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INSIDE

AHC Media

Outpatient Surgery Staff Members Can Fight Patients' Opioid Addiction

With 78 opioid-related deaths a day, what can one healthcare staff member do? The answer is plenty, according to a panel discussion at the recent annual meeting of the American Medical Association (AMA).

At its June meeting, the AMA adopted policies that promote non-opioids and non-pharmacological treatments for pain. The AMA's new policies also encourage providers to co-prescribe naloxone, which reverses the effects of narcotics, when they prescribe opioids to patients who are at risk of an overdose.

"MORE AMERICANS NOW DIE FROM DRUG OVERDOSES THAN CAR CRASHES ..." — SYLVIA M. BURWELL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

"The AMA and our nation's physicians have demonstrated our commitment to ending this epidemic," said **Patrice A. Harris**, MD, MA, chair-elect of the AMA and chair of the AMA Task Force to Reduce Opioid Abuse. "These policies will save lives. That's the bottom line." Also, insurers must change and cover non-opioid and non-pharmacological therapies, Harris said.

The Department of Health and Human Services (HHS) recently announced several actions, including a proposal to eliminate any potential financial incentive for doctors to prescribe opioids based on patient experience survey questions. CMS also is taking action: to provide greater access to buprenorphine, which is an FDA-approved opioid addiction treatment, to encourage greater reliance on state Prescription Drug Monitoring Programs, and to invest in research and training.

These changes can't come soon enough. According to the Associated Press (AP), there were more than 47,000 drug abuse fatalities in the United States

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in 2014, which was double the death rate in 2000.[1] Most of the deaths were from heroin or opioids, AP said.

HHS Secretary **Sylvia M. Burwell** said, "More Americans now die from drug overdoses than car crashes, and these overdoses have hit families from every walk of life and across our entire nation."

Part of the blame might fall on outpatient surgery providers. Physicians are prescribing more opioids than ever to patients undergoing common outpatient surgeries, according to research reported on by *Same-Day Surgery* in the May issue. *(Readers can see "Researchers show rising opioid prescriptions following low-risk surgeries" at http://bit.ly/1rgmCi6.)*

In more recent research published in *JAMA Internal Medicine,* common surgical procedures were tied to increased risk for chronic opioid use in the first year after surgery by opioid-naïve patients, who were patients who hadn't filled a prescription for the pain relievers in the year before surgery.[2] Patients who underwent some procedures, including laparoscopic cholecystectomy, were particularly vulnerable. Other procedures that showed patient vulnerability for chronic opioid use included total hip arthroplasty, total knee arthroplasty (TKA), simple mastectomy, open cholecystectomy, open appendectomy, and cesarean delivery.

The incidence of chronic opioid use in the first postoperative year ranged from 0.119% for cesarean delivery to 1.41% for TKA. For nonsurgical patients, the baseline incidence of chronic opioid use was 0.136%. Patient factors that were tied to increased risk included being male; being older than 50; and having a preoperative history of drug abuse, alcohol abuse, depression, benzodiazepine use, or antidepressant use.

Eric Sun, MD, PhD, instructor in the Department of Anesthesiology, Perioperative and Pain Medicine at Stanford University School of Medicine, California, and coauthors analyzed administrative health claims data for privately insured patients: 641,941 opioid-naïve surgical patients and more than 18 million opioid-naïve nonsurgical patients for comparison. They defined chronic opioid use as having filled 10 or more prescriptions or more than 120 days' supply within the first year

EXECUTIVE SUMMARY

The number of drug abuse fatalities has doubled to more than 47,000 annually. Common surgical procedures have been tied to increased risk for chronic opioid use in the first year after surgery by opioid-naïve patients, including laparoscopic cholecystectomy, total hip arthroplasty, total knee arthroplasty, and simple mastectomy.

- Providers should be judicious about prescribing opioids and consider non-opioid and non-pharmacological treatments of pain. They should track opioid use after surgery.
- Educate patients about sharing, storing, and disposing of medications, as well as their expectations on pain. A one-page resource can help providers discuss the risks and benefits of these medications with patients. *(To access the resource, go to http://bit.ly/1PE1mNT.)*

after surgery. They excluded the first 90 postoperative days because some opioid use is expected during that period.

One important lesson from the research is to be "always judicious about prescribing," Sun says. "That's the bottom line. Keep in mind the increased risk, and think, do you really need an opioid to control pain?"

Sun and his coauthors say that "results suggest that primary care clinicians and surgeons should monitor opioid use closely in the postsurgical period."

