

# SAME-DAY SURGERY

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## Save Money by Embracing Green Techniques in the Operating Room

**O**Rs are major generators of waste, leaving a large energy use footprint. By focusing on practical green techniques, surgery centers can save money and help the environment.

“The operating room is really the elephant in the room because of all the intensity of supply use and energy requirements,” says **Julie Moyle**, RN, MSN, member engagement manager for Practice Greenhealth of Reston, VA.

ORs also log high rates of air exchange and use many disinfectant chemicals. “Operating rooms can generate up to one-third of total hospital waste and up to two-thirds of regulated medical waste,” Moyle reports, adding regulated medical waste is up to five times more expensive in disposal costs than municipal solid waste.

The CDC says healthcare facilities can take a practical approach to medical waste management by identifying waste that represents sufficient potential risk for causing infection during handling and disposal. These can include microbiology laboratory waste,

pathology and anatomy waste, blood and other body fluid specimens, and contaminated sharps instruments.<sup>1</sup>

The biggest contributors to the medical waste stream are fluid medical waste and blue wrap. This blue wrap, a No. 5 plastic composed of polypropylene, is placed around trays before trays are put on a shelf. After trays are opened, the wrap goes in the trash. The material does not break down in landfills and comprises about 19% of the waste that comes out of the OR.<sup>2</sup>

Surgery centers can reduce waste and save on supply and disposal costs by taking several pragmatic steps. These include more efficient purchasing, reducing, reusing, reprocessing, repurposing, and recycling.

To start, surgery centers can reduce waste by placing only the most frequently used items in surgical custom packs. Custom packs used in operating rooms often waste 30% to 40% of the items in them. For larger surgical practices, this can translate into hundreds of thousands of dollars a year, says **Gail Horvath**, MSN, RN, CNOR,



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**AUTHOR:** Melinda Young  
**EDITOR:** Jonathan Springston  
**EDITOR:** Jason Schneider  
**EDITORIAL GROUP MANAGER:** Leslie Coplin  
**ACCREDITATIONS DIRECTOR:** Amy M. Johnson, MSN, RN, CPN

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senior patient safety analyst and consultant at ECRI.

“My rule of thumb was that whatever you put in those packs had to be used 95% of the time,” Horvath says. “It was amazing what we removed from the packs.”

For example, the packs might include three or four surgical gowns or 20 laparotomy sponges, most of which are not needed. “Go into any operating room in the country and see people wearing surgical gowns as warm-up jackets,” Horvath says. “It sounds like a picayune thing, but it adds up to lots of money.”

A surgery center can reduce this waste by conducting an analysis of custom pack use over a two-week period. “Have staff save everything from the packs that are not used and divide them by procedure,” Horvath suggests.

Surgery centers should constantly adjust custom tray packs to reduce waste, says **Don Schreiner**, MBA, chief executive officer of Ortho Illinois in Rockford, IL. Schreiner says surgeons can keep preference cards that list the essentials for each procedure. The idea is to keep the list lean and always question whether each item really is essential every time.

Reducing waste in a tray pack is an ongoing process because new technologies or supplies could require adjustments. There also might be tools and parts that were disposable,

but now can be refurbished and reused (e.g., high-quality metal blades that could be sharpened after each use and reused).

After data are collected on how much unused custom pack items are thrown out, a surgery center director can use the information to educate staff and help them change their behaviors. “Working with a team and surgeons, I showed them how [the savings] could make their jobs easier,” Horvath says. “I showed them the opportunity cost.”

For example, with these savings, the surgery center could send staff to conferences or purchase equipment. Still, nothing will replace the visual of a pile of waste. “We showed them, and they knew a lot of it was wasted,” Horvath says. “They thought it had to be in the [pack] just in case. Getting out of that mentality was the biggest challenge.”

Items can be listed on a preference card, but kept out of the custom pack. Instead, nonessential items can be placed on a cart, available to use if needed, and then put back into inventory if they are not used.

There are several examples of ORs repurposing supplies during the pandemic’s early months. Some people repurposed blue wrap by turning those into isolation gowns or bags to hold patients’ belongings. Others sterilized single-use N95s once a week, which could extend their lifespan by a month or two.

## EXECUTIVE SUMMARY

ORs generate a lot of waste, costing surgery centers more in purchasing and disposal costs than if they followed practical green techniques.

