of details to remember when the pressure is on.

To explore chaos prevention best practices that can help prevent bad results, Outpatient Outcomes asked two highly experienced former surgical technologists — Margie Summerfield, CST, CBSPD, and Hassan Bilal, CST, CRCST — to share their favorite tips for ensuring instruments are prepared and organized when your OR team is under the hot lights of the surgical suite.
Be sure you have a complete set of instruments. Make sure nothing is missing from the instrument set at the start of the procedure. You don’t want to have an empty hand when the surgeon asks for a specific instrument.

Check the grade level of the instruments. As you’re laying out the case, check the instruments to ensure they are surgical-grade stainless steel and not one-time use, floor-grade instruments. Because they look similar, sometimes floor-grade can get mixed in with the surgical instrument set. To tell the difference, surgical-grade instruments are usually marked with company name, item number and perhaps even the country of origin. Also, you can often tell by comparing the weight and feel of these instruments. If you think you’ve found a floor-grade instrument, set it aside.

Check instruments for functionality. When setting up the procedure, inspect all the instruments and be sure they are clean, sterile and working properly. There is nothing worse than handing a surgeon a clamp or forceps that is not working correctly.

Keep instruments clean and properly working throughout the procedure. Keep a moist lap sponge (with sterile or distilled water) close by to wipe off any gross contamination on the used instruments. Dried blood can become sticky and difficult to remove, which can impact the handoff to the surgeon and the instrument’s functionality if used more than once during the procedure.

Presoak instruments once the case is over. Place instruments in a basin and spray them down with a presoak (such as Bio-Zolve from Medline). Doing so will break down the bioburden in the blood and other material to help make the decontamination process easier and more effective.

Do not use sodium chloride (saline) to clean instruments prior to returning to the SPD. The salt will break down the stainless steel and damage the instrument. Instead, use a presoak liquid as cited above.

Organize unused instruments. Restring unused instruments and place them back in the tray. This way, they’ll be cleaned and sterilized more quickly and ready for the next case.

Check instruments for rust or staining. More than likely, it won’t be rust. Here’s a quick check method: Rub the instrument with a pencil eraser. If you can remove the stain, then it’s a problem with your water. It may have too much magnesium and calcium, or you have dirty steam lines in your autoclave process. The solution is to use a deionizing or a reverse osmosis system to purify or soften the water. If it is rust, throw the instrument away. Rusting can create safe havens for bioburden and compromise the integrity of the instrument itself. Following standards for instrument care and maintenance should keep instruments from rusting.

Crosstrain on other procedures. In case of emergencies or scheduling conflicts, you’ll make yourself indispensable by learning procedures in other specialty areas. Additionally, as personnel resources become tighter, learning multiple procedures or skills may become the standard method of operation at most agencies. Flashcards can help teach you the different instruments, and observing different cases will ensure you are comfortable with them if you are ever called on to help.

Handle wrapped trays with care. The sterilization wrap can tear and compromise the sterile barrier. When handling trays, always place them on a solid, smooth surface. In addition, do not place them on a ring stand that can cut fabric, do not drag trays across shelving and, when moving the tray, place your hands underneath and lift. Each tray is limited to 25 pounds, per AAMI standards. If you stack wrapped trays, be sure to follow the manufacturer’s instructions for use.

About the contributors
Margie Summerfield, CST, CBSPD, and Hassan Bilal, CST, CRCST, are product and sales specialists in Medline’s Operating Room division. Between them they have more than 60 years of experience in the OR and central sterile processing, and they maintain leadership roles in industry associations and train new technologists.
On Oct. 1, 2015, the U.S. medical industry formally adopted ICD-10 as its coding standard, ushering in some of the most extensive alterations ever made to the medical coding system.

ICD-10 vastly increased the number of medical codes utilized to classify diagnoses, with an estimated 68,000 codes compared with approximately 13,000 in ICD-9. More codes mean more specific diagnosis criteria — for example, different codes to distinguish a right knee injury from a left knee injury — and thus better-focused patient care and more accurate billing.

But the change has also meant a lot of prep work, training and adjustments for medical offices and personnel around the country.

Now that a year has passed since the implementation of ICD-10, center administrators are reflecting on the transition and on how steps taken over the past year will affect their facilities moving forward.

What went right
Early on, administrators knew it would take months of preparation to position their organizations for the changeover. At Bergan Mercy Surgery Center in Omaha, administrator Leslie Voigt began working with her team in January 2014 to create a timeline. “We knew we’d have to get IT involved early, testing the connectivity of our systems, and we knew we’d have a period of intensive training and implementation,” Voigt says. “We needed a map for who we’d bring in to the conversation and at what time.”

