Outpatient total joint replacements

PPIs are possible in your packs

Infection preventionists’ influence on PPIs

Physician Preference Items
How Physicians’ Surgical Care Center efficiently manages PPI

PLUS: Managing Physician Preferences in the Supply Chain
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Surgery centers have been forerunners of value-based care. As this care becomes the norm, many center leaders are looking at supply costs as a significant target, with clinical standardization — specifically surrounding physician preference items (PPIs) — seen as an even greater opportunity.

Read about how the materials manager at Physicians Surgical Care Center in Winter Park, Florida collaborates with their physicians regarding selection of PPIs. Learn how Matt employs compromise and transparent communication with physicians to manage PPIs in a way that balances clinical and financial goals.

For tips on how to work with your distributor to add efficiencies to your supply chain, check out our article “Managing physician preferences.” You will find advice from Medline distribution experts on ways to curb costs at your facility by expanding the volume of PPI purchased through distribution.

Similarly, Medline’s chief nursing officer shares insights on the best ways to engage physicians at your ASC and win their buy-in regarding PPI decisions that increase cost efficiencies. She advises taking an empathetic approach toward understanding the reasons behind their preferences.

Orthopedics is a specialty widely associated with PPIs. Did you know that more than 200 ASCs across the U.S. now perform total joint replacements (TJR)? Find out how more cases are moving out of hospitals and into ASCs and why this trend is growing.

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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PPI standardization:
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Performance measures for THKR certification

Late last year, the Joint Commission finalized performance measures for Total Hip and Total Knee Replacement (THKR) certification. As of Jan. 1, 2018, all THKR-certified programs and those seeking certification must collect and report monthly data for four standardized measures. These are:
- THKR-1: Regional Anesthesia
- THKR-2: Postoperative Ambulation on the Day of Surgery
- THKR-3: Discharged to Home
- THKR-4: Preoperative Functional/Health Status Assessment

The THKR measures apply to patients undergoing a total hip or a total knee replacement in the inpatient or outpatient setting. ASCs are required to report data to the Joint Commission via the Certification Measure Information Process (CMIP) on the Joint Commission Connect secure extranet site.1

Updated guidance for Clostridium difficile

The Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America recently updated their 2010 clinical practice guideline on Clostridium difficile infection (CDI). The goal of the 2017 update is to improve diagnosis and management of Clostridium difficile, which is the leading cause of healthcare-associated infection in adults in the United States.

Published in Clinical Infectious Diseases in February, the updated guideline includes major changes in the management of CDI, discusses optimal diagnostic methods and calls for increased antibiotic stewardship to control CDI rates. It also incorporates new recommendations on epidemiologic surveillance, diagnosis and treatment of the infection in children.

To view the guideline recommendations, visit https://academic.oup.com/cid/article/66/7/e1/4855916.

MedPAC recommends mandatory ASC cost reporting

The Medicare Payment Advisory Commission (MedPAC) made two ASC-specific recommendations to Congress in its March 2018 report. These recommendations are:
- Keeping Medicare payment rates the same in 2019. According to MedPAC’s analysis, “the number of ASCs has increased, beneficiaries’ use of ASCs has been stable, and access to capital has been adequate.” Therefore, Congress should eliminate the 2019 update to Medicare payment rates for ASCs.
- Making cost reporting mandatory for ASCs. ASCs participating in the Medicare program should be required to submit information on total facility costs, Medicare unallowable costs (such as entertainment, promotion and bad debt), total Medicare payments and several other areas.

MedPAC also advised Congress to create two new quality assessment measures: (1) the number of Medicare beneficiaries discharged from ASCs who had a subsequent unplanned hospital visit, and (2) the rate of surgical site infections at ASCs. To view the full report, visit www.medpac.gov/docs/default-source/reports/mar18_medpac_ch5_sec.pdf?sfvrsn=0.

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OASCA ANNUAL CONFERENCE & TRADE SHOW
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The University of Oregon
Eugene, Oregon
Attend roundtable discussions and breakout sessions, and interact with vendors, at this annual event hosted by the Oregon Ambulatory Surgery Center Association. For more information, visit www.ascoregon.org.

OAASC ANNUAL MEETING
Sept. 19-20
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At this multidisciplinary conference, the Ohio Association of Ambulatory Surgery Centers helps Ohio’s ASC professionals stay updated on timely issues that are important to their centers and professions, from clinical research to quality improvement to materials management, and more. For more information, visit www.oaasc.net.