- ORs can generate up to two-thirds of regulated medical waste.
- Fluid medical waste and blue wrap are the biggest contributors to the medical waste stream.
- As much as 30% to 40% of items in custom packs often go to waste.

When a surgery center cannot find a repurposed use for discarded supplies, they could donate the material to nonprofit organizations, such as medical missions. “Blue wrap could be made into sleeping mats [or] ponchos to keep it out of the waste stream,” Moyle offers.

The COVID-19 pandemic has ushered in, at least temporarily, a return to reusable supplies. “There was a push prior to the pandemic to do single-use items because it’s cheap, quick, easy, and then you dispose of them,” says **Kaeleigh Sheehan**, member engagement manager and program manager for the Greening the OR Program at Practice Greenhealth. “Those hospitals that before the pandemic were using reusable linens and had more reusable items on hand were not left with quite as much of a shortfall to access linens and products when those shortages came about. Now, we’re looking at hospitals adding in more reusable items on hand.”

Supply chain disruptions continue to challenge hospitals and surgery centers as the pandemic drags on. “That just-in-time, disposable inventory wasn’t all it was cracked up to be in the face of a pandemic,” Moyle observes.

Some of Practice Greenhealth’s sustainability techniques were adopted overnight during the pandemic. “One hospital that was among the first to treat COVID-19 patients in Oregon said they went through more personal protective equipment in February and March 2020 than did their entire multihospital system in all of the previous year,” Moyle reports. “We knew we would not have enough supplies to continue to practice the way we had practiced with disposable PPE. The CDC tried to help with extended-life guidelines on how to

process single-use disposables with available technologies.”

OR practices changed as organizations sought to secure their inventory. “People started looking for other options because the supply chain could not be relied upon,” Moyle says. “In some ways, the pandemic has forced us to re-examine our purchasing practices and where we’re getting our supplies from. The pandemic, in some respects, has helped reduce waste. Then, in other aspects, there’s an overreaction where they’re wrapping everything in plastic.”

For surgery centers, some items might not be practical to reuse because of the cost of directing employees to perform additional sterile processing. In other cases, there might be reusable items that can be wiped down and disinfected within a few seconds.

By spring 2021, there might be data on how much waste was generated by ORs during the first year of the COVID-19 pandemic.

“Anecdotally, I was chatting with a [leader at a health system], and they were generating 20,000 pounds of waste of isolation gowns per day during the height of the pandemic,” Moyle says. “Now, they are looking at bringing on board reusable gowns.”

Surgery centers also can improve waste management by eliminating single-use disposable supplies in fluid management systems. For example, Moyle suggests surgery centers could bypass the single-use disposable plastic suction canisters process altogether. Instead, fluid management systems can dispose of fluid medical waste by treating it and discharging it directly into a sanitary sewer, following federal guidelines.<sup>1</sup>

“This would eliminate disposable suction canisters made of plastic, eliminate the need for a chemical

solidifier, and vastly reduce the amount of solidified medical waste going into the regulatory medical waste stream,” Moyle explains. “Fluid waste can make up 40% of the regulated medical waste stream in surgery. The medical waste stream is five times more expensive to dispose of than municipal solid waste.”

There is an upfront capital investment, but the return can be speedy, depending on the surgery center’s procedures and whether they generate high volumes of fluid.

Another area in which surgery centers can save considerable costs is by dialing back their HVAC systems on weekends and at night. Be sure to consult with outside experts first before making these changes. “This is a big opportunity for ambulatory surgery centers,” Sheehan says. “There are standards [that dictate centers] need to have 20 air exchanges per hour when occupied and in use. When unoccupied, these can be set back to as low as six air exchanges per hour.”

Surgery centers also can adjust the temperature to save both energy usage and costs. “Setting computers and equipment on standby or powering them down at the end of the day are small behavioral things that can result in energy savings, and that adds up,” Sheehan explains. “This translates into dollar savings as well, and prolongs the lifespan of those pieces of equipment.” ■

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# Quality Improvement Project Reduces Sharps and Biomedical Waste, Saves Money

A surgery center nurse assessed her facility's biomedical waste to look for ways to cut costs. She found many items that could have been disposed of in a generic garbage bag with the regular trash.

"I just looked in the bag and saw all of these bottles that didn't need to be in there," says **Joyce Kaine**, RN, director of nursing and former quality coordinator for Surgery Center of Fairfield County, a part of Surgical Care Affiliates, in Connecticut.

