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Written by Sabrina Rodak | April 02, 2013

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Michael Bailey, CHESP
AHE 2014 President

Welcome to 2014 and what will certainly be another year of big change in health care. The implications and ramifications of the Affordable Care Act will become ever more apparent as we move forward. There are plenty of questions surrounding this new program but, at this point, not many answers. One thing is for sure: business as usual will not be an option if health care institutions are to continue to grow and thrive. Shrinking reimbursements and increasing regulations will force all of us to seriously review our operations and strategy. In other words, we need to be strong, vibrant and visible leaders in our institutions.

A recent survey of hospital CEOs listed financial concerns as the main issue on the table in 2014. Reduced Medicare and Medicaid payments, anticipated decreases in volumes, increasing acuity levels, and increasing equipment and supply expenses are all adding to a situation that will take knowledge and leadership to address. We are dedicating this edition of *EXPLORE* to the discussion of how these issues will affect environmental services across all care settings. Let's take a look at a couple of the most pressing problems confronting our profession in the immediate and the near future.

Measureable and defensible evidence

If CEOs are worried about finances, then it would be prudent for us to more than consider them and how we can contribute to ease some of the pressure on the executive teams and the boards of directors. Most of us are accustomed to staffing cuts at this point. A manager swallows the pill and does what has to be done to meet the targets. However, a leader understands the importance of being at the table armed with not only passion for what we do but more importantly, armed with the data we need to substantiate the investment being made in our services.

Do you have the data, information and leadership skills to represent yourself and your department at the table? Simple answers and explanations will not serve us going forward. We need measureable and defensible evidence, metrics and data to illustrate the impact and value of our services to our customers. We need to be worthy of the respect we desire. Do you know who has this information or how to create your own?

Impact of HCAHPS scores

Because a portion of reimbursements are tied to satisfaction, we cannot forget about the impact of HCAHPS scores on our institutions. With dwindling resources and increasing expectations, we need to think innovatively when looking at staff productivity and ask ourselves whether we are getting the return from our labor dollars. Have we developed a hiring protocol for the department that addresses not only experience but behaviors? Are we conducting behavior-based interviewing and hiring for customer-focused skill sets to ensure we have the service-minded personalities on the front line? Do we teach strategic skill-building? Can staff make ethical choices? Are we hiring the first person through the door hoping we can on-board them with a fast wave of technical training? Are we hiring coachable, teachable staff that will assimilate into the culture of service? Are we coaching *and* nurturing the next wave of supervisors and managers so we can lead, not just work?

As leaders, we need to develop criteria and expectations for our hiring and orientation programs to ensure we are getting the best and brightest. Great attitudes and high performance will be the key to our success with customer service.

Increasing territories and responsibilities

In addition to finance and customer service issues, we also need to be focused on the increasing territories

and responsibilities being added to our plates. Most of us are dealing with more than one facility, and many of us are being asked to take on other departments. According to the trending experts, health care is and will continue to be delivered away from the acute-care hospital setting. What types of issues does this present to us as patients are seen farther away from our concentration of resources? What is your vision for the care and services that are provided away from the core? Who are the partners that will help?

Utilize tools and resources

These are the questions AHE has received in conversations with members throughout 2013. Just as we delivered on your requests for free member education and training as part of dues, 2014 promises to provide you with the tools and resources you will need to respond to these challenges, demonstrate leadership, and formulate the vision necessary to make you and your teams invaluable. Keep asking, and we'll keep listening. As we prepare to deliver these exciting new tools, programs and resources, I am asking you to do a few things to enhance your skills:

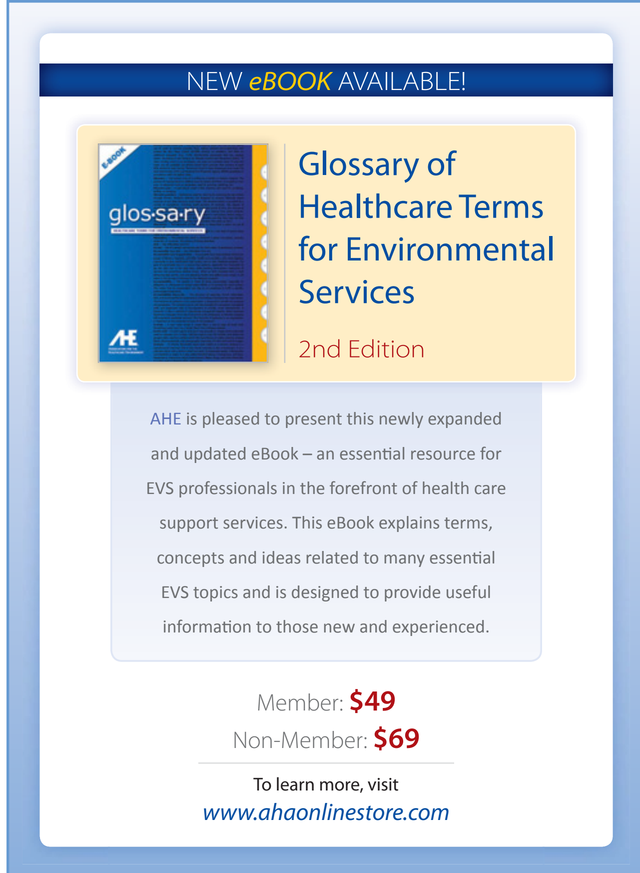
- Achieve or renew your CHESP.
- Maintain your AHE membership and encourage a peer to join.
- Visit **www.ahe.org** often for the latest information on what's coming and when.
- Visit **www.aha.org** – that's right **www.aha.org**. The American Hospital Association website has resources that will get you thinking about what keeps your executive management team awake at night. It will help you with the vision I spoke of earlier. It will help you ready yourself, not only for what may be coming but how you leverage what we will be delivering.