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For more information or to request samples, please contact your Medline ASC representative.
Sterile solutions for irrigation

For most of 2017 and into 2018, U.S. healthcare facilities have been impacted by supply disruptions to sterile solutions. Baxter, B Braun and Hospira had supply chains that were all affected and led to significant backordering.

This shortage impacts not only injectables such as saline, glucose and LRs, but also sterile water and normal saline for irrigation. A key difference between sterile solution for injection and sterile solution for irrigation is that injectable solution is considered a pharmaceutical, whereas irrigation solution is considered a medical device.

Medline’s full line of sterile solutions for irrigation in sizes 100ml, 250ml, 500ml, and 1000ml helped many facilities during the shortage and remains a viable cost effective choice. To date, our sterile solutions have been free of the backorders and shortages affecting the bulk of this market.

Medline sterile water and saline solutions are:

- Packaged in a sterile plastic bottle with an induction seal to ensure sterility and protect the contents of the bottle. The bottles can be warmed to temperatures up to 50°C (122°F) for up to 45 days, and they have a two-year expiration date.

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To learn more about Medline’s sterile solutions for irrigation, contact your Medline ASC sales representative or email asc@medline.com.

To date, our sterile solutions have been free of the backorders and shortages that have significantly affected this market.
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Yes, PPIs are possible in your packs

Redefining what preference means and how to achieve it

Getting physician preference items (PPIs) into your packs involves these key ingredients: communication, common ground and volume.

The challenge with PPI requests is that some facilities view preference items as costly and sometimes wasteful, explains Angela Carranza, clinical resource manager for the Medline Sterile Procedure Tray (SPT) division. But done right, PPIs can help streamline a surgery center’s rigorous supply budget and fold seamlessly into packs or more complete systems, such as Medline’s complete delivery system (CDS), which includes everything needed for every stage of the procedure.

“PPIs tend to scare off centers because they limit the scope of who can use an SPT or a CDS if they are too surgeon-specific,” Carranza says. Instead, Carranza has seen many facilities shift toward using a universal pack that aligns across more cases and minimizes pack management.

Building a universal pack

The idea of going universal is changing the landscape of physician preference. Rather than creating a surgeon-specific pack, Carranza recommends building a universal pack by specialty and volume.

It all begins with a dialogue to understand the facility’s clinical practices. To open the discussion, Carranza employs her clinical expertise to gain an accurate understanding of the center’s utilization, preferences and high-volume surgeons.

Utilization. “I start with an open conversation about what they’re currently using and how it can be improved,” Carranza says. “There are times we receive pushback, such as, ‘Our packs are fine just the way they are,’ ‘I always just pull [the item] if we need it,’ or ‘If it’s expensive, we can wait.’”

To diffuse resistance and invite honest dialogue, Carranza collects first-hand knowledge from the nurses and surgical techs to find out which items are truly being utilized for a procedure. Questions that help to evaluate a

“If three surgeons are performing the same procedure at a center, but one surgeon is using different components than the others, we need to focus on the commonalities.”

– Angela Carranza, clinical resource manager for the Medline Sterile Procedure Tray (SPT) division
EFFICIENCY

process include:
• How many surgeons are utilizing this pack? Which one uses it the most?
• Talk me through your setup process. What extra items are you always pulling?
• If you could have the perfect pack, what would you put in it?

Based on these insights, Carranza can recommend the most efficient and cost-effective components that can serve the entire facility. “We really want supply flow improvements to help increase patient focus for the clinical team,” she says.

Preferences. Data are essential to streamline PPIs into packs. In addition to interviewing a center’s clinical team, Carranza requests preference cards.

“Preference cards give us great insight, but we know there are gaps,” she says. “I’m not sure there’s a preference card out there that covers 100 percent of what’s needed for a procedure, but it’s a good start. It’s important to balance preference card information with tribal knowledge from procedure experts.”

Preference cards can help you determine where it makes sense to create a pack with PPI. Look for consistencies in item usage among different surgeons or across specialty areas. Do you have enough surgeons in aggregate using a certain PPI for a procedure? Or, is there one high-volume surgeon who does a large number of cases with a PPI?

“We talk volume a lot — overall facility volume and if it will dictate doing a more surgeon-specific pack — but we’ve done a lot of specialty-specific packs, too,” Carranza explains.

Finding the right mix of products often comes down to finding commonality among multiple surgeons.