The work began as a quality improvement project, approved by the surgery center's quality committee. Kaine handled the physical work of going through biomedical trash and used tools to prevent injury. "I didn't involve other staff members because I didn't want to expose anybody else to sharps," she notes.

The biggest proportion of waste that should not have been put in the biomedical bag involved intact medication bottles. "If the bottles were broken, they'd have to go in the sharps container, but an empty,

intact bottle could go into the trash," Kaine explains. Paper products that were not contaminated with fluid also were loaded into the biomedical waste bag unnecessarily.

Before separating biomedical waste from the regular trash, Kaine reviewed OSHA and state regulations on what constituted medical waste, along with other guidance from pharmacy websites and biohazardous bags.

Kaine collected three months of biomedical and sharps waste data from the disposal company. She also went through the sharps container and a biomedical waste bag, removing the unnecessary waste from each, and found the difference in what should have been the biomedical waste weight and what the actual weight was.

"It was almost a five-pound weight difference when we did our audit," Kaine says. This proved the surgery center was spending more money on biomedical waste than it needed to.

Kaine presented what she learned to staff to help them understand

what they could throw away in the sharps container and the hazardous drug box. They also learned what could be dumped down the sink or thrown in the regular trash.

The facility purchased the Drug Buster Drug Disposal System, a solution that dissolves medications and pills.

"You dump any residual medications you have into the intact, empty bottle to render it non-retrievable before you put it in the trash," Kaine explains. "These large jugs are installed in operating rooms and have a charcoal solution that renders it non-retrievable."

Habits changed quickly. In one month, the facility recorded a 43% reduction in sharps and biomedical waste. "After that, we were able to renegotiate our contract with the biomedical waste company, and we now save \$1,200 a month," Kaine reports.

For her work, Kaine won the 2019-2020 Bernard A. Kershner Surgical/Procedural Care Award from the Accreditation Association for Ambulatory Health Care. ■

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## Boost 2021 Marketing Campaign with Visual and Audio Elements

Surgery centers can improve their outreach and marketing by focusing on techniques that have become more popular in recent years, including video stories and podcasts.

"The biggest thing you can do for marketing is video," says **Cheryl Zapata**, chief development officer for Texas Back Institute in Plano,

TX. "It is unbelievable what video has done in terms of the medical marketing side of the house."

Since the start of the COVID-19 pandemic, people are spending more time at home, giving them additional time to see videos on YouTube.

"People have more time to do the research they need to do ... and a lot of that research is via the internet,"

Zapata says. Vivid visual elements are critical. On top of video, surgery centers also could include plenty of photos of their facilities online to illustrate their services.

Podcasts are another useful marketing tool. These are audio discussions of various topics in the informal speech tradition of talk radio. This medium also has become

more popular during the COVID-19 pandemic. “We understand why people want to watch video content, but our podcasting has increased significantly,” Zapata reports. “We ... converted a lot of our videos to podcasts to add to our library because [of rising demand].”

Typically, podcasts are longer than videos and are tied to the organization’s website blogging. For instance, a staff member could record an audio interview with a physician. The highlights of that interview can be featured in a written blog. Later, the entire recording can become a podcast. “It makes sense to use every media we have,” Zapata says.

Think of a podcast as something unedited and unscripted. “We don’t want physicians to be prepared, meaning we don’t want them to have studied what we’re going to talk to

them about. We don’t always give them the questions in advance,” Zapata explains. “We tell them, ‘When you come in, we’ll talk to you about 3D printing and how it impacts spine surgery today.’”

Before the session, the interviewer might send the subject an article with up-to-date information for review. Beyond that, the idea is to keep a conversation casual.

“We like them to talk off the top of their head. It’s so much more natural when you are interviewing them,” Zapata explains. “During an interview, [subjects] constantly will say, ‘I forgot to say this or that,’ but if you are [simply] talking with them, it comes out anyway and flows much easier.”

Videos and podcasts help fill the void of quarantine. Without family, friends, and coworkers around,

people may take comfort in hearing conversations. “I also think that people don’t just want to get caught up in watching content,” Zapata adds.

The goal for 2021 is to record a series of podcasts instead of separate, standalone content. “We will start doing things like a ‘Day in the Life,’ and follow our doctors and listen to them,” Zapata says.