In an interview with *SDS*, Sun said, "Your surgeons are in a world where patients get discharged. You need coordination between surgeons and primary MDs in terms of patients' subsequent opioid use after surgery."

Ultimately, it will be the primary care doctor who is following the patient, Sun says. "It's important that they know what's going on."

David Hoyt, MD, FACS, executive director of the American College of Surgeons, says that when providers receive a request for more medication, they should refer back to the medical record to see if adequate medication has been given and whether it is appropriate to renew. Also, some states have registries that track prescriptions for opioids, Hoyt says.

The emphasis on tracking is backed by the American Academy of Orthopaedic Surgeons (AAOS) Board of Directors, which released an information statement in 2015 that outlined ways to track opioid prescription use. *(Readers can see the full information statement online at http://bit.ly/2aAICxK.)*

David Ring, MD, PhD, who has served as a member of the AAOS Patient Safety Committee, encourages providers to address patients' concerns about post-surgical pain and to develop a strategy that includes acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDS), ice, elevation, and splinting.[3] Ring also encourages providers to call patients the day after outpatient surgery. He said that being able to communicate with patients and show empathy are critical. Providers should develop a script for difficult situations that allows them to practice what they will say, he says. Empathy is a key component, he says.

Educating providers can make a difference. Officials at Labette Health in Parsons, KS, used a team approach and focused their efforts on education in staff meetings, where staff reviewed policies, forms, and reporting procedures.

Phillip Gorman, MD, medical director of anesthesia, says, "We stay up-to-date and implement multi-modal pain management strategies such as IV acetaminophen, gabapentin, steroids, NSAIDs, and regional anesthesia with local."

As a result, the number of patients receiving opioids dropped by 36%. In one year, the health system reduced the use of naloxone by 51%.

"These strategies have not only helped reduce the amount of opioids being administered, but also improved the patient experience related to pain management," Gorman says.

Pain management scores for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) rose at Labette Health. Starting in fiscal year 2018, CMS proposes to no longer use results from three pain management questions in the HCAHPS survey in determining hospitals' value-based purchasing program scores, the agency said in the outpatient prospective payment system proposed rule for calendar year 2017. *(See stories on that proposed rule in this issue.)*

Educating Patients Is Key

Educating patients can help them manage opioids, according to an article in the August issue of *Pharmacology Watch,* also published by AHC Media. *(Access the article at http://bit.ly/2actWUV.)*

A survey showed patients have little to no idea about opioid management. The article examined a recent research letter that looked at 3,300 respondents who had received an opioid prescription and examined their sharing, storing, and disposing of the medications, according to **William Elliott**, MD, FACP. "About 21% reported sharing their medication with another person, primarily to help the other person manage pain," Elliott said. "More than half of respondents reported they had leftover medication, of which 60% reported keeping the medication for future use. Nearly half did not recall receiving information on safe storage or disposal of opioids."

Also, patients need to understand that pain tolerance and the length of time they are in pain is variable, Hoyt says. They should understand that there will be a transition from the immediate postop period, through the first couple of days, and the time that follows.

"Transition periods are not pain-free," Hoyt says.

At the same time, patients should understand that physicians will try, in general, to make this experience as painless as possible. "That's an educational conversation and goal you need to have with the patient," Hoyt says.

Another important part of the conversation with patients should focus on disposal, he says. Many

places, including hospitals and pharmacies, are set up to collect unused medication, Hoyt says. Emphasize that the medications should not be used by another patient who is not under the direct care of a physician, he says.

To assist providers, the American Hospital Association and the CDC just released a one-page resource for patients who are prescribed opioids before discharge so staff can discuss risks and benefits of these medications. *(To access the resource, go to http://bit.ly/1PE1mNT. For an additional resource, see the end of this article.)*

A lot of providers and patients are anticipating more medication than is needed, which leaves leftover medication that can be stolen or sold, Hoyt warns. "The length of time should be adequate to control symptoms from the operation or other source of pain, followed by disposing of it," he says. "That is the best practice."

The bottom line? "Physicians need to be vigilant as they treat pain and not overtreat it, for sure," Hoyt says. "Patients need to realize if they have excessive medication, it's probably best to get rid of it so someone else doesn't get a hold of it. This is particularly the case for patients with young kids who might want to experiment. If it's around, it increases the opportunity for that to occur." *(For more information on opioids, see "American Pain Society publishes guideline for post-surgical pain management,"* SDS, *April 2016, at bit.ly/1XNBWwi and "The Joint Commission Defends Standards Under Fire as Opioid Abuse Grows,"* SDS, *July 2016, at http://bit.ly/28Jz2b1.)* ■

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3. Hofheinz E. AAOS taking on opioid epidemic. *Ortho This Week* Oct. 16, 2015.