“If three surgeons are performing the same procedure at a center, but one surgeon is using different components than the others, we need to focus on the commonalities,” Carranza says. “For example, surgeon C uses the 10 mm trocar, while surgeons A and B use the 5 mm trocar. We need to evaluate surgeon C’s volume.”

It helps to ask questions such as, “How often is the surgeon performing this procedure?” and “Will the surgeon be using this PPI for another procedure where a pack specific to this PPI makes sense?”

“When we start reviewing the details of the clinical practice, we can identify when it makes sense to include the preference item,” Carranza says. “In other circumstances, we can help by leveraging our position as a global kitting manufacturer to provide alternatives.”

Getting buy-in
If a surgeon is reluctant to adopt a standardized or universal item, getting buy-in comes down to communication, Carranza says. It’s important to address the surgeon’s loyalty to a particular product or brand respectfully, regardless of the specific difference.

“Usually, it’s not the product,” she explains. “It’s the way the conversion is happening or the way a product is put into use. Leveraging our product specialist and clinical resources adds support that a center may need throughout a transition.”

What’s next for PPIs in surgery centers? As ASCs take on more complex procedures, Carranza says vendor partners must be ready to provide them with the protocols and products they need to perform at an optimal pace.

“It’s an exciting time,” Carranza says. “Outpatient facilities do so much more with less. They can be change leaders for surgical supplies and PPIs.”

Angela Carranza is a clinical resource manager in Medline’s Sterile Procedure Tray division. She applies her clinical background to match facilities with the most efficient and cost-effective products for their needs. When she is not meeting on-site with customers, she is busy on the main line of SPT, evaluating the compatibility of each and every component.
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Managing physician PREFERENCES

Physician preference items, their impact on the supply chain, common pitfalls and best practices

Ambulatory surgical centers spend more money on drugs and medical supplies than on any other operating expense. Even employee salaries and wages, which come in at 21.6 percent of the median ASC budget, cost less, according to VMC Health’s Multi-Specialty ASC Intellimarker¹.

Physician preference items (PPI) account for a significant portion of medical supply spending, and they also create supply chain inefficiencies, unnecessarily driving up costs. As ASCs continually search for ways to streamline supply chain and control operational costs, improving PPI management offers a promising opportunity.

Managing the supply chain
Surgery supply costs vary widely due to surgery’s reliance on devices, ranging from surgical mesh to knee implants. Not only do ASCs hold significant device inventory, they generally stock PPIs that are often more expensive than standard alternatives.

To complicate matters, many ASCs acquire PPI from disparate sources. Either their distributor doesn’t support PPI management, or the ASC administrator assumes implementation will be too cumbersome and expensive. In some cases, the physicians themselves work directly with medical device companies, throwing another wrench into the management plan.

“Larger surgery centers may have some inventory in consignment,” says Medline Distribution President Bill Abrams. “Other inventory or facilities without consignment may be just-in-time deliveries direct from the manufacturer, and the rep is stopping by and servicing with trunk stock. The nature of existing supply chains is not consistent and has literally an infinite number of permutations and combinations.”

This inconsistency in supply ordering leads to

ASCs can streamline supply chain, control costs and possibly improve clinical outcomes by getting a handle on PPI. Communication — with both distributors and physicians — is key.
unnecessary expense. Nurses prepare items in anticipation of a procedure, but surgeons don’t use them. Products expire on the shelf. Admins inadvertently order duplicate devices. “Surgery centers buy high-cost products that have expiration,” says Medline Distribution’s Vice President of Vendor Relations Greg Hylton. “The odds of finding a stray expensive product in a drawer that’s obsolete or expired go up without managed PPI.”

Most physicians choose PPI due to perceived clinical outcome improvements. But do those choices improve outcomes?

A study by University HealthSystem Consortium analyzed cost and quality outcomes at 10 academic medical centers. One surgeon identified in the study regularly used a custom hip implant that cost more than Medicare reimbursement rates. The implant was also associated with longer hospital stays and higher readmission rates.2

ASCs can streamline supply chain, control costs and possibly improve clinical outcomes by getting a handle on PPI. Communication — with both distributors and physicians — is key.

Distributor partnerships and PPI

Although some full-line distributors previously didn’t service PPI, that’s less of an issue today. According to a 2017 Acute Care Market Survey conducted by Health Industry Distributors Association (HIDA), nearly half of all hospitals surveyed have explored purchasing PPI through their distributor, and about 90 percent of those organizations decided to move forward with those partnerships.3

“It’s a false choice in today’s world that you have to decide whether something is a standard med-surg item or whether it is a physician preference item,” says Abrams. “The only question for the manufacturer is, do they want to take advantage of a best-in-class supply chain to service the customer for their product?”