Podcasts and videos help people understand who surgeons are and more about a facility’s mission. Such media can humanize staff and build trust. “We spend a lot of time ... making sure we’re building relationships through video and blogging,” Zapata adds. “In a video series, we work on not just what [surgeons] do and how they do it, but how they are. We’ll showcase them as a person.” ■

## Creating a Good Marketing Video Can Attract and Inform Patients

Most people will research their condition and treatment options before visiting a surgeon. Centers can educate potential patients about their medical issue and attract them to learn more through video marketing. “Typically, what serves best in the video is a patient’s story,” says **Cheryl Zapata**, chief development officer for Texas

Back Institute in Plano, TX. “They are not testimonials.”

According to Zapata, patient testimonials focus on the surgeon or center. These include lavish praise about the experience. Patient stories focus on an experience with debilitating pain or disease before transitioning into the surgical solution.

“These videos are compelling for another patient who may have the same condition or need that same kind of treatment,” Zapata offers. “It helps encourage [potential patients] and helps them understand that where they are today, that they can get some help.”

The video lengths average around 3.5 minutes, with none running

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longer than 4.5 minutes. There is one patient story per video.

“We want people to see somebody who has a compelling story,” Zapata explains. “This could be anything from ‘I couldn’t lift my children in the past, but now I can,’ to ‘I used to ride horses, and then I couldn’t, and now I can.’”

One recent patient story video featured a man who struggled with day-to-day moving around his ranch. He told his story, with the ranch in the background, and spoke about how surgery changed his life, returning him to regular daily activities.

Zapata reports Texas Back Institute typically does not have to scout for stories because patients come to the institute about sharing. These patients say they are eager to encourage others to seek help.

The facility employs an in-house videographer who helps with creating videos and ensuring they receive views online. At first, the videographer filmed people at the clinic or hospital. Now, the videographer asks patients if the home or another meaningful place can serve as a filming background, such as the patient on his ranch.

After the video is edited and ready to be viewed, it is posted on

YouTube and shared through social media, primarily Facebook.

“We post videos on our website and sometimes send links out to patients, depending on what the video is about and who we are targeting,” Zapata says.

Everything posted on YouTube or Facebook is organic, and the organization does not pay to boost searches.

“We have gotten very good at understanding what key words to use and how to change them,” Zapata says. “If we’re talking about low back pain, we say ‘back pain,’ ‘pain in the low back.’”

When someone creates a video to market their surgery center, they also should remember that people search for information differently when it is on a desktop computer vs. a mobile phone.

“When people are at their desktop, they search most for web pages about conditions and treatment,” Zapata says. “On the mobile device, they’re looking for a spine surgeon near them, and they usually speak their search request.” For example, a person will ask his or her phone to find a spine surgeon near their current location or to find a surgeon who handles a certain condition.

“The way you speak is very different than the way you type. When we’re doing something that is on mobile devices, we use long-term key words,” Zapata says.

On a desktop computer, a person will type the name of their problem and try to find information about it. These require two different ways of marketing. One is to put key words in a mobile search context that emphasize location for various types of surgeons. For desktop search, the key words would emphasize the disease, problem, or pain and potential surgical solutions and treatments.

During the COVID-19 pandemic, Texas Back released a safety video to help patients understand the facility. The video included information about safety precautions and how serious surgeons are about protecting patients’ health and wellness.

“We’ve decided to be more lighthearted about it because people were getting overloaded ... our chief executive officer, who is leading the safety video, and another [staff member], show everything we’re doing for safety,” Zapata says. “We get out the message that we’re here to take care of you, and it’s been well-received.” ■

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## More Hospitals, Health Systems Want to Call the Shots on ASCs

From 2019 to 2020, hospitals and health systems planning to increase their investments in ambulatory surgery centers (ASCs) rose from 44% to 67%, a 23% change, according to a recent survey.<sup>1</sup>

The third annual 2020 ASC Survey of healthcare executives and clinical leaders also revealed 76% of

larger hospitals have increased their investment into ASCs, and close to the same proportion already have opened more than one ambulatory surgery center.

“Payer pressures and other market forces have softened hospitals’ historically defensive posture toward ASCs, paving the way for overall

growth, lower operating costs, and heightened patient satisfaction,” **Joan Dentler**, president and CEO of Avanza Healthcare Strategies (which led the survey), said in a statement.<sup>2</sup>

These trends strike home for some surgery center leaders who are experiencing growth and increasing interest from health systems. For

example, there is a physician group working with a hospital partner with a minority ownership of a surgery center in Rockford, IL. The same physician group is in the process of planning a new surgery center in Beloit, WI, a few miles north of the Rockford center, says **Don Schreiner**, MBA, chief executive officer of Ortho Illinois.