RESOURCE

See an on-demand webinar from AHC Media about the CMS Conditions of Participation hospital requirement on safe opioid use. Access the webinar at http://bit.ly/2ajEMtS.

CMS Proposes 1.2% Rate Increase for ASCs

CMS has released the 2017 proposed payment rule for ambulatory surgery centers (ASCs) and under the proposed rule, ASCs would see an effective update of 1.2%, according to the ASC Association (ASCA). The update is a combination of a 1.7% inflation update based on CMS' estimation of the change in Consumer Price Index for All Urban Consumers (CPI-U) and a productivity reduction mandated by the Affordable Care Act of 0.5 percentage points, ASCA said.

CMS proposes adding eight procedures to the ASC list of payable procedures for 2017, according to ASCA. This list includes five codes that are payable in the hospital outpatient department (HOPD) setting, as well as three codes that are on the inpatient-only list.

"Unfortunately, all of these codes are add-on codes, and thus will not be separately payable," ASCA said in a released statement.

These codes are:

- 20936 (Sp bone agrft local add-on);
- 20937 (Sp bone agrft morsel add-on);
- 20938 (Sp bone agrft struct add-on);
- 22552 (Addl neck spine fusion);
- 22840 (Insert spine fixation device);
- 22842 (Insert spine fixation device);
- 22845 (Insert spine fixation device);
- 22851 (Apply spine prosth device).

ASCA CEO **Bill Prentice** said, "In addition to our perennial concern that the use of different inflation factors continues the divergence in payments between ASCs and HOPDs for performing the same procedures, we are also disappointed that CMS remains slow to recognize that ASCs can safely perform many more procedures than currently allowed. Adding procedures that ASCs are currently performing with great success on commercial patients to our list of payable procedures would reduce costs for both beneficiaries and the Medicare program."

CMS also is seeking public comments on whether CPT code 27447 (Total knee arthroplasty) should be removed from the inpatient-only list, the ASCA reports.

The proposed rule was published in the *Federal Register* on July 15, and the proposal can be accessed online at http://bit.ly/29NT4Em. Readers can submit comments until 5 p.m. EST on Sept. 6, 2016, by going online to

http://www.regulations.gov. Readers can follow the instructions listed under the "submit a comment" tab. In commenting on the proposed rule, readers can refer to file code CMS-1656-P. ■

Measures Added to Hospital, ASC Quality Program

CMS did not propose to add new measures to the Ambulatory Surgery Center (ASC) Quality Reporting Program for 2018 or 2019 payment determinations, the ASC Association said. However, the agency proposed that seven measures be added for 2020 payment determinations for ASCs and hospital outpatient departments.

Two proposed measures that require ASC data to be submitted directly to CMS are:

• ASC-13: Normothermia Outcome, percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care unit;

• ASC-14: Unplanned Anterior Vitrectomy, a procedure performed when vitreous inadvertently prolapses into the anterior segment of the eye during cataract surgery.

There are also five proposed measures for ASCs and hospital outpatient (OP) departments based on the use of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS). The OAS CAHPS is a 37-item survey to assess the experience of care for patients who have received surgeries and other procedures in hospital OP departments and ASCs. "CMS would require OAS CAHPS data to be collected and submitted quarterly starting with visits on Jan. 1, 2018," the American Hospital Association said.

The five proposed measures are:

• ASC-15a (OP-37a:) OAS CAHPS – About Facilities and Staff;

• ASC- 15b (OP-37b): OAS CAHPS – Communication About Procedure;

• ASC-15c (OP-37c): OAS CAHPS – Preparation for Discharge and Recovery;

• ASC-15d (OP-37d): OAS CAHPS – Overall Rating of Facility;

• ASC-15e (OP-37e): OAS CAHPS – Recommendation of Facility.

For the CY 2020 outpatient quality reporting program, CMS proposes two more measures for hospitals:

• OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687);

• OP-35: Admissions and CMS-1656-P ED Visits for Patients Receiving Outpatient Chemotherapy.

The proposed rule can be accessed at http://bit.ly/29NT4Em. ■

1.55% Pay Boost Proposed for Hospital Outpatients

CMS proposed to update hospital outpatient prospective payment system (OPPS) rates by 1.55% in calendar year 2017 compared to CY 2016, according to the American Hospital Association (AHA).

