SAME-DAY SURGERY

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INSIDE

RELIAS MEDIA

Surgeons and Investigators Find Ways to Spare Opioids

As the nation's opioid epidemic rages on, surgeons are among those leading the way toward finding opioid-sparing solutions.

Healthcare providers contributed to the epidemic, writing opioid prescriptions at a rate that increased by 3% each year between 2006 and 2010 before slowly decreasing. Since then, the rate has settled in at 58.5 prescriptions per 100 persons (as of 2017).[1]

The opioid epidemic was fueled, in part, by the healthcare industry's earlier evolution regarding pain management. Patients began to expect a pain-free experience after surgery. Doctors referred to pain assessment as the fifth vital sign, says **Kirk A. Campbell**, MD, assistant professor in the department of orthopedic surgery at NYU Langone Health.

"Patients and providers were more likely to mention pain, and patients expected zero pain from procedures," Campbell says. "However, you have to balance the risks and benefits of using very powerful medications in terms of narcotics. There's no denying the reports that more patients and family members are dying from these medications."

In a national database study of American adults who filed insurance claims after surgical procedures between 2008 and 2014, investigators found that 5,276 surgery opioid-naïve patients before surgery developed persistent opioid use up to six months after surgery. While surgeons had prescribed opioids to surgical patients for the first three months after surgery, primary care doctors continued writing the prescriptions.[2]

"In today's environment, with widespread appreciation of how common and dangerous prescription opioid abuse is, it is critical to avoid allowing the perioperative encounter to become a starting point for a patient's opioid dependence," says **David Liska**, MD, a colorectal surgeon at the Cleveland Clinic. Reducing opioid uses in perioperative care also benefits patients medically, he adds.

By 2016, nearly one in five adults and youths in the United States reported drug use or misuse, including misuse of prescription painkillers. In that same

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AUTHOR: Melinda Young
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson

year, there were more than 63,000 drug overdose deaths, two-thirds of which involved opioids.[1] Health systems, physicians, and surgery centers are starting to change their opioid-prescribing practices, acknowledging the dangers and drawbacks of overprescribing narcotics for pain.

"Even before the opioid epidemic started making national headlines, minimizing opioids in perioperative care was recognized to be an important factor in accelerating patients' recovery," Liska says. "Opioids have well-established short- and long-term side effects that can impede a person's recovery after surgery. These include oversedation and dizziness, which interfere with patients' ambulation and physical therapy."

Another important side effect that is especially notable in GI surgery is the opioid-induced development of postoperative ileus or constipation, Liska says. The problem with surgeons continuing to prescribe opioids as usual is that patients really do not use all the pills. The leftovers can be swiped by someone who is abusing the drug.

"In trying to curb the opioid epidemic, when patients came into our office, we asked how many prescribed medications they were using. We found the vast majority of patients were not using their prescribed medications," Campbell reports. Patients kept leftover pills in medicine cabinets, which can lead to someone else using the medication, he notes.

A current theme in opioid-sparing involves helping patients reset their expectations about pain. Patients might expect to receive enough opioids to last a month, but surgeons need to help patients understand that this is not in their best interest.

Various research presented at the American Academy of Orthopaedic Surgeons 2019 Annual Meeting, held March 12-16, 2019, in Las Vegas, revealed success with pain treatment that did not rely heavily on opioids. The authors of a study of 80 orthopedic surgery patients at NYU Langone found that when patients are prescribed 600 mg of ibuprofen along with a 10-pill rescue prescription of oxycodone, they consume significantly fewer opioids than if they only had a prescription of 30 tabs of oxycodone 5 mg, Campbell says. One week after surgery, patients who were given prescriptions for ibuprofen and opioids for breakthrough pain would only use two pills of Percocet on average. This contrasted with patients who received only the opioid prescription. Those patients used 4.5 tablets of Percocet on average, Campbell reports.