Of all the resources we will be launching in 2014, your CHESP, your membership and its benefits, the information offered on the websites above, and your passion for what you do will be your most valuable resources as you navigate the uncertainty of health care and your role.

As you read the pages of this important issue of *EXPLORE*, take note that vision and leadership will be the key to success for all of us. Please take advantage of your membership benefits. ENGAGE in AHE's webinars and courses, and leverage the knowledge and intellectual capital available to you from others who participate in courses and committee work. Consider getting involved and join them. Take advantage of the AHE and AHA library of publications that are inexpensive yet critical to our mission.

Don't forget to budget for and attend the best learning and networking event for the profession at EXCHANGE 2014 in Tampa, Fla., September 21–24. You will be surrounded by amazing talent, unfettered networking opportunities and an information repository that extends beyond the program dates. Make 2014 the year of vision, growth and success! Let us help you! Help yourself! ENJOY this issue of *EXPLORE*, and I hope to see you in Tampa! ●

Director, Environmental Services
Greenville Health System, Greenville, South Carolina

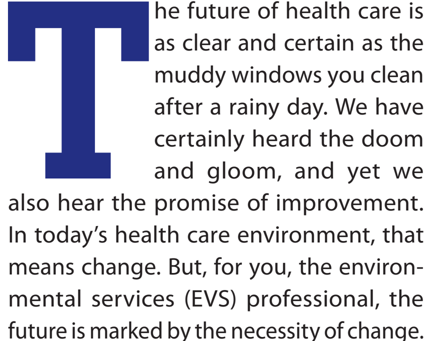


FEATURE

THE FUTURE OF EVS

EVS is Changing—Prove Your Value

By Colby C. Morris, CHESP



The future of health care is as clear and certain as the muddy windows you clean after a rainy day. We have certainly heard the doom and gloom, and yet we also hear the promise of improvement. In today's health care environment, that means change. But, for you, the environmental services (EVS) professional, the future is marked by the necessity of change.

Showing your value

The EVS professional, as we know it, will and should fade away. Gone are the days of just assuring the place is clean. The task of walking the areas to straighten the chairs in the lobby is enhanced, but only by the interactions you will have while doing so. The days of only providing an overtime and supply-expense report to your boss are gone. In its place you will show the value that the position, *your position*, provides to the hospital.

Value, by definition, is *relative worth, merit or importance*. The changing role of the EVS professional is one of adding value, partnering with patients and nurses, and demonstrating the importance of our position by adding a defined, tangible value to the facility. That value could be shown in HCAHPS scores, your Press Ganey scores or other patient satisfaction evaluations. EVS now has an even greater responsibility for HCAHPS scores that will help determine the hospital's reimbursements.

You could also show your value in how you manage your budget, your payroll and how you collaborate on issues in other departments. We have valuable insight concerning what materials should and should not be used in particular areas. We should be the right-hand partner of the infection control department. When people wonder who can get something accomplished, you and your department should be one of the first mentioned.

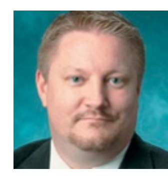
Hospitals are changing – be proactive

More and more hospitals are moving toward building clinics and surgery centers. Acute outpatient care settings are moving away from the hospital. The hospital itself will provide service to the sicker, more critical patients. In that case, you need to know how to provide better service to this new patient mix and be able to quantify the value. You will need to provide ATP (*adenosine triphosphate*) results to your infection control department. It will also become a way to evaluate your EVS technicians. You will move toward actual measureable results (objective) instead of your opinion (subjective) of how clean surfaces are.