The rule also proposes to implement the site-neutral provisions of Section 603 of the Bipartisan Budget Act of 2015, which requires that, with the exception of dedicated ED services, services furnished in off-campus provider-based departments (PBDs) that began billing under the OPPS on or after Nov. 2, 2015, would no longer be paid under the OPPS. Instead these services would be paid under other applicable Part B payment systems beginning Jan. 1.

CMS proposes that, in 2017, the physician fee schedule (PFS) would be the payment system for the site-neutral rates for most services furnished in a new off-campus PBD, according to the AHA. Specifically, CMS would pay physicians furnishing services in these departments at the higher "nonfacility" PFS rate. "There would be no payment made directly to the hospital by Medicare," the AHA said.

Existing off-campus PBDs that expand their services to include those in new clinical families would receive the site-neutral rate for those services, the AHA said. Also, any existing off-campus PBD that relocates after Nov. 2 would lose its excepted status and be subject to site-neutral payments. "An existing off-campus PBD that undergoes a change of ownership would only maintain its excepted status if the new owner accepts the existing Medicare provider agreement from the prior owner," the AHA said.

AHA Executive Vice President **Tom Nickels** said the association is "extremely dismayed by the short-sighted policies" in the proposed rule. "Taken together, it appears that CMS is aiming to freeze the progress of hospital-based health care in its tracks," Nickels said. "We will submit detailed comments to the agency

urging them to revise these misguided policies so that hospitals can continue to provide the highest quality health care to their communities."

The proposed rule can be accessed at http://bit.ly/29NT4Em. ■

CMS Proposes to Drop Physician Pay Rate 0.08%

After applying the 0.5% payment increase required by the Medicare Access and CHIP Reauthorization Act of 2015 and other budget neutrality cuts, CMS estimates a 0.08% decrease in physician payment rates for 2017 compared to 2016, according to the American Hospital Association.

For CY 2017, CMS proposes to separate moderate sedation services from hundreds of procedure codes, including most GI endoscopy procedures under Medicare Part B, according to the American Gastroenterological Association (AGA). There will be no financial impact for gastroenterologists who perform their own moderate sedation, the AGA said. Beginning in January 2017, gastroenterologists performing their own moderate sedation for endoscopic procedures will report two codes instead of one: the procedure code and the proposed moderate sedation code, the AGA said.

Gastroenterologists who use anesthetists will see the value of most GI endoscopy procedures reduced by 0.10 relative value units (RVUs), the AGA said. CMS has created Healthcare Common Procedure Coding System (HCPCS) G codes for moderate sedation for GI endoscopy procedures.

The proposed value for moderate sedation for GI endoscopic procedures for 2017 is 0.10 work RVUs. "An add-on code for each additional 15 minutes of intra-service time also will be available, but will have only practice expense," the AGA said.

The proposed rule can be accessed at http://bit.ly/29NT4Em. ■

SDS Manager

Your Most Expensive Asset Might Be at Risk

By Stephen W. Earnhart, MS
CEO
Earnhart & Associates
Austin, TX

I enjoy writing about issues that affect all of us in the surgery industry, from freestanding ambulatory surgery centers to hospital-based to office-based.

One area that we all have issues with is employees. Employees are expensive. Not just in dollars, but in your facility image and patient and surgeon satisfaction. Nothing irritates surgeons more than walking into the OR and seeing new faces. The new staff member is eager to please and probably well-trained, but still, there is a learning curve. It's an unwanted distraction.

I am always suspicious of managers and administrators who have high or even moderate staff turnover. I know that productivity is going to suffer as a result of losing any employee. Clearly, there usually are good reasons why a staff member might leave. However, losing a valuable member of your staff is a loss for all.

So, how can you prevent the drain?

I did a survey several years ago on why staff members left facilities. Granted, the survey is now dated, but the results still are valuable. Of 28 individuals who left employment at 15 facilities over a one-year period, here were the reasons, which I believe were honest.

The study was more than just the below, but these are the end results:

- 7% left because they were offered more money at another facility;
- 11% left because of a personality conflict with other staff;
- 14% left due to a physical move out of the area;
- 68% left because they were unhappy and wanted new challenges.

Not much could be done about the money issue and moving out of town, but 79% could have been saved!

How? Here are some ways it can be prevented:

1. Set clear expectations of staff members, both long- and short-term.
2. Have frequent staff meetings that include all members.
3. Show each employee how they can "shine" in the workplace (such as reduce waste, shorten turnover time, etc.).
4. Give your staff the tools to be successful.