"We also found that 53% of patients who got just Percocet chose not to use the Percocet and used over-the-counter anti-inflammatories or Tylenol," Campbell says. "This one study has opened our eyes. We're definitely overprescribing." Researchers also found no significant difference in pain control and patient satisfaction between patients on the opioid-sparing protocol and patients who received only opioids.[3]

Surgeons have been hesitant to adopt opioid-sparing programs, and patients have been hesitant in complying with them. Thus, education is necessary on both sides of the scalpel, says **Roy I. Davidovitch**, MD, Julia Koch associate professor of orthopedic surgery at the NYU School of Medicine and director of the outpatient joint replacement program and The New York Hip Institute at OrthoManhattan.

"As orthopedic surgeons, we have a social responsibility to decrease the footprint of opiates in our daily clinical practice," Davidovitch says. "Obviously, only a small percentage

of our patients will become dependent on opiates overall, but the vast majority of heroin addicts started out with prescription opiates. It's definitely necessary for that cycle to be broken somewhere."

Surgeons should start the process of changing the opioid-prescribing paradigm.

"It's the kind of thing where you climb a mountain and think it's the only pathway to get to the top. Then, you look down, and people are figuring out other types of approaches to this," Davidovitch says.

Davidovitch and colleagues now send patients home with an opioid prescription that includes no refills. "We wanted to track how much opiates the patients were taking," Davidovitch says.

"If you send patients home with refills, you don't know how much of the drug they are taking." With the prescribing change, patients demonstrated improved movement and reported fewer adverse effects, Davidovitch adds.

A recent consensus statement published by the American Society for Enhanced Recovery and Perioperative Quality Initiative addresses opioid-sparing and opioid-free anesthesia. The statement's goal is to minimize opioid-related complications by providing risk stratification, optimal perioperative treatment approaches, and optimal discharge and continuity of care management practices for patients receiving opioids preoperatively. *(Editor's Note: Learn more about the consensus statement at: http://bit.ly/2IHpv7V.)*

"This was a consensus conference where European and American societies got together to write consensus statements on opioid use," says **David A. Edwards**, PhD, MD, assistant professor at Vanderbilt University Medical Center. The focus of the paper is a consensus that is based on the quality of research about opioid use for surgical patients.

"Not a lot of literature talks about the risks of patients who are already on opioids or who live with chronic pain," Edwards says. "We're in the middle of an opioid crisis, and we're taking all of these patients into surgery, and we have little to go on."

Some healthcare organizations are taking the lead on developing opioid-reducing programs. For example, the Cleveland Clinic's department of colorectal surgery offers an enhanced recovery pathway in which they routinely employ multiple tactics to minimize perioperative opioid use, Liska says. Also, patients in the preoperative holding area receive a multimodal cocktail of non-opioid pain medications aimed to pre-emptively treat the surgical pain, he adds.

"During surgery, our anesthesiologists continue using different non-opioid medications to minimize the need for opioids," Liska explains. "Our surgeons use minimally invasive surgery techniques, using small incisions, which have been shown to reduce postoperative pain."

Surgeons or anesthesiologists also administer a transversus abdominis plane block that anesthetizes the abdominal wall and reduces pain. Sometimes, an epidural is placed before surgery, which can be effective in reducing postoperative pain, Liska adds.

"Following surgery, we continue administering scheduled non-opioid medications, including acetaminophen, NSAIDs, and gabapentin. Opioids are only being used for breakthrough pain," he says. "At the time of discharge, many of our patients don't require any opioids to go home with and will continue using non-opioid medications to manage any residual pain." ■

EXECUTIVE SUMMARY

Surgeons nationwide are developing opioid-sparing methods to help surgical patients avoid narcotic misuse and abuse.

- The U.S. opioid epidemic has resulted in more than half a million deaths over the past two decades, and healthcare providers have contributed to the problem.
- A recent American Academy of Orthopaedic Surgeons meeting featured several studies that revealed success with reducing opioid prescriptions and preoperative use of opiates in surgical populations.
- Surgery centers need to prevent the perioperative encounter from becoming a starting point for patients' opioid dependence.