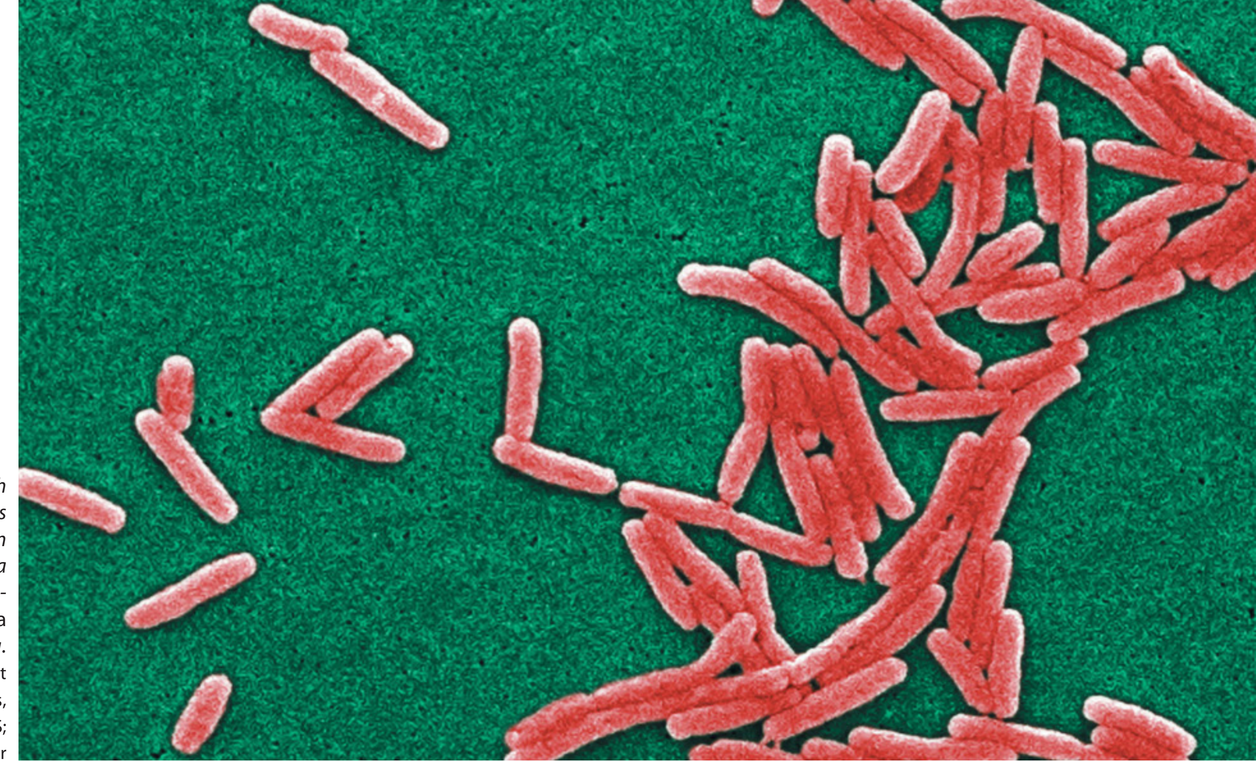
Much of this may sound like things you're already doing. However, you will need to be proactive in looking at your business and trying to figure out the answer to one question: "What's next?" You will be the one who can decide and act on those things you see as must-have action items. You are the one who will be called upon to think out of the box to solve an issue. Do you need to recommend moving toward no-wax flooring? If you have to cut staff in the future, which positions would you need to cut? What things will you recommend that your team either stop doing or do less of? Do you have the political and social capital to make that happen? You have to be the one to see into your future and take control of it before it is here.

EVS is changing. Prove your value. Show that you know what it takes to be in the business – not just in the operations, but in the *business*. That time is now. You have to be the constant, because from here on out in health care, the only constant is change. ●

"The changing role of the EVS professional is one of adding value, partnering with patients and nurses, and demonstrating the importance of our position by adding a defined, tangible value to the facility."



Colby C. Morris, CHESP, *is assistant director – facilities operations for environmental services at the largest pediatric hospital in the nation, Texas Children's Hospital in Houston. Morris is experienced in both contract EVS and in-house services and has taught leadership for more than 15 years.*



Under a high magnification, this colorized scanning electron micrograph depicted a large group of Gram-negative Legionella pneumophila *bacteria.* SOURCE: 2009/CDC/ Margaret Williams, PhD; Claressa Lucas, PhD; Tatiana Travis, BS; CREDIT: Janice Haney Carr

LEGIONELLOSIS

An Unintended Consequence of Building Water Systems

Part one of a two-part series

By Eric R. Myers, MSc; Scott W. Millar, BS; and John H. Hanlin, Ph.D.