Certain categories of devices are already finding their way into the

ASC physicians have a vested interest in controlling PPI costs. Because many physicians are partners in the center, cost control and improved outcomes directly impact their practice.
Outpatient volume increased 33 percent from 2006 to 2013, according to Regent Surgical Health data. As hospitals continue to refer certain patients to ASCs for outpatient care, these facilities stand to benefit from value-based care. As volume increases, so do medical supply costs. Considering that physician preference items (PPIs) account for at least 40 percent of those supply costs, ASCs are taking a harder look at what physicians purchase. As part of that analysis, ASCs would do well to talk with their distributor about managing PPI inventory and distribution.

With more than 40 distribution centers across the country and a large vehicle fleet, using a company such as Medline for PPI could lead to big savings. Medline distributes and manufactures more than 550,000 med-surg products.

“If the customer worked with their ASC rep, there could be categories of PPI very likely that Medline already distributes, because we have such a broad portfolio,” says Medline Distribution’s vice president of vendor relations Greg Hylton. “In addition, Medline adds new relationships every day that get initiated by customer requests.”

Hylton suggests ASCs take a close look at what and where they’re spending on PPI. In many cases, they can move some of their PPI to their distributor.

“We suggest customers review their needs and determine if our supply chain would be preferable,” says Hylton. An ASC may use items previously considered PPI that are more standard now. “If a center wants to advance their use of supply chain for certain devices they’re already buying, no one has to recreate the wheel and do a lot of negotiating for a surgery center,” he says. “There are probably product-line extensions, endo-mechanicals and electrosurgery items they could buy from Medline or their local distributor.”

Bottom line: if you’re interested in lowering PPI spend, talk to your distributor. You might be surprised how he or she can help you.

Resources
supply chain, and ASCs should discuss them with their distributor, says Hylton. “These items could be brought through the channel to the center,” Hylton says. “There are other items that might not be in the supply chain yet that, with a thoughtful conversation, are just one negotiation away from working something out with that manufacturer.”

According to the HIDA survey, hospitals purchase just 19 percent of PPI through distributors. Of those that do, more than half plan to expand the volume of PPI purchased through distribution. Primary distributors present an open door to PPI management improvement.

**Facing physician opposition**
ASC physicians have a vested interest in controlling PPI costs. Because many physicians are partners in the center, cost control and improved outcomes directly impact their practice.

An article in *Becker’s ASC Review* reported that physicians respond to data about their individual performance. During regular meetings with individual physicians, ASCs should consider presenting data about their product/supply use and cost per procedure. The data not only opens their eyes to what they spend but also spurs conversation among physicians about devices used and cost impact. These conversations may also prompt friendly competition. If a
If a physician discovers his costs exceed that of his colleagues, he may work to shift those numbers to get ahead of his peers. Also, knowing that his PPIs influence supply chain savings, which affects other purchasing decisions, could inspire change.4

Financial incentives have also proven successful. In a 2016 study published in JAMA Surgery, a hospital gave physicians a goal to reduce costs by 5 percent. One group received scorecards detailing certain line items, while the second group received no information. The scorecard group reduced median supply costs by 6.5 percent, while the non-scorecard group’s costs rose 7.5 percent. Researchers concluded that improved supply cost awareness and a willingness to emulate high-performing peers influenced the results5.

Clinical outcomes
Clinical outcomes and cost are the two most important factors influencing PPI decisions, Premier Inc. reports.6 With the adoption of value-based care, administrators have more clinical outcomes data than ever before.

“The availability of sophisticated outcome data is far more within reach that it was five years ago,” says Abrams. “If a physician wants to know if a PPI choice is driving better outcomes, that can now be proven with data.” ASCs can analyze data to compare outcomes against devices. When data indicates a trend in positive or negative outcomes when using a particular product, ASCs can present that data to physicians when discussing PPI choice. Clinical outcomes not only influence provider reimbursement, they also affect drug and device pricing.

To further control costs, if a high-end PPI shows promising clinical outcomes, ASCs can consider a trial of a nonbranded PPI. Premier Inc.’s research showed more than 70 percent of clinicians and C-Suite personnel surveyed were willing to trial a nonbranded PPI.