“The Beloit surgery center will be an expansion of the same services currently being offered in Rockford,” Schreiner adds.

Surgery center shareholders want their facility to be a good value to payers and to set up fair contracts. “We’re not looking for out-of-network gouging,” Schreiner says.

Surgery center physicians and others often prefer to own a majority share in their surgery centers, according to Schreiner. “Hospitals might want to be in the surgery center and have 51% ownership. They want to have control,” Schreiner says. “We fully intend to be at 75% or more owned by doctors.”

In the 2020 ASC Survey, 58% of hospitals and health systems with ASCs report they are party to at

least one ASC joint venture, which is down from previous surveys. Seventy-nine percent of hospital respondents indicated they prefer to own more than half of a joint ASC venture. The bigger the facility, the more likely that is to be the case.

**SEVENTY-NINE PERCENT OF HOSPITALS SAID THEY PREFER TO OWN MORE THAN HALF OF A JOINT ASC VENTURE.**

As hospitals and health systems continue going into the ASC business for themselves without third-party equity, outside contracted management, or other individual investors, leaders of some existing freestanding ASCs might need to start thinking about what is next. This could include trying to partner with hospitals and systems still willing to take that route.

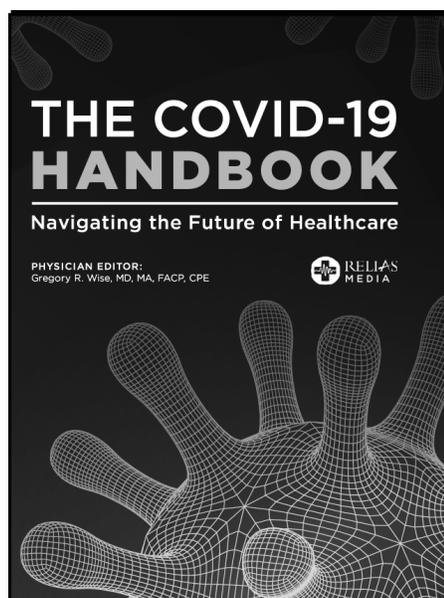
“Surgery centers are growing into bigger practices and starting to consolidate. Private equity also is getting involved, putting up the dollars,” Schreiner says. “Hospitals are appealing [because] they will put up a lot of capital to build the facility, which doctors may not want to do. Usually, it’s a big dollar amount of investment up front, so this is a safe bet for them. Hospitals can do contracting better than [physicians] could do on their own.”

For established surgery centers that are strong financially, there is far less incentive to accept a hospital’s majority ownership offer.

“We’re fiercely independent and will never go with private equity because we want to remain independent,” Schreiner says. “We will not work for a hospital or private equity company.” ■

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# COVID-19 Vigilance Must Continue in 2021

As the healthcare industry learned during the COVID-19 pandemic, space can become a premium as cases spike. This is where ASCs show even more value.

If hospitals need more space, they might use their ASCs in which they own majority shares to solve the problem. A freestanding center run by physicians might make their facility available for emergency needs in the event area hospitals are overflowing with patients.

“You have to be ready to be a community asset if needed,” says **Don Schreiner**, MBA, chief executive officer of Ortho Illinois. “If a hospital needed us or called upon us, we were prepared to jump in.”

## Secure Supplies

Whatever roles ASCs play as the COVID-19 pandemic drags on, leaders should prioritize securing supplies in the event of another worldwide supply chain disruption. For instance, Schreiner says Ortho

Illinois developed connections with vendors that supplied every item they needed in 2020, despite the pandemic-induced gaps, Schreiner says. The group also secured COVID-19 testing materials so they could ensure staff and patients were safe from the virus.

Surgery centers should be prepared for as many eventualities as they can imagine. For instance, if their area is in a COVID-19 hotspot, the state may force administrators to close these centers for weeks or even months.

“In Rockford, the state did not shut us down because we were so low with COVID cases,” Schreiner reports. “We are dependent on how the government and states respond to COVID outbreaks and how they respond to managing it.”