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Help Patients Set Reasonable Expectations Regarding Pain

Through the harsh lens of a drug misuse epidemic that touches American lives from coast to coast, healthcare providers have learned that there is no such thing as a pain-free drug approach without terrible risk.

Surgeons and other providers are returning to non-prescription and opioid-sparing treatment approaches to help patients cope with pain. One such tactic is to talk with patients, discussing their pain relief expectations and helping them adjust those expectations as necessary.

"Surgery is not going to be a pain-free thing," says **Kirk A. Campbell**, MD, assistant professor in the department of orthopedic surgery at NYU Langone Health. "You can be very comfortable, but you will not have zero pain. Pre-op counseling tells patients what to expect."

For instance, Campbell does not provide pain prescription refills; he explains how patients typically do not take all their pain pills and how long a patient might need help from medication. He also can refer patients to pain management professionals if they need additional help coping with pain.

If a surgery patient is taking a narcotic medication already, then the patient is directed to meet with the pain management team before surgery. The patient is encouraged to decrease their narcotic consumption, Campbell adds. Other surgeons follow a similar path.

"During the preoperative visit, we have a detailed conversation with patients to discuss with them our pain management plan," says **David Liska**, MD, a colorectal surgeon at the Cleveland Clinic. "It is important for patients to understand what to expect in terms of postsurgical pain and what we will do to help them through this." If patients need additional help, a psychologist can meet with them to discuss coping mechanisms, Liska adds.

Healthcare providers can explain to surgery patients that opioid use can cause unpleasant side effects and actually slow down their recovery, says **Roy I. Davidovitch**, MD, Julia Koch associate professor of orthopedic surgery at the NYU School of Medicine and director of the outpatient joint replacement program and The New York Hip Institute at OrthoManhattan.

"We tell patients, *'You can use opiate medication, but you need to understand you are buying certain side effects that are very uncomfortable,'"* Davidovitch says. "There is dizziness, nausea, vomiting, sleep disturbance, and the sensation of being out of sorts."

Opioid medication can prevent patients from getting out of bed and walking around as quickly as they might without the drugs. In observing patients after surgery, Davidovitch noticed patients often were not standing and moving or performing their physical therapy because of their opioid medication side effects of nausea, vomiting, and lightheadedness.

"Patients were walking around with IV poles and looked like zombies," he recalls. "I decided to take them off opioids and see how they do. I immediately noticed that patients were more alert and getting out of bed. They weren't asking for opiates as much as they were."

Davidovitch's change in how he viewed postsurgery pain management evolved as he watched his patients and noticed trends. "We need to be more mindful of medication side effects from opiates. This requires more investment on the education front," he says. "As these opioid-sparing protocols become routine, there will be a generation of patients who have gone through it, and it's something you won't have to explain as much."

After more than a decade of patients receiving large quantities of opioids to manage their pain, the new paradigm will take some time before it adopted universally. Davidovitch believes sparing opioids is better for patients. He says patients need to know how the new methods will help them feel better and improve faster after surgery. ■

EXECUTIVE SUMMARY

In the new era of sparing opioids to help stem the opioid epidemic, surgery providers are talking with patients about pain management.

- Help patients understand that pain treatment can make them feel more comfortable after surgery, but it will not eliminate pain entirely.
- Surgeons also might refer patients to pain management professionals and psychologists to help them cope with their anxiety and concern about pain.
- Discussions should center on the unpleasant side effects related to opioid use.

Total Joint Arthroplasty Study Spares Opioids Successfully

A new study shows that a standardized opioid-sparing protocol in total joint arthroplasty can result in a dramatic reduction in opioid use. The pilot study demonstrated that patients in the narcotic-sparing cohort consumed 75% fewer morphine milligram equivalents (MMEs) within the hospital setting.[1]

"We decided to do a trial of an opioid-sparing protocol with same-day discharge total hip replacements, which our facility currently does in the hospital," says **Roy I. Davidovitch**, MD, Julia Koch associate professor of orthopedic surgery at the NYU School of Medicine and director of the outpatient joint replacement program and The New York Hip Institute at OrthoManhattan. "We instituted a protocol based on starting pre-op medications the day before."