Managing inventory
Regardless of whether an ASC uses PPI, efficient inventory management is crucial to controlling costs and improving productivity. Take a good look at your spend to determine if there are items with which a supply chain fit is preferred, then talk to your distributor.

“What fits in a med-surg distribution supply chain is decided on a case-by-case basis,” says Hylton. “The cost of the item should not be the barometer.”

Hylton says ASC administrators may assume that a clinically complex or expensive device wouldn’t fit in a med-surg distribution supply chain. Ask anyway.

“There are plenty of products that are perfectly capable of riding along,” says Hylton. “In the spirit of being open and collaborative with each other, if a facility sat down with their rep, it could find opportunities to expand.”

 Abrams says that when he has gone through this type of exercise with a customer, everybody involved is surprised by what they’re spending.

“Inventory often grows organically, without discipline,” he says. “When you bring discipline to the process, you have these ‘aha’ moments of, ‘I didn’t know we were buying this much of that product.’”

During this type of evaluation, an ASC may discover it is buying products in small quantities from several vendors. Consolidation leads to a more efficient buying process, and by letting one distributor handle the job of multiple vendors, an ASC gives the distributor the opportunity to negotiate for volume discounts. Doing so also lessens the chance of an expensive medical device expiring on the shelf.

“ASCs and hospitals have similar challenges,” says Hylton. “They don’t have the storage room to carry a lot of stock, and they look for distribution to be their safety buffer.”

As hospitals and ASCs alike focus on standardization in an effort to control costs — PPI included — they must also assess logistics. Communicate openly with physicians about device costs and outcomes so they can make informed decisions. Detailed conversations between the ASC and its distributor will help both parties determine the most efficient course of action in managing PPI.

RESOURCES
Matthew Stewart, materials manager, Physicians’ Surgical Care Center
Ambulatory surgery center supply costs can account for between 15 and 32.7 percent of net revenue, making supplies a significant line item in surgery centers’ budgets.1

Surgery center administrators and supply managers work to create an efficient, cost-effective supply ordering system to garner the items they need to provide quality patient care. But office staff members aren’t the only ones who have a say in surgery center supplies. Physicians may want specific items, and these requests are often made from a purely clinical standpoint, very often forgetting about the bottom line. Surgery centers have to find a delicate balance between maintaining physician relationships and controlling supply costs.

Physicians often have preferences for certain items, some of which are easy to satisfy and some of which take creative maneuvering. Medical devices are expensive, accounting for 6 percent, of $200 billion, of annual U.S. healthcare spending.2 As a result, preferences for certain implants can quickly drive up costs. Here’s how one multispecialty surgery center in Florida successfully manages its physician preference items.

Maintaining a balance
Physicians Surgical Care Center, a six-operating-room ASC in Winter Park, Florida, is a joint venture between Jewett Orthopaedic Clinic and management company Surgical Care Affiliates. The multispecialty center has an annual caseload of more than 9,000 procedures, the majority of them in orthopedics.

Twenty-five orthopedic surgeons and eight ENT surgeons perform cases at Physicians’ Surgical Care Center, where Matthew Stewart has worked for three years. He started as a surgical technician and today is the materials manager. In this role, Stewart fields physician preference requests and has learned to manage those requests while balancing physicians’ relationship with the center and the ever-important bottom line.

Addressing preferences
Many physicians at surgery centers also operate at larger hospitals and health systems, which have more resources available. Hospitals can access the latest implants and supplies without as much consideration for their overall supply costs. ASCs, on the other hand, work with much tighter margins.

“I handle this issue with ENT and orthopedics. Physicians want the latest and greatest equipment at their disposal,” says Stewart. “They are often used to having a specific item at one of the local hospitals, and they want to use that same item.”

Balancing requests and costs
Stewart understands the value of keeping physicians happy and has never said no to a physician preference item.

“I locate the item, set it up so we can bring it to the center, and try to do that in the quickest amount of time possible,” he says.

Yet Stewart understands the value of managing supply costs. Here’s how he has balanced that core goal with physician preference items.

Communication
Managing physician preference items comes down almost entirely to communication, says Stewart. “There has to be good communication between the person fielding the

(Physicians) are often used to having a specific item at one of the local hospitals, and they want to use that same item.”