Surgery centers should make sure they follow all public health guidelines, set up processes to test staff, and maintain social distancing. Leaders need to know how to process people through the clinic and

surgery center during an outbreak. “There is a lot of manpower that goes into planning that and making it safe,” Schreiner says. “You can’t just say, ‘Open it up, and come on in.’ You have to manage it, and follow all the guidelines.”

## Staffing Hurdles

In 2021, surgery centers also will continue to face staffing challenges. Finding good employees always is a challenge, but the COVID-19 pandemic makes this more difficult since employees could be exposed to COVID-19 at any time and need two weeks of quarantine.

Schreiner says cross-training always has been an Ortho hallmark, but the COVID-19 emergency has taken it to the next level.

“It’s gone up another notch so people can do multiple jobs if they have to,” he explains. “We have had to hire extra staff, and we have extra teams of PRN staff to stand in when needed.” ■

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# OIG Report on VA Operating Rooms Reveals Best, Worst Practices

A recent Office of Inspector General (OIG) report on Veterans Health Administration (VA) ORs paints a clear picture of what makes an OR run efficiently, and what makes it more chaotic.<sup>1</sup> “The overall message of the report is that you have to collect information to make an organization operate efficiently,” says **Leigh Ann Searight**, deputy assistant inspector general for audits and evaluations, VA OIG. “If you have measures, use those measures to help influence decisions.”

The OIG report is the result of an audit by the VA OIG conducted to determine if the VA effectively used National Surgery Office (NSO) data to identify and address OR efficiency problems. The audit team focused on four measures:

- **Surgical case cancellations.** The number of surgeries canceled within 48 hours of the scheduled start time and measured as a percentage of the total scheduled surgeries.
- **OR first-time starts.** The number of first operations of the day

that start on time or earlier than the scheduled start time, also measured as a percentage of total first starts.

- **OR use rate.** The total run hours of the active ORs as a percentage of the total number of assigned OR nurse hours.
- **Lag times.** The elapsed time needed to clean, reconfigure, or prepare the OR between surgeries, expressed as the percentage of total surgeries meeting the threshold.

The study authors found OR efficiency data was not used

consistently by facilities to help inform decisions, Searight reports. The VA medical facilities with less efficient ORs experienced more problems, including OR closures and canceled surgeries. Their inefficiency was caused by not following up on using data to identify problems and initiate corrective actions. These facilities started programs, but did not monitor them to ensure staff continued to follow best practices and maintain their compliance and efficiency.

“There is inconsistency between facilities and how they use that data,” Searight notes. “The VA collects a lot of information to inform decisions, and there is such inconsistency in how that data is used.”

That inconsistency is expressed in the striking difference between how the most efficient and least efficient facilities use the data. “It came down to communication and collaboration within services,” Searight says. “You have sterile processing service [SPS], environmental and resource management, and surgeons and nurses who all have different chains of command. If those four groups didn’t collaborate and work together, we saw a lot of breakdowns in the process.”

For instance, a chief of surgery might say a problem is SPS’ responsibility, and hand off the issue, instead of finding ways to collaborate and work together to solve the

problem, Searight offers. When facilities ignored opportunities for collaboration and communication, their efficiency suffered. “Those were the ones that weren’t able to solve the problems because they required collaboration,” Searight says.

One example is the surgical kit. Sites that did not communicate clearly with SPS about which tools a particular surgeon needed would end up with kits that either contained unnecessary items or were lacking the items the surgeon wanted.

Another problem observed among the inefficient sites was surgical kits sometimes showed up with the sterile wrap damaged. The wrapping might have been cut, rendering it no longer sterile.

“[Investigators] walked through the process and discovered that when the kits were being delivered to the OR, they were jarred. This resulted in cuts that made it less sterile,” Searight says. “They might deliver multiple kits, sitting on a cart, and somehow they’re getting damaged in that transport.”

In less efficient ORs, leaders would receive quality assurance reports or inspections that consistently highlighted issues that needed to be addressed. But when these less efficient sites made changes to correct the problems, they did not follow-up on the changes. “They didn’t make sure those changes took hold, and then they’d go back to their

old ways,” Searight explains. “They never followed through with their action plans. They started them, but didn’t follow through, and a month later they were back to the old ways.”

There also was no accountability for the people who did not maintain best practices. “It’s a leadership problem,” Searight adds.