A clunky computer that crashes all the time makes it difficult to do QA and risk management assessments. Update your equipment. Hardware is cheap today!

5. Do a one-on-one talk with

everyone at least once a month. If you are the employee, ask your manager for a 10-minute evaluation of your job performance. If you are a manager, this request can be a sign to you that someone is not confident of his or her performance or just needs some positive reinforcement.

6. Share the success of your work. If you are hospital-based and cannot give individual bonuses, at least acknowledge individuals in your now frequent staff meetings. If you are "for-profit," share the money! While money itself is not always the motivator, the recognition that a bonus gives will far outweigh the cost in retaining staff.

7. Give praise for a job well done and suggestions for when it doesn't go so well.

8. Overall, in my experience, people want to be successful and please. Let them. Never underestimate the positive impact of a smile to someone you work with, for, or under. High fives are out, but smiles are in!

9. Never steal someone's thunder. Acknowledge others' suggestions as their own, and be vocal about it at meetings.

10. Lastly, follow your gut. If you sense another staff member or employee is unhappy, seek out him or her and talk about it. I think we all have a sixth sense about spotting unhappiness.

Will the above 10 points help? Yes. Maybe not all of them for everyone, but certainly some of them for some. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

Pre-Surgery Optimization Clinic Supports Patients at High Risk for Complications

PinnacleHealth in Harrisburg, PA, is opening its PinnacleHealth Surgery Optimization Clinic to all high-risk orthopedic surgery patients, followed by high-risk surgical patients in other service lines by year's end.

The program aims to improve patient satisfaction and overall health and to decrease surgical complications, readmissions, same-day surgery cancellations, and length of stay.

Before an elective surgery, PinnacleHealth's surgeons refer high-risk patients to the clinic to assess health status. Consultations between the clinic's registered nurses and certified registered nurse practitioners and patients are held over the phone or in person at the clinic.

"The PinnacleHealth Surgery Optimization Clinic is a multidisciplinary team approach to identifying and mitigating pre-surgical risks," said **John T. Cinicola**, MD, medical director of the PinnacleHealth Surgery Optimization Clinic. "Optimizing health increases the odds for a successful procedure, and preventing complications means patients are less likely to return to the hospital."

Conditions such as uncontrolled diabetes, high blood pressure, tobacco use, and being overweight or underweight can have negative effects on surgical outcomes. After the evaluation, the nurse will talk with the patient's surgeon about medical conditions that may significantly increase the patient's risk for surgery. As a result of these consultations, surgeons may recommend that patients improve their health before surgery. Interventions could include a new treatment, seeing another doctor for additional therapies, or recommending lifestyle changes such as smoking cessation.

Joseph Answine, MD, anesthesiologist with Riverside Anesthesia Associates, said, "The clinic broadens our perspective well beyond the surgical procedure. We look at the whole person. It may require improving kidney function, lung function, or the patient's nutrition, but taking this holistic approach can result in reduced risk for infection and decreased recovery time and pain after surgery."

The clinic also provides one-on-one pre-surgical education and coordinates care among the patient, primary care provider, surgeon, and anesthesiologist.

In January 2015, PinnacleHealth launched a peri-optimization program on a limited scale for elective total knee, total hip, and spine patients. **Jack Frankeny**, MD, CPE, CEO and executive director, the Orthopedic Institute of Pennsylvania in Camp Hill, said, "We found that patients who are engaged in their care prior to surgery have less anxiety and a better understanding of what to expect.

Knowing that they have an active role in improving their health to achieve better outcomes offers a sense of empowerment. Patients realize they can influence what happens post-surgery." At press time, the clinic was scheduled to open in August. *(For more information, go to http://bit.ly/2a5uYoc.)* ■

Patients Prep for, Recover from Surgery with App

A new smartphone app is helping surgery patients at the University of Virginia (UVA) Health System in Charlottesville follow a treatment program to better prepare them for surgery and speed their recovery.

Since 2013, colorectal surgery patients at UVA have used the Enhanced Recovery After Surgery (ERAS) program. ERAS aims to educate patients, improve their outcomes, and help to make them more comfortable before and after their surgery. In the first six months after ERAS was implemented for elective colorectal surgery, the overall median length of stay for patients decreased, overall complication rates were reduced by about 50%, and patient satisfaction scores improved across the board.