As part of the larger Bergan Mercy Medical Center hospital system, Voigt’s facility worked with the hospital to train coders, managers and physicians, and continued to coordinate efforts with the IT department.

“Overall, we really did a good job of communicating over those two years, all the way up to and including the main portion of our implementation, which was between March and June 2015,” Voigt says. “We had an action plan in place from the start, and it made all the difference.”

At Valley Ambulatory Surgery Center in St. Charles, Illinois, administrator Daniel Hauer knew the transition would require a
balance between training and productivity. Staff members couldn’t sacrifice ongoing productivity to learn the new system and would have to juggle the present and the future during the transition period.

The solution?
“We trained — and trained some more,” Hauer says. “We needed to experience the change, and how it would affect our jobs, well before the change took place. So apart from regular job responsibilities, I held physician meetings to discuss the implementation of ICD-10, and we sent all appropriate staff to various classes. We even conducted a mock billing session to give our staff real-time experience in coding with the new system.”

Room for improvement
As with any major transition, there are teachable moments for staff and administrators alike.

Hauer said his center was challenged to find a sweet spot — preparing staff while not overreacting and committing resources before they were necessary.

“There is always a bit of hidden fear around getting it right the first time, so you want to be on guard and have your resources lined up,” he says. “You hear time and time again about how this change to ICD-10 is going to happen, but then it keeps getting pushed back. It’s like crying wolf — people start to wonder if it’s ever going to happen. You’re fighting an uphill battle against that, too.”

Voigt says that even though the Bergan Mercy communication strategy was an overall success, it’s never a flawless process. Providing clear communication represented an ongoing challenge throughout the transition.

“From a facility level, we didn’t stay as close to the offices as we could have,” Voigt says. “There are incidences where you aren’t really sure what questions you should be asking each other, particularly between us in administration and the offices of the physicians who operate here. So you’re always going to be circling back on things like that.”

Moving ahead
Hauer says he hasn’t seen enough data post-implementation to accurately gauge whether the changeover to ICD-10 has delivered the desired results. But he believes the net result of ICD-10 will be positive for both caregivers and patients.

“I fully expect the access to additional data to make some positive impacts throughout the healthcare system as a whole,” Hauer says. “And it will go beyond just reimbursement tracking. It will include quality reporting requirements. That’s an additional burden for centers, but when you have all of this new data that can allow for more precision in diagnoses and treatment, you should put it to work for the patient’s benefit.”

Voigt also wants to take steps to help ensure the data access provided by ICD-10 does, in fact, benefit the patient and not just the bottom lines of medical providers and insurance payers.

“That’s what we all want to see long term — that this data gathered leads to long-term patient benefit,” Voigt says. “Decisions can’t always be made based on revenue or reimbursement. ICD-10’s ultimate result should be an increased ability to provide the best possible patient care.”
Ambulatory surgery centers are first and foremost places for patient care and service. And while the focus is on quality healthcare, innovative treatment and patient satisfaction, at their core surgery centers are places of business in a rapidly changing and highly competitive industry. Here are eight facts, figures and trends that help define the marketplace and illustrate where ASCs fit in.

1. There are approximately 5,400 to 5,500 Medicare-certified surgery centers in the country. These are freestanding ambulatory surgery centers, and almost all of them have some level of physician ownership.

2. Of these surgery centers, management companies hold an equity interest in approximately 1,500 to 2,000 of them. Some of these management companies own a majority interest, while others own a minority interest and yet others are in partnership with hospitals.

3. Similarly, approximately 1,500 hospitals own interests in surgery centers. Hospitals invest in surgery centers either as an offensive maneuver to develop more market share with physicians, or as a defensive maneuver to try to block competition from entering the market. Further, hospitals increasingly invest in surgery centers as a low-cost option for surgeries.

4. The number of surgery centers has remained relatively flat over the last five years. This has included approximately 100 surgery centers opening and 100 surgery centers closing per year.

5. Reimbursement can be challenging for surgery centers. Medicare reimbursement has been relatively flat, commercial reimbursement is all over the board, and the ability to operate out of network is becoming increasingly difficult in many places.

6. The surgery center market has benefited from increased transparency and competitive pricing, as well as from responding to customer concerns about high-deductible plans. These improvements have made surgery centers more attractive for patients.

7. The most prominent specialties for surgery centers include ophthalmology, gastroenterology, orthopedics and pain management. The number of neurosurgeries — mostly spine surgeries — has increased in surgery centers, too.

8. The strength and growth of surgery centers is largely dependent upon independent surgeons. In essence, those specialists are not employees of hospitals. The trend toward the employment of physicians by hospitals has worked against surgery centers over the last five to 10 years.
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