Patients take 1 gram of oral Tylenol every eight hours before an operation. Then, patients receive an anti-inflammatory. On the day of surgery, in the preoperative area, they receive another anti-inflammatory and undergo a spinal anesthetic that does not contain any opiates, Davidovitch explains.

"We would inject an opiate-free cocktail into the soft tissues during the procedure, which includes bupivacaine, and then we also injected long-lasting bupivacaine that would last two to three days," he says. "The cocktail also has Toradol."

Patients receive IV Tylenol. In the postoperative area, they do not receive opiates until their pain is at a level 6 or higher, he adds.

"We start with 15 mg of tramadol PO," Davidovitch says. "But the important piece is we educate the patient and nursing staff to assess their pain relative to their preoperative pain level."

For instance, if a patient reports in the preoperative time frame that the pain is an average of level 7 or 8, and the postoperative pain is in the range of 5 or 6, then the patient's pain has been reduced without introducing new opiates.

"We would ask the patient if it would make sense to try to avoid opiates postoperatively," Davidovitch says. "A lot of pain is anxiety about impending pain."

Also, patients sometimes feel that they should not experience any pain after surgery. "We want them at a tolerable level of pain or discomfort," Davidovitch notes.

When patients are discharged, they can go home with 81 mg aspirin taken twice a day for DVT prophylaxis as well as to help with pain. Patients also take Mobic once a day, and they receive Tylenol (up to 3 grams per day), Davidovitch adds.

"We tell patients to take Tylenol on a standing basis," Davidovitch says. "Whether or not their pain is high or low, they should keep on taking it."

The theory is that if patients maintain a high basal level of Tylenol in the bloodstream at all times, then it prevents fluctuations in pain, Davidovitch explains.

"If pain spikes above that level, then we send the patients home on 12 pills of tramadol, 50 mg, without any refills," Davidovitch says. "It's one of the weakest opioids and has no street value, which is why we use it."

With a nation focused on the opioid epidemic, the opioid-sparing protocol offers an alternative pathway to managing patients' pain after total knee arthroplasty and total hip arthroplasty.

In addition to decreasing narcotic use, the protocol helps maintain consistent clinical outcomes, length of stay, discharges, and Hospital Consumer Assessment of Healthcare Providers and Systems scores.[1] ■

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EXECUTIVE SUMMARY

Opioid use declined by 75% with a standardized opioid-sparing protocol employed in total joint arthroplasty patients, according to the authors of a new study.

- The opioid-sparing protocol included the use of oral Tylenol and Toradol.
- Patients were discharged with aspirin, Mobic, and Tylenol.
- Opioids were used sparingly for breakthrough pain.

International Consensus Reached on Opioid Use for Surgical Patients

New international consensus statements pave the way for opioid-sparing protocols in surgery patients. The American Society for Enhanced Recovery (ASER) and Perioperative Quality Initiative (POQI) calls for opioid-free intraoperative management in patients who have been exposed to opioids or who have other risk factors.[1]

There are three parts to the consensus on opioids and surgery, including one on perioperative management, a second on operative management of patients who have been taking opioids, and a third on management of opioids for patients who are opioid-naïve, says **David A. Edwards**, PhD, MD, assistant professor, Vanderbilt University Medical Center. The consensus statements cover presurgery, intrasurgery, and postsurgery.

"We did a systematic review of all the literature that discusses management and risks for patients around opioids and surgery," Edwards says. The paper's authors graded the quality of studies and examined descriptions of opioid risks to see if these were analyzed by subgroups in the research. "We graded all the evidence, and based on all of that evidence, we came up with the consensus guidelines," Edwards explains.