Part one of this two-part article provides an overview of Legionnaires' disease, the source of the bacterium in hospital water systems and aerosol vectors of infection. Part two will focus on the important role that a multidiscipline team plays in managing the legionellosis risk. The specific role environmental services (EVS) plays in collaboration with infection prevention, facility engineering, and risk management in the establishment and implementation of a *Legionella* Water Safety Plan will be described in part two. Additional public health information can be found at **www.cdc.gov/legionella/index.html**.

Tragedy in Philadelphia

The year was 1976; the location was Philadelphia and the 58th American Legion convention with more than 4,000 attendees. During and after the July convention, more than 200 people became sick and, tragically, 34 people died from a severe respiratory illness. News reports at the time called the ailment "Mystery Fever" and "Philly Killer."[1]

After months of investigation, scientists at the U.S. Centers for Disease Control and Prevention (CDC) finally isolated the organism that caused the illnesses. They had discovered a new bacterial pathogen. It was named *Legionella pneumophila,* and today this bacterium is recognized as one of several species of *Legionella* that causes legionellosis. Nearly 40 years later, we know much more about the disease, the bacterium, vectors of infection, at-risk populations and approaches to prevention.[2]

Overview of the disease

Legionella is a waterborne pathogen that can colonize the water systems of cooling towers, decorative fountains, whirlpool spas, pools, hot tubs and showers. It infects people when contaminated aerosols or water mists released from these systems are inhaled. Cases of legionellosis have also been associated with

BUILDING TYPE	SOURCE	YEAR	NOTES
Hospital, Wisconsin[6]	Decorative water wall fountain	2010	eight cases, exposure in public area
Hospital, Pennsylvania[7]	Sink in ICU, room shower, other locations	2011-2012	21 cases and five deaths
Long-Term Care Center, Ohio[8]	Air conditioning, cooling tower and several water sources	2013	39 cases and six deaths
Unknown, Quebec City[9]	Cooling tower(s)	2012	180 cases and 13 deaths
Unknown, UK[10]	Cooling tower(s)	2012	99 cases (confirmed or suspected)
Retail Premises, UK[11]	Spa pool on display	2012	21 cases and two deaths

Table 1. *Recent outbreaks of Legionnaires' disease associated with building water systems.*

ice machines, oxygen bubblers, nebulizers and water dental lines. *Legionell*a needs to enter the lungs to cause illness.

Most people who develop legionellosis exhibit mild flu-like symptoms and do not develop pneumonia. This milder form of legionellosis is called Pontiac fever. The more severe form of legionellosis is called Legionnaires' disease and is characterized by severe pneumonia, cough, fever, headache and chills. According to the CDC, the at-risk population includes current or former smokers, the elderly and other people with weakened immune systems. Cases of pediatric legionellosis have also been reported.

Morbidity and mortality

Every year, there are numerous reports of Legionnaires' disease outbreaks in health care facilities including hospitals and long-term care facilities. In a recent study published by the CDC, 11 outbreaks of Legionnaires' disease in health care and related facilities were reported in 2009 and 2010.[3] Health care settings often serve a greater at-risk population, but outbreaks can occur at other types of buildings with large, complex water systems including hotels, office buildings and manufacturing plants (Table 1). Thus, legionellosis can be considered both a hospital-acquired and community-acquired infection.

The CDC estimates 8,000–18,000 hospitalizations annually and a fatality rate between 5 and 30 percent. A 2.5-fold increase in cases between 2000 and 2009 has been reported. This trend is driven by several factors, including an increasing population of older persons and other at-risk people, enhanced surveillance and improved diagnosis and reporting.[4]

Vectors of infection – ecology of the organism

The *Legionella* bacterium is native to natural, freshwater environments. However, it is engineered water systems that have enabled this pathogen to find niches for its growth wherever building water systems are not properly operated and maintained. According to the CDC and other published industry guidance, conditions that support system colonization include water temperatures of 77–108°F (25–42°C), periods of water stagnation, presence of scale and sediment, biofilm development and a lack of an effective water disinfectant residual.[5] Once a system becomes colonized, the water mists or aerosols from decorative fountains, whirlpool spas, bathing showers, cooling towers and other potential sources containing the *Legionella* bacteria become the vectors of infection by which the microorganism gains access to the lungs of sensitive individuals. There is no evidence that legionellosis can be contracted through drinking water unless the water or ice is aspirated, and there is no evidence of person-to-person transmission. ●