The ERAS program includes:

• having patients drink sports drinks two hours before surgery to reduce the need for IV fluids;

• providing non-narcotic medications to minimize use of opioid pain medications;

• getting patients out of bed and walking soon after surgery;

• having patients eat as soon as possible after surgery.

The key to making ERAS work is extensive patient education before and after surgery, UVA care providers said. Patients already receive an educational handbook and a paper checklist to ensure they complete needed tasks.

"We are bringing patient education into the digital age with an ERAS website and a mobile app to complement the handbook. This ensures patients have the information they need to understand their care and be better prepared for surgery," said **Bethany M. Sarosiek**, RN, the ERAS development coordinator at UVA. "The app puts the information directly at their fingertips." *(To access the ERAS website, readers can go to http://bit.ly/2aoaZNw.)*

How the App Works

UVA worked with Charlottesville, VA-based Willowtree to develop an app that brings information from the handbook and the checklist to a patient's smartphone, said **Derrick Stone**, director of software development at UVA Health System. Patients download the free app in the clinic, then enter their surgery details and information. Reminders are sent directly to their smartphone in preparation for surgery.

For example, patients receive a checklist of when to stop taking certain vitamins and supplements. This information is important because, without a reminder, patients may forget, and surgery could be postponed.

Patients also receive a pop-up message on their phone on the morning of their surgery that includes directions to the hospital and information about where to park.

After surgery, patients receive reminders about getting up to walk around. This reminder helps improve their mobility while preventing breathing problems, reducing the risk of blood clots, and ensuring early return of bowel function.

"Having the reminders sent directly to their smartphone allows them to see the information at the right time, wherever they are," Sarosiek said. "We are hopeful this will improve compliance, reduce surgery cancellations and postponements, improve patient outcomes, and reduce hospital readmissions."

As the ERAS program rolls out to additional surgery services at UVA, so too will the app. Gynecologic surgery will be the next program supported. *(For more on the health system's efforts, see "With new protocols, patients come out of the OR nearly discharge-ready," Same-Day Surgery, October 2014, at http://bit.ly/2aEoJ8Q.)* ■

FDA Clears New Treatment for Low Back Pain

A minimally invasive nerve-ablating procedure, recently cleared by the FDA, may give some people with chronic low back pain a new treatment option.

"In 25 years of practicing orthopedics, this is the most important clinical study I've ever done," said **Jeffrey Fischgrund**, MD, chairman of orthopedics and orthopedic surgeon at Beaumont Hospital, Royal Oak (MI) and

principal investigator of the FDA-approved trial of Surgical Multicenter Assessment of RF Ablation for the Treatment of Vertebrogenic Back Pain (SMART). "The system is proven to be safe and effective in clinical trials. It is much less invasive than typical surgical procedures to treat low back pain."

Fischgrund helped design the research study. Research teams in the United States and Germany recruited 225 participants, with 150 receiving the minimally invasive ablation treatment and 75 receiving the placebo.

The outpatient treatment uses radio frequency energy to disable the targeted nerve responsible for low back pain. Under local anesthesia with mild sedation, through a small opening in the patient's back, an access tube is inserted into a vertebral body. Radio frequency energy is transmitted through the device, which creates heat that disables the nerve. The access tube is removed. The minimally invasive, implant-free procedure takes less than one hour.

"This is a new way to treat back pain. This type of treatment has never been done before," said Fischgrund. "It's revolutionary, compared to more traditional therapies. The odds of success are much greater."

Patients eligible for this new procedure typically are candidates for more invasive back surgery or take strong pain medications, such as opioids. Those research participants who had the radiofrequency ablation procedure noticed significant improvement in their back pain within two weeks of surgery.

The nerve ablation procedure and technology was developed by Relievant Medsystems, a Redwood City, CA-based medical device company.

Back pain is the most common reason people go to their doctors. According to the National Institutes of Health, 80% of adults will experience low back pain in their lives. Chronic low back pain, lasting 12 weeks or longer, affects nearly one-third of the nation's population. ■

Zika Transmitted by Needlestick to Lab Worker

First documented occupational Zika infection reported by a health department

By **Gary Evans,** *Senior Writer, AHC Media*

The question of whether Zika virus can be transmitted via needlestick is no longer hypothetical.

As feared, the virus can indeed transmit to a healthcare worker who suffers a percutaneous injury, but a Pittsburgh lab worker who was infected occupationally is recovering nicely, the Allegheny County (PA) Health Department (ACHD) reports.