Before surgery, the consensus authors recommend that patients who are at high risk undergo a presurgical specialist consultation with an addiction psychologist, psychiatrist, or pain management provider. The goal is to set the patient's expectations and to identify their risk factors for opioid misuse, Edwards says. "One of the risks for people on opioids is uncontrolled anxiety," he notes. "If you don't manage those things and set expectations, then patients use opioids to manage anxiety and depression."

Investigators categorized the various risk factors for persistent postoperative opioid use, finding that preoperative opioid use and depression have the greatest level of evidence. Substance use, preoperative pain condition, and smoking also are risk factors with a high level of evidence. Some evidence also suggests that anxiety, sex, and psychotropic drug use pose a risk.[2] Knowing patients' risk factors is important because even opioid-naïve patients could end up with a long-term opioid problem, Edwards notes.

"A single exposure to opioids can prime some people to seek it further," he says. "They are in a high-risk group, and we might not know who they are, but maybe they have a genetic predilection for it."

The working group that examined persistent postoperative opioid use found that surgical patients who were preoperative opioid users were 10 times more likely to develop persistent postoperative opioid use than opioid-naïve patients following arthroplasty and abdominopelvic procedures.[2] Some are finding that patients who have been taking opioids before their first visit with a surgeon will fare better with postsurgery pain management and medication side effects if their opioid prescriptions are tapered before the procedure. Then, when these patients are prescribed new pain medications after surgery, they will not need such strong doeses of opioids as they would have without pre-op tapering.

"They are less likely to have side effects and complications," Edwards says. "There is less risk of respiratory arrest, and the lower the dose a person is discharged with, the less likely they are to be on opioids long term." The consensus paper addresses management of patients on opioids and how to discharge patients with fewer opioid pills. For instance, surgery centers could use multimodal treatments, keeping drugs at low doses, and employing nonmedication approaches, Edwards says. Expectation management is crucial. "Everyone is different and deals with the stress of surgery differently," he adds.

Surgeons can assess patients' catastrophizing scores. Those with high catastrophizing scores are likely to use opioids and experience worse outcomes relative to surgical pain. "You need to recognize those people and support them all the way through the process," Edwards says. "Maybe they can see a psychologist or receive enhancement service, holding their hands a little more and communicating with them."

For opioid-naïve patients, the optimal method is to help them manage their pain without use of opioids. "If someone is opioid-naïve, and you can keep them opioid naïve, that's a good thing as long as their pain is controlled," Edwards says. "A lot of major centers develop opioid-free pathways. In principle, this paper deals with that."

For intrasurgery, the consensus paper discusses blocks and spinal and regional anesthesia. There are multiple medical approaches and potent medications that would spare opioids, including ketorolac, an IV nonsteroidal anti-inflammatory drug that can be as effective at managing pain as 10 to 15 mg of IV opioids, Edwards offers.

The consensus guidelines provide pathways and suggestions for surgery centers and other healthcare groups

that want to begin opioid-sparing regimens that are based on the best available evidence. "Outside of academic centers and progressive centers, the major pain medication during surgery still is an opioid. The main opioid is fentanyl," Edwards says. "We all know that fentanyl is the number one abused drug in opioid overdoses right now." But if physicians can avoid using fentanyl, they should. Instead of fentanyl, they could use ketamine infusions, lidocaine, or other drugs, Edwards suggests. "Even major spine fusions can be done without opioids," he adds. ■

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Comparing IV vs. Oral Acetaminophen in Total Hip Surgery

The authors of a study examining a comprehensive opioid-sparing multimodal analgesia approach found that patients in both IV and oral acetaminophen groups scored low on pain scales, limited opioid usage, and reported minimal opioid side effects. There was no difference between groups.[1]

"We have a multimodal low opioid protocol that we've refined over many years for total hip replacement," says **Geoffrey Westrich**, MD, director of research for the adult reconstruction and joint replacement service at the Hospital for Special Surgery (HSS) in New York City. "That's our starting point, and that's critical because when we discuss findings, you can't decide that IV acetaminophen doesn't work. The patient satisfaction was 9.0 and 9.1 out of 10 in both groups of IV and oral acetaminophen."