FOOTNOTES

1 *Newsweek*, August 16th, 1976.
2 www.cdc.gov/legionella/index.html
3 Hilborn et al, 2013. Surveillance for waterborne disease outbreaks associated with drinking water and other nonrecreational water – US, 2009–2010. Morbidity and Mortality Weekly Report 62 (35) 714-720.
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5 ASHRAE, 2000. American Society of Heating, Refrigeration and Air-Conditioning Engineers, Inc. Minimizing the Risk of Legionellosis Associated with Building Water Systems. ASHRAE Guideline 12-2000.
6 Haupt *et al*, 2012. An outbreak of Legionnaires' disease associated with a decorative water wall fountain in a hospital. Infect. Control Hosp. Epidemiol. Feb (33) 185 - 191.
7 Hicks, 2013. Testimony before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations United States House of Representatives. February 5, 2013.
8 Crane, 2013. *The Columbus Dispatch* Sep 26, 2013.
9 www.healthmap.org 2012
10 McCormick *et al*, 2012. Public health response to an outbreak of Legionnaires' disease in Edinburgh, UK, June 2012. Eurosurveillance 17 (28).
11 Coetzee *et al*, 2012. An outbreak of Legionnaires disease associated with a display spa pool in retail premises, Stoke-on-Trent, UK, July 2012. Eurosurveillance vol 17 (37).

The CDC estimates 8,000–18,000 hospitalizations annually and a fatality rate between 5 and 30 percent.

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ENCOURAGING POSITIVE CHANGE

The Leadership Development Program at Wheaton Franciscan Healthcare

By Paul Picciurro, CHESP

A well-trained staff is the cornerstone of any Environmental Services Department. Well-developed and polished Shift Leads are even more important to the department's growth and success. For that reason, Wheaton Franciscan Healthcare in Milwaukee, Wis., created a year-long Leadership Development Program for Shift Leads to sharpen their skills and help elevate the department's level of service.

While we have existing Shift Leads enrolled in the program, we have also invited frontline "Charge" staff who expressed an interest in advancement and acquiring more responsibility. The Charges act as assistants to the Shift Leads, learning the role to cover in a lead's absence or to support the department when needed. In total, we have 16 employees from four facilities enrolled. Each of the 16 enrolled were chosen by their respective managers and received a formal invitation from the EVS director.

All of the EVS managers met and created specific prerequisites for the course, which include:

1. No corrective action within the past six months.
2. Ability to perform specific job duties including standard housekeeping tasks and basic floor care work.
3. Administrative skills such as the ability to compose and manage emails and voice mails, and the ability to create and modify the daily schedules.

The program covers basic leadership skills including conflict management, dealing with difficult situations, and time management. It also gives participants a chance to discuss their own specific challenges at each of the four facilities. Classes meet monthly and participants are given homework to be completed for the next session.

The Leadership Development Program compiles information and advice from different sources such as AHE Webinars, Sodexo trainings, other association publications, and podcasts from Mind Tools. Participants discuss the material and relate it to their daily experiences. In addition, each of the EVS managers participates in the program and teaches a session.

Ongoing testing and assessments are done throughout the program, and participants meet one-on-one with the EVS director and their managers to identify specific needs each participant may have. Development plans are created, and participants are mentored to improve and sharpen their skills. Participants are also asked to create resumes and participate in mock interviews with EVS leadership at all levels. Once the program has concluded, graduates of the first round will participate in and help develop the next.

While we are still in the beginning phases of this program, we have already observed positive results. Many of the frontline staff have asked what it would take for them to be promoted, and in 2013, at just Wheaton Franciscan Healthcare – St. Joseph, we promoted six EVS staff within the department, we saw two members of the EVS department be promoted to other departments within the facility, and we had the privilege of promoting one of our Shift Leads to a Sodexo manager position.

Along with the promotions, the Wheaton Franciscan Healthcare – St. Joseph facility has seen inspection scores increase from 2.79 to 3.19 (3.0 being a passing score) over a six-month period and black-light inspection results show a 96 percent passing rate.

The overall goal of the program is not only to improve the level of service the EVS department provides, but to equip each participant with the skills needed to advance in the industry and within the organization. We are also anticipating a decrease in staff turnover as employees become more engaged and invested in their work.

Developing future leaders is also developing the future of an EVS department. Although creating and conducting a Leadership Development Program is a major time investment for EVS leaders who are already pressed for time, it is well worth the commitment. Investing time developing your staff results in internal promotions and produces future leaders not only for the department, but for the organization. ●

Paul Picciurro, CHESP, *is operations manager at Wheaton Franciscan Healthcare – St. Joseph, in Milwaukee, Wis. For more information, he can be reached at* paul.picciurro@wfhc.org.

AHE VOICES

Leaders Share their Expertise Related to Health Care Reform and its Impact on the EVS Professional

EXPLORE **spoke with Rock Jensen and Greg May, CHESP, about health care reform and its impact on the EVS professional, including expanded service levels, volumes, the impact on today's hospitals and how this will directly affect EVS departments.**

Q: Do hospitals expect any changes in volume/admissions due to health care reform? If so, how will this impact Environmental Services (EVS)?