The case appears to be the first documented instance of Zika transmission via needlestick, although healthcare officials have warned since the epidemic began that it was certainly possible. It underscores that healthcare workers must be vigilant with infection control precautions and needle safety to protect themselves from Zika and a host of other bloodborne pathogens.

The woman "contracted the virus from a needlestick while working with the Zika virus on an experiment in a laboratory. Her symptoms have resolved and she is doing well," Allegheny health officials reported. The needlestick reportedly occurred on May 23 at a University of Pittsburgh lab, with the worker becoming symptomatic about a week later and then fully recovering.

The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis. While now a confirmed occupational threat to healthcare and lab workers, Zika is primarily spread by *Aedes* mosquitoes and can be transmitted sexually.

The worker reportedly was advised to cover up when outside and use insect repellent to reduce the chances of spreading the virus to others via a mosquito bite.

In other Zika news, the CDC has found persistent mosquito populations in a square-mile area of Miami where 14 people, at press time, have acquired the Zika virus. The agency has issued a travel advisory warning pregnant women to avoid the area of transmission.

The CDC recommendations include the following:

- Pregnant women should not travel to the identified area.
- Pregnant women and their partners living in this area should consistently follow steps to prevent mosquito bites and sexual transmission of Zika.
- Pregnant women who traveled to this area on or after June 15, 2016, should talk with their healthcare provider and should be tested for Zika. *(For the latest on Zika from AHC Media, publisher of* Same-Day Surgery, *visit AHCMedia.com/Zika.)* ■

Amid Protests from Hospitals, CMS Releases Overall Star Ratings

*By **Jill Drachenberg,** Managing Editor, AHC Media*

CMS has launched its new overall quality star ratings for Medicare hospitals, which is raising the ire of hospitals and medical associations that have pushed the agency to block, or at least revise, the ratings system.

The star ratings use data from 64 quality measures reported to Hospital Compare, including:

- outpatients who received cardiac imaging stress tests before low-risk outpatient surgery;
- deaths among patients with serious treatable complications after surgery and surgical site infections from colon surgery;
- rate of complications for hip/knee replacement patients;
- rate of unplanned readmission after hip/knee surgery;
- percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy;
- percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe;
- patients who received treatment to prevent blood clots on the day of or day after hospital admission or surgery. *(See the quality measures at http://bit.ly/1OTT6ZB.)*

Hospital officials have resisted the release of the ratings, and they have argued that treating high numbers of complicated cases, and CMS' possible use of outdated statistics, could make some high-quality and prestigious medical centers look bad. "We are … disappointed that CMS moved forward with release of its star ratings, which clearly are not ready for prime time," said American Hospital Association (AHA) President **Rick Pollack** in a statement. "As written, they fall short of meeting principles that the AHA has embraced for quality report cards and rating systems."

A total of 129 hospitals scored only one star. *(The full list of hospitals and their star ratings can be found at http://bit.ly/1OTT6ZB.)*

The AHA and other industry organizations opposed the overall star ratings and expressed concerns that the information would not accurately represent hospitals in a meaningful way. Hospitals with high numbers of patients with complicated conditions, low income, or low health literacy may have higher rates of readmissions or adverse events that do not reflect on the hospital's overall quality of care. Members of Congress also urged CMS to postpone the star ratings and reconsider how the ratings are determined.

"[W]e are especially troubled that the current ratings scheme unfairly penalizes teaching hospitals and those serving higher numbers of the poor," Pollack said. Medicare ratings do not adjust for socioeconomic conditions.

The current ranking breaks down as follows:

- 102 hospitals (2.2%) received five stars;
- 934 hospitals (20.3%), received four stars;
- 1,770 hospitals (38.5%) received three stars;
- 723 hospitals (15.7%) received two stars;
- 133 hospitals (2.9%) received one star.

The remaining 937 healthcare facilities (20.4%) were not rated because they didn't report enough data. ■

Pediatric Groups Update Sedation Clinical Guidelines

*By **Leslie Coplin,** Executive Editor, AHC Media*

(This information first ran as breaking news on July 5 on the website for our publisher, AHC Media. To keep up with breaking news in the healthcare field as it happens, readers can go to AHCMedia.com.)

The American Academy of Pediatrics, with the American Academy of Pediatric Dentistry, has issued updated clinical guidelines for delivering safe sedation to pediatric patients before, during, and after diagnostic and therapeutic procedures.

Over the past 20 years, the number of procedures performed on children in outpatient settings has increased, which has led to the need for increased awareness of the importance of providing safe sedation. The guidelines include two major changes to sedation procedures.