The double-blinded, randomized, controlled trial included 154 hip replacement surgery patients who received either IV or oral acetaminophen as part of the standard multifaceted pain control protocol postsurgery. The patients who were given IV acetaminophen also received a placebo in pill form. The other group of patients received the opposite: acetaminophen pill and IV placebo.[1]

Researchers expected to find that IV acetaminophen would reduce pain with activity, opioid usage, and opioid-related side effects when compared with oral acetaminophen. "The oral acetaminophen worked as well as IV at our hospital with our multimodal pain management, low-opioid protocol," Westrich reports. "You can't tell other hospitals not to use the IV form because if they use other protocols, then IV forms might work better for them."

HSS still uses IV medication in knee and spine surgery. "Some patients are nauseous and can't take oral medication. We use IV in the first 24 hours because we think it works well," Westrich says.

"But based on our study, we wouldn't use it in routine total hip surgeries." The next step is to compare IV medication to oral medication in total knee replacement patients because they experience more pain postoperatively, Westrich says. "We think IV might be beneficial over oral for those patients," he adds. "But that is to be determined."

From an ambulatory surgery center (ASC) perspective, oral medication would work fine in many cases, Westrich says.

"If they are not following our protocol exactly, then they could benefit from using an IV form," he says. ■

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COMING IN FUTURE MONTHS

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Successful ASCs Track Key Performance Indicators

Daily, weekly, monthly, and annually, every ASC needs to track key performance indicators (KPIs).

"Is it happening daily, weekly, monthly in every surgery center? No, you get busy in the hustle and bustle," says **Jocelyn C. Gaddie**, vice president of business development for In2itive Business Solutions in Overland Park, KS. "If you want to be successful, you have to track these things. It's kind of like a disciplinary action. You won't see a lot of changes on a day-to-day basis, but if you track regularly, on a daily basis, then you will see things stand out and you can mitigate them quickly."

Tracking KPIs keeps surgery center staff accountable and motivated. If the indicators demonstrate success, then everyone wins, she says. Surgery centers could direct a business office manager or administrator to collect KPIs.

"The lifeblood of a company is cash," Gaddie notes. "If you are evaluating these KPIs on a daily, weekly, and monthly basis, you are going to have a successful surgery center. You will be ahead of the game with revenue coming in."

ASC administrators might think they do not have time to collect KPIs. However, if managed regularly, collecting KPIs can lead to success and make goal-setting simplified for staff.

"Key performance indicators make it clear what our expectations are and what we're working for," Gaddie says. "We all want to work and succeed, and measuring KPIs is a great way to do that."

There are several KPIs an ASC could collect, including the following:

• **Aged accounts receivable (AR) older than 60 days.** "You want to look at your aging AR on a monthly basis," Gaddie says. "You want the aged AR over 60 days to be less than 25% of your AR."

If there are too many old ARs, then the ASC can study the data to understand why. Problems might include sending claims in a timely manner, conducting quality follow-up, sending proper information to payers, denials from front-end processes, and entering incorrect demographic or insurance information.

"The longer your money sits out on your aging AR, the harder it is to collect," Gaddie warns.

ASCs could try different tactics to resolve problems. For instance, they could follow up a delayed payment with a paper claim to move the process more quickly.

"Maybe there's a new process that needs to be put in place so those claims are not denied and are paid quicker," Gaddie says.

• **Aged AR older than 120 days.** Fewer than 10% of AR should be older than 120 days. Surgery center leadership should be worried if that percentage is higher, according to Gaddie.

When looking at this indicator, identify any payer-specific issues, such as clearinghouse rejections. Some surgery centers will submit claims through a clearinghouse to reach payers. They code a case, enter charges, click a button, and that sends data to the clearinghouse to send to payers, who pay according to the contract, Gaddie explains.