Rock Jensen (RJ): Most hospital and health care organizations I work with are anticipating an increase in patient volumes as a result of health care reform. With nearly 34 million uninsured individuals entering the health care marketplace, hospitals are developing unique strategies to get new patients into and through the hospital system. Many are developing aggressive triage units that direct less acute patients into separate care level structures with a goal of limited hospital admissions.

While hospital inpatient volumes and admissions will most likely decline under health care reform, outpatient services are anticipating significant increases in their activity.

EVS departments are being driven to adapt to these volume and service/acuity changes. Typically, the inpatient areas receive focused and frequent cleaning services each day. EVS departments often provide discharge teams the ability to quickly turnover rooms upon patient discharge. More often than not, outpatient locations receive the majority of cleaning focus at the end of the day, on a one-time-per-day frequency.

As patient volumes shift and higher outpatient activity occurs, EVS departments will have to make adjustments as well. Reallocating resources to address these changes will be a key to successful outcomes. Developing highly mobile response teams to manage high turnover locations will be a new focus. Instead of the assigning an EVS technician to a set number of rooms and common areas for which to be accountable, the new module will require individuals and teams who are capable of effective and efficient communication to remain on top of the ever-adjusting workloads. These workers will have to be capable of flexing to the level of cleaning requirements, which can vary with patient acuity and need.

Consequently, a good understanding of the hospital infection prevention processes will be essential in helping them make appropriate adjustments to the level of cleaning required for the variable case cleanings presented in the ever-expanding outpatient setting.

Greg May, CHESP (GM): Health care leaders are moving to leverage cost-efficient outpatient settings, however, I believe they expect both admissions and inpatient days to increase. The reasons for this pre-date health care reform as we know it today. That is, baby boomers continue to age. And this largest group of health care consumers' health acuity will continue to rise for the foreseeable future.

EVS departments will be tasked with cleaning a variety of spaces with various levels of regulatory oversight. Many spaces will likely stay on the acute care license, requiring the same level of regulatory oversight and therefore same or similar levels of cleaning provided within these settings. In some cases, cleaning will be contracted, which will place EVS management in the role of cleaning regulatory overseer.

As an example, with contractors cleaning off-site space associated with our acute-care license, I require they follow our cleaning procedures and further require their staff to complete an orientation from my managers, as well as demonstrate the competencies involved. This has been especially important for areas that have procedure rooms, ambulatory surgery rooms, interventional radiology and infusion spaces. We also address the many waste streams (e.g., bio-hazardous waste, pharmaceutical waste, confidential waste, etc.). Many contractors

have not been required to follow procedural cleaning processes and, as a result, can create significant issues for the health care environment if not addressed.

Q: If in fact there is an expected change in service levels, where is that volume anticipated to present for care? Is AHE's membership appropriately situated to be a player/provider of EVS services in those settings?

RJ: Outpatient services are where the anticipated increases are expected by most of the hospitals I work with. AHE is the premier organization for EVS professionals to ensure they stay ahead of the curve in regards to upcoming changes in health care reform. Monthly AHE training webinars are focused on developing and supporting skills within the industry that allow them to successfully navigate changes within their specific organization and maintain growth within their profession.

In addition, the annual AHE conference has numerous educational and training courses designed to keep EVS managers informed on aspects ranging from the patient experience, infection prevention and technologic advancements with experts in each of those fields.

An AHE membership is perhaps the single most significant advantage a manager/director can have to ensure timely education and updates, as well as numerous networking opportunities with peers in the industry.

GM: Historically, inpatient-associated services including ambulatory surgery, conscious sedation procedures, infusion, dialysis and interventional radiology will likely continue their transition to dispersed outpatient settings with significantly increased volumes. Efforts will continue to place lower acuity patients in a wide range of alternate settings including skilled nursing, long-term care and assisted living. There are new care models being explored such as medical homes. Inpatients will become increasingly more acute.

I believe AHE members are able to be very well situated. AHE members have access to premium resources for managing in these times – AHE recommended practice manuals, annual AHE educational programs, as well as the largest network of EVS professionals. This all lays the foundation for well-informed decision making, planning and performance.

Q: What are the other potential health care reform impacts to today's hospitals? Is there a trickle down impact for EVS, and if so what is it?

RJ: On average, Medicare and Medicaid patients account for more than 50 percent of the care provided by hospitals. Any expansion of these programs under health care reform will result in divergent issues for hospitals. As noted earlier, more patients may end up being covered; however reducing reimbursements will most likely offset any budgetary gains. To remain viable, hospitals will need to focus more attention on their payor mix and how they set and manage rates.