First, children who are deeply or moderately sedated should have

capnography monitoring to measure expired carbon dioxide and ensure airway patency and gas exchange. Second, the assistant to the person monitoring sedation is required to have pediatric advanced life support training.

Other key highlights of the guidelines include:

• appropriate fasting for elective procedures and a balance between the depth of sedation and risk for those who are unable to fast because of the urgent nature of the procedure;

• recovery to the presedation level of consciousness before discharge from medical/dental supervision;

• no administration of sedating medication without the safety net of medical/dental supervision;

• careful presedation evaluation for underlying medical or surgical conditions that would place the child at increased risk from sedating medications;

• a focused airway examination for large (kissing) tonsils or anatomic airway abnormalities that might increase the potential for airway obstruction;

• a clear understanding of the medication's pharmacokinetic and pharmacodynamic effects and drug interactions;

• appropriate training and skills in airway management to allow rescue of the patient;

• age- and size-appropriate equipment for airway management and venous access;

• appropriate medications and reversal agents;

• sufficient numbers of staff to carry out the procedure and monitor the patient;

• appropriate physiologic monitoring during and after the procedure;

• a properly equipped and staffed recovery area;

• appropriate discharge instructions.

(To access the guidelines, readers can go to http://bit.ly/29kkgXj.) ■

Falls May Be a Strong Indicator of Baseline Health

In a study of 15,000 adults undergoing elective surgery, researchers at Washington University School of Medicine in St. Louis found that falling up to six months before an operation is common and often causes serious injuries across all age groups. The frequency of falls among middle-aged patients was slightly higher than among those who were age 65 or older.

The researchers also linked preoperative falls to a lower quality of life and the inability to carry out daily tasks, such as using the bathroom independently. This finding suggests a patient's history of falling may be a powerful pre-surgical tool in assessing overall health.

The study was published online in the August issue of *Anesthesiology*, the journal of the American Society of Anesthesiologists. To access the study, go to *http://bit.ly/2aiOLMl.* ■

CMS Corrects New Fire Safety Requirements

(We tweeted about this information July 1. To keep up with breaking news as it happens, follow us on Twitter @SameDaySurgery. For more information on the original standards, see "Final Rule Published on Fire Safety Requirements," July 2016 SDS Accreditation Update *supplement, at http://bit.ly/24wWtrv.)*

CMS has published a correction to its recently updated fire safety standards for hospitals, according to the American Hospital Association (AHA).

The May final rule adopted the National Fire Protection Association's 2012 *Life Safety Code*, with minor amendments, and most chapters of its 2012 *Health Care Facilities Code* for hospitals, ambulatory surgery centers, and certain other facilities that participate in the Medicare and Medicaid programs, the AHA said. The clarification states that hospital outpatient surgical departments must meet *Life Safety Code* provisions applicable to ambulatory healthcare occupancies, "regardless of the number of patients served." The standards for ambulatory healthcare occupancies normally apply to facilities providing services simultaneously to four or more patients. *(To access the correction, go to http://bit.ly/29gcXUo.)* ■

COMING IN FUTURE MONTHS

- Is your facility safe from ransomware?
- Is cost cutting jeopardizing your patients?
- HIPAA concerns in outpatient surgery
- Tips to make your teams work well together

SAME-DAY SURGERY

CE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to AHCMedia.com then select "My Account" to take a post-test. *First-time users must register on the site.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After completing the test, a credit letter will be emailed to you instantly.

5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE/CME QUESTIONS

1. **In research published in *JAMA Internal Medicine*, which common surgical procedures were tied to increased risk for chronic opioid use in the first year after surgery by opioid-naïve patients?**

   a. Laparoscopic cholecystectomy
   b. Total hip arthroplasty
   c. Total knee arthroplasty
   d. All of the above

2. **Which of the following measures did CMS propose to add to the quality reporting program for 2020 payment determinations?**

   a. About Facilities and Staff
   b. Overall Rating of Facility
   c. Recommendation of Facility
   d. All of the above

3. **According to Stephen W. Earnhart, MS, CEO of Earnhart & Associates, what steps can help prevent employees from leaving?**

   a. Acknowledge others' suggestions as their own.
   b. Post average industry salaries.
   c. Create new positions so employees can be promoted.
   d. All of the above

4. **The PinnacleHealth Surgery Optimization Clinic addresses which of the following medical conditions that can impact outcomes?**

   a. Uncontrolled diabetes
   b. High blood pressure
   c. Tobacco use
   d. All of the above

CE/CME 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.