"Clearinghouse problems could [include] a claim submitted incorrectly with the wrong payer attached or incorrect information submitted with the claim," she says. One possible reason for late payments is the paper process. Electronic payments arrive more quickly and are processed faster.

"If you can set those up electronically through your clearinghouse, you will see your payments that much faster," Gaddie adds.

• **Days in AR.** For this KPI, surgery centers will want to look at data showing how quickly they are paid. "The industry standard is below 30 days," Gaddie says. "Just how quickly can you get paid for the net revenue that you have billed out?"

Surgery centers also should track their net revenue that is billed out. "A clean claim equals a faster payment," Gaddie says.

ASCs should use those numbers to calculate how quickly their money is coming in and how many days they are in accounts receivable, she adds. "You can calculate that number by your average last three months net collections, divided by your ending AR, to calculate your days in accounts receivable."

There are variables to keep in mind. For example, government payers typically pay quickly, but workers' compensation payers pay slowly. A surgery center's KPI of days in AR partly depends on its payer mix.

• **Net collection percent.** The net collection percent should be 95% or higher, Gaddie says. "Basically, that's your net collection divided by your net revenue," she says. "Net revenue is your actual dollars."

This KPI should be observed over a 12-month period to determine an average, rather than looking only at one month, which could be an outlier. For example, there could be heavy orthopedic surgeries that month or a higher-dollar caseload

that month, Gaddie observes. If an ASC's net collection is below 95%, then the surgery center needs to capture revenue better. "Look at the insurance side and patient side. Are you educating those patients up front, letting them know what kind of service you provide and what the expectations are?" Gaddie says.

Patients need to be aware that payment is due at the time of service. "If you educate patients as to what is expected, then they're more likely to arrive for surgery, ready to pay, and you don't have to chase that money on the back end," Gaddie explains. "Make sure there are good, clear processes on the billing cycle to get those claims submitted clean."

• **Bad debt as a percent of net revenue.** Bad debt should be less than 1% of net revenue, Gaddie says.

"We don't want to write off any more than 1% of actual revenue each month," she adds. "These can include denied claims that missed timely filing."

Typically, insurance carriers will only allow a claim to be submitted within a set period, such as 90 days. If the claim is not submitted correctly, then they will not accept it and pay.

"You need to understand time restrictions with all payers so you don't have to write off an account," Gaddie says. "Another way to prevent this from happening is making sure you verify patient benefits prior to the time of service."

ASCs should make sure patients have benefits that are on file. A center should not perform a procedure and then find out it is not covered. This could lead the center to have to write off the entire procedure since staff did not collect the correct information prior to the service, Gaddie adds.

• **Clean claim rates.** "We want 98% clean claim rates," Gaddie says. The best way to make sure claims meet that KPI is by tracking and following claims monthly. Someone should track front office errors, demographics issues, whether authorizations are on file, incorrect patient identifiers, or expired eligibility, Gaddie explains.

Other items to track for this KPI include coding errors, lack of specificity, incorrect bundling of codes, non-utilized fees, incorrect codes, billing errors, untimely filing, missed appeals deadline, duplicate claims, and out-of-network claims.

"Trend those denials and report on those denials each month," Gaddie suggests. "Where are they coming from: the front office, coding, or the back office? Walk through the steps to figure out what the issue is so you can eliminate that problem."

• **Days to bill.** The industry standard is five days to send a claim. "We always want 24 to 48 hours of receiving reports," Gaddie says. "Common sense says the quicker the claim can go out the door, the quicker we can get paid," she says. "You want to code the claim within 24 hours of receiving the operation report, and you want charges entered that day, if possible, or at least the next day."

This is a KPI that should be tracked daily, measured weekly, and acted on monthly, Gaddie says.

• **Statement lag.** This KPI refers to how often a surgery center's statements are sent. "The industry standard is five days or less," Gaddie says.