Part of the health care reform being implemented calls for hospitals and health care facilities to provide improved clinical outcomes, as well as deliver preventive health services. Health care reform also results in payors demanding and rewarding lower-cost alternatives to expensive hospital stays. One of the most significant consequences – and perhaps changes – brought on by health care reform is the reality that hospital revenues will have less to do with patient volumes and more to do with clinical outcomes, quality and cost efficiency.

Hospitals that show good results for patients and keep costs down will be rewarded with performance payments, shared savings and other revenue enhancements. Those hospitals that fail to meet these expectations will see financial penalties that affect revenues and potentially tarnish the hospital's reputation and credit standing.

Is there a trickle-down effect for EVS? In many ways, it may seem that the message is not too different from the mantra heard for years in EVS: "*Do More With Less.*" However, the real message is quite

> Mastering service and cleaning requirements in multiple, complex settings and training and overseeing staff and contractors will require professionals with vision, energy and excellent knowledge and management skills.
>
> —**Greg May, CHESP**

A leader who is in tune with making adjustments will quickly overlook the status quo of '*We've always done it that way*' and implement changes based on '*How it should be done.*'

—**Rock Jensen**

the opposite! With reimbursement levels from payors being directly tied to the quality of care, then to simply focus on doing more with less will only result in a downward spiral that lands the hospital and EVS manager in a position from which they may not be able to recover.

Those facilities and professionals who are able to adjust to the new measurement structures will find themselves in a better position to acquire successful outcomes and sustainability in the new health care landscape. Some of the key components to this success will be:

1) **Developing a strong patient experience program within the department**: Understand what the patient is wanting and needing.
2) **Developing useful and efficient tools to reduce repetitive functions and wasted time**: By focusing these tools on shifting workload levels affected by health care reform, you will ensure the right people are in the right place at the right time.
3) **Gaining a strong financial grip over your operation**: Know where the dollars are going on every level. Work hand-in-hand with your purchasing organization to ensure the products you use and supply are the most cost-effective and useful in the industry.
4) **Where staffing/labor and salaries are the single highest expense the department has, drive workload studies within your organization**: Each position must be measured for its time requirements and functionality. The questions to ask: *"Is this important to the organization?"* And, *"Can the frequency be adjusted?"* These two questions will lead you to ensuring essential functions are covered at an appropriate level.

A leader who is in tune with making adjustments will quickly overlook the status quo of *"We've always done it that way"* and implement changes based on *"How it should be done."*

GM: Health care reform has placed several serious challenges before acute care providers and health systems in general. Efficiency in care models is mandatory in order create opportunity for profit margin. These margins have already been negatively impacted by sequestration and the most recent federal budget legislation. Reimbursements look to be permanently reduced. In addition, the risk of lowered future reimbursement based on HCAHPS scores looms, as well as the costs associated with patients readmitted within 30 days.

The impact and challenge for EVS professionals will be to articulate care of the environment into the risk conversation. Clearly the environment can have impact on readmissions and HCAHPS scores. EVS will have either a positive or negative impact in these areas requiring dialogue and analysis.

The expected outpatient volume increases will challenge EVS professionals to justify adequate staffing to support all health care spaces under the specter of expected reduced costs. The challenge will often focus on the need to provide service to licensed spaces with the expectation that costs will be less "because" they are outpatient settings. However, if the space is part of an acute care license, there is likely no change in service requirement. While some outpatient spaces may not fall under the medical center license, there will likely be a patient expectation that those environments will meet the same criteria for acute care environments. Communicating the importance of balancing the needs for efficiency and a clean, safe health care environment to senior leaders is crucial.

Q: As hospitals evolve from being volume-based providers to providers of value-based care, what part can EVS play?

GM: EVS professionals will be an integral part of changing health care provision models. Mastering service and cleaning requirements in multiple, complex settings and training and overseeing staff and contractors will require professionals with vision, energy and excellent knowledge and management skills.

Providing environments in which health care is provided in a clean, safe manner is not only desired, it is required. This allows health care organizations to maintain their overall focus on maintaining health and doing no harm when our patients are with us.