In the VA system, there is a Veterans Integrated Service Network (VISN) that oversees multiple VA Medical Centers (VAMCs). They conduct quality assurance reviews to monitor how facilities are performing. “If [investigators] don’t hold [sites] accountable for those inspections and make sure [leaders] follow through with action plans, then nothing changes,” Searight says.

Inefficient ORs fell through the cracks because their leadership did not hold employees accountable to make sure the action plan was foolproof. Sometimes, facilities neglected monitoring and follow-up practices because of staffing issues.

The most efficient facilities engaged in various practices that helped them become more efficient. For instance, some would presoak instruments after surgery in anticipation of SPS taking them. The less efficient facilities did nothing to prepare the instruments for cleaning and sterilization.

The more efficient ORs also handled cancellations and late starts better than the less efficient ones.

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More efficient facilities held surgeons and others responsible if they caused a late start. If the surgeon, anesthesiologist, or chief nurse is late, the more efficient facilities would hold keep them off rotation or not give them first-start surgeries. “At the more efficient facilities, you found

that the [patient] was assigned one person or a group within a service to be responsible for ensuring all prep [actions] were done,” Searight says. “They made sure all tests were done and the veteran was ready for surgery and had done everything needed in preparation.” ■

## REFERENCE

1. Department of Veterans Affairs, Office of Inspector General, Office of Audits and Evaluations. *Improved Oversight of Surgical Support Elements Would Enhance Operating Room Efficiency and Care*. Sept. 17, 2020. <https://bit.ly/36nQBF>

# Survey: Few Outpatient Surgery Complications During Early COVID-19 Pandemic Period

The results of a recent survey showed hundreds of ambulatory surgery centers (ASCs) continued performing outpatient procedures during the initial weeks of the COVID-19 pandemic with little harm to patients.

The ASC Quality Collaboration surveyed 709 ASCs in eight states about outpatient surgical procedures performed on 84,446 patients in March and April 2020. The survey revealed only 16 patients tested positive for COVID-19 within 14 days after the procedure. Of these, two required hospitalization.

“Together with the additional COVID-19 safety measures ASCs have in place today, including heightened preoperative screenings, additional sanitary measures, and air filtration protocols, ASCs can maintain a safe, sanitary environment to treat patients, while keeping the health professionals providing their care protected,” **Ann Shimek**, executive director of the ASC Quality Collaboration, said in a statement.<sup>1</sup>

These are promising data, but eight states represent a limited sample size. Also, there appear to be little if any data from the six months since April. Further, the ASC Quality Collaboration noted it is unknown how or when the 16

patients tested positive for the virus (i.e., Were they already positive before surgery? Did they contract the virus days after their procedure?).

Another study<sup>2</sup> showed COVID-19 infection was associated with a 23.8% mortality rate among surgery patients within 30 days after surgery, as reported in the August 2020 issue of *Same-Day Surgery*. The international, multicenter, observational cohort investigation included 1,128 patients with SARS-CoV-2 infection who underwent surgery at 235 hospitals in 24 countries. Overall, 268 patients died within 30 days after surgery. More than half of patients experienced pulmonary complications, and these patients accounted for 82.6% of all deaths.

Investigators incorporated data on different types of surgeries, including elective procedures and emergency surgery. About three-fourths of the surgeries were emergency cases, and one-fourth were elective surgeries. Procedures included head and neck, cardiac, gastrointestinal, OB/GYN, neurosurgery, ophthalmology, orthopedics, thoracic, and others. The cohort of cases included about 32% of emergency surgery patients who received a preoperative SARS-CoV-2 diagnosis and 66% who were diagnosed after surgery. Data were

missing for some patients. (*Read more at: <https://bit.ly/3pNIEJ4>.*)

It is unknown (and may never be) just how many ASCs and hospital outpatient departments carried out normal operations throughout the COVID-19 pandemic and which facilities closed for a period.

In the May 2020 issue of *Same-Day Surgery*, several sources explained some changes their facilities had made during the initial pandemic period. (*Read more at: <https://bit.ly/2IJ0gDB>.*)

In a three-part question and answer series published in the June 2020 issue of *Same-Day Surgery*, dozens of surgery center administrators and directors from across the United States were asked about their facilities’ experiences during the pandemic’s early weeks. The leaders talked about their region’s outbreaks, their decisions, and how the emergency affected their work and operations. They spoke candidly about difficult staffing decisions but also shared lessons learned, providing hope the industry can prepare better for the next emergency. (*Read more at: <https://bit.ly/2IJ1DCg>.*) ■

## REFERENCES

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performed essential outpatient surgeries safely during the first months of the pandemic, survey finds. Oct. 8, 2020.