– Matthew Stewart, materials manager, Physicians’ Surgical Care Center
requests and the physicians, and between the person fielding the requests and the supplier’s reps. As long as there is strong communication, there shouldn’t be a problem getting items and working together to get the cost as low as possible.“ Clear communication sets manageable expectations, allowing supply managers to understand what physicians want and physicians to understand what it takes to get a specific item. Reps know what the center needs and work to get it there at the right cost.

Compromise. Stewart has not turned away any physician preference item requests, but he has learned to compromise. If a requested item is too expensive, he researches acceptable alternatives, presents them to the physician and finds the middle ground. “I work with them to come to a compromise, if need be, on getting the best priced item to the center.”

Turning to reps
The reps that work with a surgery center can prove invaluable. This is has certainly been the case at Physicians’ Surgical Care Center, where Stewart has a strong working relationship with his Medline rep, Dustin Myers. When a physician comes to him with a request for a specific item, he calls Myers. “I know I can go to him, even if the item in question is made by a different company,” says Stewart. “I can bounce ideas off of him and find out if Medline has an alternative item at a better cost.”

Physician preference items are a central part of any surgery center supply manager’s responsibilities, but they don’t have to dread those requests. The right approach, driven by transparent communication and compromise, can put those supplies in physicians’ hands and keep the center running smoothly — effectively balancing the clinical and financial goals.

“There has to be good communication between the person fielding the requests and the physicians, and between the person fielding the requests and the supplier’s reps.”

– Matthew Stewart, materials manager, Physicians’ Surgical Care Center

SOURCES


Conversations surrounding physician preference items (PPIs) generally involve how to achieve cost efficiencies without affecting quality of care. Administrators and business managers often concentrate on standardization and savings, whereas physicians usually focus on clinical concerns. The challenge lies in striking a balance by choosing PPIs that meet both business and clinical objectives.

Involving your infection preventionist in the PPI selection process can help shift the conversation to a more balanced focus — choosing PPIs that deliver value as well as optimal patient outcomes.

According to the Association for Professionals in Infection Control and Epidemiology (APIC), an important role of the infection preventionist is to identify and implement infection prevention and control strategies based on specific topics. One of those topics is the use of patient care products and medical equipment, which include PPIs.

Here are two ways infection preventionists can influence PPI selection at your surgery center.

1. **Collecting actionable data.** Similar to physicians, infection preventionists are highly analytical, basing their decisions on hard data. They carefully record and monitor infection rates at a facility, looking for causes and ways to bring incidence down. If a particular PPI is a contributing factor in patient infections, and corresponding data are available, physicians will be more confident in switching to a different manufacturer.

2. **Sharing insights for continuous improvement.** In addition to tracking the latest trends, research and news in infection control and prevention, infection preventionists stay well informed of emerging topics through peer-reviewed articles and active membership in professional organizations, such as:
   - Association for Professionals in Infection Control and Epidemiology (APIC), at the national and regional levels
   - Society for Healthcare Epidemiology of America (SHEA)
   - Infectious Diseases Society of America (IDSA)
   - Association of periOperative Registered Nurses (AORN)

If an infection preventionist hears news about a plate or screw that’s related to infections, for example, she can proactively recommend safer product alternatives.

When you’re evaluating PPIs with your physicians, it’s important to include your infection preventionist in the conversation. Their input can be invaluable in driving change, and it will help you make the case for choosing products to deliver the best patient outcomes.

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**Rosie Lyles, MD, MHA, MSc,** is director of clinical affairs at Medline Industries Inc. With more than a decade of experience investigating healthcare-associated infections (HAIs), she is an expert on the epidemiology and prevention of multidrug-resistant organisms. Dr. Lyles previously served as a physician-researcher at Cook County Health and Hospitals System and as head of clinical affairs at Clorox Healthcare. She has directed numerous clinical studies and interventions for both the Centers for Disease Control and Prevention and the Chicago Antimicrobial Resistance and Infection Prevention Epicenter, and she is the author of peer-reviewed journal articles.
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.

KNEE AND HIP IMPLANTS
Knee and hip arthroplasty surgeries equate to nearly 24% of OR procedures utilizing PPIs in the form implants.

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.

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 or better than those they use traditionally.

COST CONSIDERATIONS
- In most orthopedic and/or cardiac-related surgeries, a single PPI can account for 40-80 percent of the total procedure cost.
- 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.
- It is much more difficult for facilities to get wholesale rates if each physician requires specialized tools. Lower ordering volume equals higher cost.