Superbugs, CRE organisms and *C. Diff* do not know whether they are in an acute care setting, an assisted living or home health setting. They are only capable of creating havoc on those whom they find a pathway to infect. EVS professionals play an incredibly important role by preventing the environment from being that vector. ●

Rock Jensen *is a senior consultant with Soriant Healthcare in Phoenix, Ariz. He has 20 years of hospital environmental services, patient transport, laundry, food, grounds, communication, safety, security and facilities management experience. In addition, he has been accountable and responsible for the seven management plans and programs associated with the Environment of Care and correlated JCAHO regulations.*

Greg May, BA, CHESP, *has 35 years of diverse health care experience in environmental services, environmental health and safety, emergency preparedness, linen and laundry, and contracting. He currently serves as UC San Diego's Health System Director of Environmental Services, Linen and Sustainability Programs. Greg also serves on the board of the Association for the Healthcare Environment as well as Novation's Environmental Advisory Group.*

AHE NEWS & UPDATES

Calendar of Educational Events

MARCH 20: Webinar – ES Department of the Year: Winning Stories
APRIL 24: Webinar – The Efficacy of Disinfectants and Detergents in Environmental Cleaning
APRIL 28–JULY 20: Course – Employee Engagement: Going the Extra Mile *NEW FOR 2014!*
MAY 5–JUNE 1: Course – Principles of Effective Linen Management
MAY 12–JUNE 22: Course – CHESP Study Group
MAY 15: Webinar – EVS Metrics and Math (Stuff You Need to Know)
JUNE 12: Webinar – Cleaning in the OR *PART ONE OF A TWO-PART SERIES!*

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What Are Your Professional Development Goals in 2014? Could you benefit from having new and innovative EVS practices and technologies explained in clear and understandable terms? ENGAGE offers all of this, and much more. And, it's getting even better in 2014. ENGAGE courses, webinars, recordings and publications are designed to equip you with the latest content and trends in the field, and to help you take your departments, facilities and careers to new heights.

Be Recognized for Your Sustainability Efforts!

The AHE Environmental Sustainability Certificate Program provides guidance on efficient, effective and value-added environmentally sustainable healthcare operations. Participation in this program will provide recognition for being proactive and hands-on with sustainable operations and green initiatives. AHE has designed the program with not only recognition in mind, but also guidance in what it takes to be an exceptional example of successful sustainability endeavors. For more information and to view the program submission guidelines and review process, visit **www.ahe.org**.

CareerLink

AHE CareerLink is the premier electronic recruitment resource for the industry. Here, employers and recruiters can access the most qualified talent pool with relevant work experience to fulfill staffing needs. Visit **www.careerlink.ahe.org** to learn more.

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Learn About Performance Improvement Measures

The Sustainability Roadmap – **www.sustainabilityroadmap.org** – provides free, practical tools to help health care facilities reduce their environmental footprints. The AHA-sponsored site shows hospitals how to implement real-world sustainability projects, enhance existing efforts and share their environmental successes with other facilities. The Sustainability Roadmap website features search functions, how-to guides and other resources. Many new resources have been added with invaluable information on Performance Improvement Measures.

EXCHANGE 2014

September 21-24, 2014 • Tampa, Florida

EXCHANGE is an annual educational event attended by approximately 900 environment professionals. The conference brings together environmental services, infection prevention, facilities, textile, design and many other healthcare professionals to learn from and share with each other, make valuable business connections and lead change in the field of environmental services, which includes surface disinfection, environmental hygiene and infection prevention. For more information about this year's conference, visit **www.ahe.org/exchange**.

ONETOGETHER WORD SEARCH

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L O I N X W M N Q B K A E H H
T X S T A N V G T B P S U D T
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I N F L L E C Z R V L V W G U
X K L I K X L G C E Q P F L J
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X B K Z O I A R O U T O U Q L
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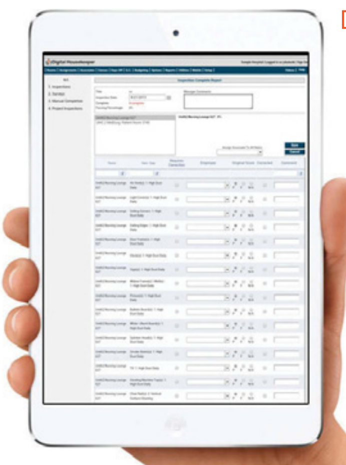

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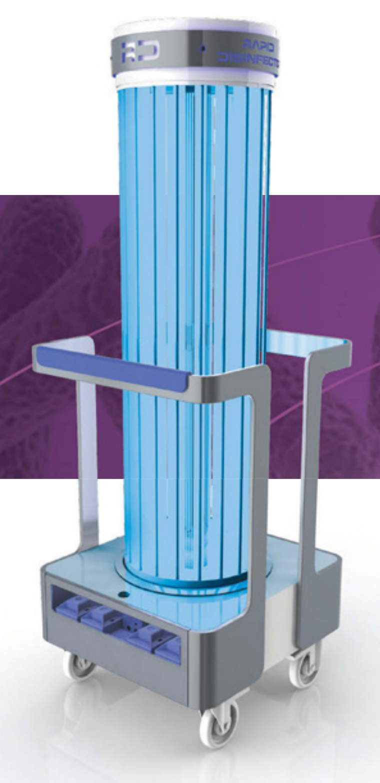

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