<https://bit.ly/3pFumsz>  
2. COVIDSurg Collaborative. Mortality and pulmonary complications in patients undergoing surgery with

perioperative SARS-CoV-2 infection: An international cohort study. *Lancet* 2020; 396:27-38.

## SDS Manager

# Kaizen: 'Change for the Better'

By Stephen W. Earnhart, RN, CRNA, MA  
CEO, Earnhart & Associates, Austin, TX

Many of us want to completely forget 2020, which was filled with pain, loss, and uncertainty. But there were lessons to be learned. We need to learn from the mistakes of the past year and change for the good to avoid such systemic failures in the future.

The dreadful nature of 2020 has reminded us all that we need to be in control of our future. We need to produce our own supply chain, developed for a long shelf life and a rapid delivery system in a crisis. We need to separate inpatient and outpatient care and services appropriately to ensure this ongoing pandemic does not consume precious resources while depriving others of ongoing elective care.

We have been working on a surgery center that is about to open in California that the investors named "Kaizen Surgery Center." The word "kaizen" is Japanese and can be translated as "improvement" or "change for the better." It also refers to a systematic approach that can give rise to a healthy work culture. Each employee ensures improvement of all processes and systems for the organization. Kaizen follows one basic principle: "Change is for good."

There are five basic parts:

- **Seiri = Sort.** Employees should sort material intuitively. Label items as not needed now, necessary,

important, critical, useless, most important, and so on. Discard useless material and set aside items not needed now. Be sure to place items considered most important and critical in safe areas.

- **Seition = Organize.** Employees waste too much time looking for important documents and items. Each item should be placed in its designated space and stored there only.

- **Seiso = Shine the workplace.** Maintain a clean workspace. Declutter. Store necessary documents in proper files. Use drawers and cabinets for storage.

- **Seiketsu = Standardization.** Every organization must set standard policies and rules to ensure top quality.

- **Shitsuke = Self-discipline.** Employees must respect the organization's policies and adhere to them. Self-discipline is vital. When

employees follow work procedures and policies, they are filled with respect and pride for the organization.

In other words, by focusing on continuous small improvements, kaizen can help produce immediate results.

Our eyes are open now to our own inadequacies and failures to focus on the little things that can cause problems or lead to improvements. I am so tired of negativity that I am going to opt for making great improvements in the new year. ■

*(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Address: 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: [searnhart@earnhart.com](mailto:searnhart@earnhart.com). Web: [www.earnhart.com](http://www.earnhart.com). Instagram: [Earnhart.Associates](https://www.instagram.com/Earnhart.Associates).)*

### CME/CE OBJECTIVES

After reading *Same-Day Surgery*, the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.



# SAME-DAY SURGERY

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## CME/CE QUESTIONS

1. **An OIG report about OR efficiency found that among VA hospital ORs, the biggest differences between more efficient ORs and less efficient ORs was:**
  - a. the more efficient ORs hired more experienced staff.
  - b. the more efficient ORs used data to identify problems, then initiated changes and followed up on those changes by monitoring staff to ensure compliance.
  - c. the less efficient ORs did not review data on how they were operating and failed to start action plans to correct mistakes.
  - d. the less efficient ORs were understaffed and used older OR equipment.
2. **The 2020 ASC Survey revealed what percentage increase in health systems' plans to invest more in ambulatory surgery centers?**
  - a. 23%
  - b. 29%
  - c. 34%
  - d. 46%
3. **Blue sterilization wrap is a plastic that covers surgical trays. Once opened, it is discarded and comprises about what percentage of the waste that comes out of the OR?**
  - a. 8%
  - b. 12%
  - c. 19%
  - d. 23%
4. **What have been two of the most important marketing trends for surgery centers during the COVID-19 pandemic?**
  - a. Print ads and radio sponsorships
  - b. Blogs and web ad buys
  - c. Email newsletters and text messages
  - d. YouTube videos and podcasts

## COMING IN FUTURE MONTHS

- Avoid common mistakes in leadership
- Study finds safety issues with many PPE types
- Quality improvement will be major priority in future of surgery centers
- Best practices in patient billing