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 use

REFERENCES
40% OF HIGH-FLUID PROCEDURES USE THE WRONG GOWN*

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Outpatient total joint replacements

Why more cases are moving out of hospitals, and what the trend means for ASCs

Every day, more joint-replacement patients are receiving new knees, shoulders and hips at outpatient surgery centers — and that number is growing rapidly. The opportunities for ASCs and patients requiring these procedures are tremendous.

“We started total joints last December,” says Sandra Berreth, administrator at Sansum Clinic Foothill Surgery Center in Santa Barbara, California. “We’re performing the same procedures as hospitals, but for significantly less cost on average. That’s a good chunk of change for patients paying 10 to 20 percent as part of their deductible and copays.”

**Why the surge in outpatient total joint replacements?**

More than 200 ASCs now offer total joint replacements (TJRs), up from just 25 in 2014.1 Meanwhile, an Sg2 report estimates that 51 percent of TJRs will be performed at outpatient facilities by 2026 (a 77 percent increase from 2016).

There are several factors driving the growth of outpatient TJRs, particularly at ASCs. There’s the Centers for Medicare and Medicaid Services’ (CMS) recent removal of TKRs from its Medicare inpatient-only list and its potential impact on future ASC reimbursement. There are the demographics: Otherwise healthy and well-informed Boomers and Gen Xers are willingly taking advantage of advanced surgical techniques, implants and the personal care afforded by today’s ASCs. There’s also the increase in hospital-ASC joint ventures, which is giving hospitals a way to hold on to some TJR revenue and expand patient services.2

“We’re seeing great value in hospital partnerships,” says Ken Rosenquest, COO of Constitution Surgery Alliance, an Avon, Connecticut-based independent owner-operator of 16 outpatient surgery centers that aims to perform more than 200 hip, shoulder and knee replacements this year. “There’s a large cohort of physically fit patients in need of joint replacements who are increasingly asking physicians to perform their procedures in ASCs.”

Advances in clinical approaches, pain control and recovery are also allowing more TJR patients to avoid long hospital stays, explains Matt Kilton, associate principal with ECG Management Consultants Inc., a Seattle-based healthcare consulting firm. This makes partnerships a “fantastic opportunity” for ASCs and hospitals that have owner-investor physician groups expressing an interest and willingness to pursue joint ventures, he says.

“The hospital will always have its traditional inpatient model, and it also will benefit from having a low-cost, outpatient total joint option,” Kilton notes.

Standalone centers, too, are benefitting from TJR opportunities. A relative newcomer to TJRs, Sansum Clinic Foothill Surgery Center performs TKRs (non-Medicare), shoulder joint replacements and...
most joint arthroscopy "as applicable to the patient," Berreth says.

Advantages in patient care
While Berreth says hospitals and ASCs both strive to provide the best care possible for patients, she notes that ASCs have certain advantages because of their smaller size and how they function.

“It’s common for an ASC nurse to be with the patient from admission through post-op, enabling an assessment of patient characteristics such as anxiety levels and comprehension, which may factor into post-op pain management and rehab recommendations,” she says.

Recent studies have found outpatient surgery centers to be more efficient than traditional hospitals, as well. For example, smaller ASCs with central supply departments to manage instruments and equipment can turn over operating rooms (ORs) in 20 minutes on average — versus 45 minutes for a hospital, Berreth says.

Additionally, hospital patients may be admitted on one floor or at one end of the hospital and then transported on a gurney to the OR on a different floor or opposite end of the facility. Whereas, "ASC patients often ambulate from the pre-op area into the nearby OR by themselves, and they are permitted to wear their underwear, and even shorts, under their hospital gown," Berreth says. "That goes a long way in terms of making the patient feel less vulnerable."

Working with payers
Kilton notes that payers are becoming more open to having a conversation about performing total joint replacements in outpatient surgery centers, though challenges remain. For example, payers must consider how local healthcare systems with economic influence will be impacted by the changing TJR model. "This is where a health system-ASC joint venture may lend value to all parties," he says.

ASCs that do their due diligence and engage payers early on in the process, ideally before starting down the path of performing TJRs, may find certain payers willing to negotiate, Kilton adds.

Rosenquest says, “Our message about the value and capabilities of ASCs hasn’t yet resonated with payers. “But in the context of an ASC-hospital system negotiation, where hospitals are engaging with their physicians to create meaningful joint ventures, we’ve been able to discuss the migration of low-risk TJRs to an outpatient setting and negotiate winning value propositions for the ASCs, payers, physicians and patients.”

If all trends continue, ASCs will play an ever-greater role in the advancement of efficient, same-day TJRs for years to come.

“ASCs will continue being the providers most in tune with advancing techniques and procedures so that patients may recover in the comfort of their homes,” Rosenquest says. "As someone who is increasingly feeling the effects of time and stiffening joints, I’m relieved to think that, one day, I’ll have a same-day surgery center as an option.”

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Physician preference items (PPIs), those often high-cost, high-risk supplies used in medical procedures at the discretion of the physician, are frequently at the center of discord among medical and administrative staff. While intended as a way to ensure physicians use the most suitable product for the procedure, PPIs may be more expensive than alternatives with the same clinical effectiveness.

Various reports estimate that PPIs constitute anywhere between 40 and 60 percent of a facility’s total supply costs. The Association for Healthcare Resource & Materials Management predicts that supply costs will exceed labor as hospitals’ greatest expense by 2020.

If how much a facility spends on surgical supplies depends so heavily on physician preferences, why is it so difficult for some physicians (even those who have financial ownership) to convert to standardized supplies and supporting protocols? As a longtime chief nursing officer at a large health system, I’ve accumulated some valuable insight through the school of head-butting. Additionally, I’ve gleaned reflection on the “why” of physician behavior by taking a step back and looking at the situation from the physician’s viewpoint.

A fear of the unknown
Though some physicians won’t admit it, most are fearful of change. If we look at behavior from our own lives, we’re often hesitant about change that we perceive as only negative.

Motivational speaker Zig Ziglar described FEAR as “fabricated evidence that appears real.” When someone is looking at change through the lens of fear, it is very real and it is difficult to reason with them.

Physicians want to remain in control of their own worlds. So, their reasoning often goes like this: “I know exactly what I need to do when I’m treating a patient. I don’t want to make an error, and I know I won’t make one when I do it the way I know how.”

Surgical gloves are among the most contentious products to standardize. Why? They’re a surgeon’s primary...
tool. Gloves are like an extension of the hands. When wearing their preferred pair, surgeons know exactly how their hands respond, feel, touch and maneuver. Changing them introduces the fear of the unknown.

What’s the solution? The first step is to recognize that we have the same goal: to provide the highest level of care possible in the most cost-effective manner. Then, how do we get there?

Five helpful strategies to standardize PPIs

1. **Approach the situation from a more human perspective.** Understand the motivation behind why a physician prefers a certain product or device. You can’t just start the conversation with “the facility can save 10 percent of the cost if you switch products.” Cost is not always a motivator, even for physician owners. They are interested in the performance and efficacy of the product and if it will deliver the quality and outcomes they want.

2. **Enlist allies when approaching physicians.** In a surgery center, an executive committee should consist of clinical peers and administrators who have shared goals of patient safety, cost containment and quality. The most important ally for conversations on supply conversions is another peer who is able to articulate knowledge and understanding of the need for the change. This party can lend clinical credibility to administration-led efforts to reduce practice variation and cost.

3. **Introduce compelling usage and cost data.** Data can be a valuable asset in helping providers to understand the need to change practice patterns. Showing them their volumes, costs and outcomes, especially when compared to their peers, can help you make a convincing case for standardization.

4. **Trial the product.** Before introducing a product into an actual procedure, let the physicians “take it for a test drive.” Referring back to the surgical glove example, let the physicians wear the gloves and simulate the movements and activities they’d perform in a surgery. Simulation labs are great places to test out new products that might require changes in workflow and practice.

5. **Establish a mitigation process.** No matter how much planning, effort and time you put into standardizing products or processes, it is highly likely that the transition will not be seamless. Establishing mitigation strategies ahead of physician conversions will help stem erosion of trust in the product.

Standardizing physician preference items isn’t always a smooth undertaking. Many times, unconscious bias and fear of harm contribute to physicians’ unwillingness to adapt to a change in PPI.

Cost awareness is only one component of any successful strategy to rein in supply costs. Clinical effectiveness is equally important. Additionally, it’s critical to introduce human factors into the solution by understanding how the product performs when putting the application into practice.

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Martie L. Moore, RN, MAOM, CPHQ, is the chief nursing officer at Medline. As CNO, she develops forward-thinking, solution-driven clinical programs as well as new products and educational services. Before joining Medline, she was the chief nursing officer at Providence St. Vincent Medical Center in Portland, Oregon. Under her leadership, Providence St. Vincent earned a third and fourth Magnet designation.
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