"We feel confident that your statement should go out on a daily basis. Once the money is received and the payment is posted, then at the end of the day all the statements should be sent out on a daily basis. This is staggering the statements so you don't have a bunch going out at once and then get an influx of patients calling at one time."

Patients need to see their balances as quickly as possible so they can pay.

• **Staffing.** This could be 1.5 full-time equivalents per 1,000 cases, Gaddie says. "This can be controversial," she notes. "It's an industry standard, but at the same time you have to focus on your specific surgery center and what kind of cases you're handling."

Whether an ASC handles single specialty GI, orthopedic, or neuro cases can make a difference in staffing. "Staffing is a good KPI to look at, but you should know that it may vary depending on your surgery center," Gaddie says. ■

Research Suggests Physicians Should Screen for Osteoporosis Before Surgery

Investigators have found that nearly half of about 300 patients planning to undergo spinal fusion surgery for pain were newly diagnosed with osteoporosis or osteopenia.[1]

Metabolic bone disease affects around 200 million people across the world and has a high prevalence in the United States among adults 50 years of age and older. In their study, using criteria from the American College of Radiology, investigators found that 43.6% of spine fusion patients were diagnosed with osteopenia and 14.9% had osteoporosis.

The osteoporosis/osteopenia diagnoses occurred even in patients who had undergone dual-energy X-ray absorptiometry (DXA) bone density scans that did not reveal such findings. This suggests that the osteoporosis incidence is higher than previously known, according to **Alexander Hughes**, MD, orthopedic surgeon with the Hospital for Special Surgery in New York City. Hughes was the study's senior investigator.

"I was not surprised that the incidence of patients with metabolic bone deficiency is higher than the previously understood rates," Hughes says. "In men, we have not typically focused on diagnosing bone deficiency because insufficiency fractures impact females at a higher rate."

What physicians should keep in mind is that poor bone density and quality in men can lead to perioperative complications, the same as for women. "Therefore, it's important to understand this aspect of a patient's health before embarking upon spinal surgery," Hughes says.

The study results suggest that surgeons should routinely scan spine fusion patients older than age 50 years for osteoporosis. "We feel it is helpful to have bone densities performed on all patients undergoing spinal fusion surgery," Hughes says. "Quantitative computed tomography (QCT) is readily derived from standard pre-op CT scans. Therefore, in this context, it is not an additional procedure or study."

Surgeons need this information to reduce risk to spine fusion patients. "Osteoporosis or bone health deficiencies can be effectively managed and safely navigated if spine surgeons are aware of the underlying condition," Hughes says. "There are many perioperative medications available and new surgery technologies that improve outcomes in this setting."

When metabolic bone deficiency is unrecognized, it can lead to intraoperative or postoperative fractures, Hughes warns.

"Furthermore, healing of the bones can fail to take place after surgery," he adds.

The Hospital for Special Surgery uses QCT routinely and is solely replacing DXA scans as a more reliable measure of bone density. "We are moving toward using QCT on all preoperative patients undergoing spinal fusion surgery," Hughes says.

The study's findings are novel because the majority of prior orthopedic literature on osteoporosis prevalence is based on DXA data and femoral neck measurements rather than lumbar spine QCT.

"The takeaway is that through continued research into the underlying global health of patients, we are maximizing outcomes following spinal surgery," Hughes says. ■

REFERENCE

1. Carlson B, Salzmann SN, Shirahata T, et al. Prevalence of osteopenia and osteoporosis diagnosed by quantitative computed tomography in 296 consecutive lumbar fusion patients. Presented at the American Academy of Orthopaedic Surgeons Annual Meeting, March 12, 2019, Las Vegas.

The Annual Questions and Answers Column

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

First, I want to thank the readers for the many emails you sent regarding negotiation tactics that appeared in the May issue. It seems plenty of readers found those tips helpful — not just for your surgical department, but life in general. Thank you all for your kind words.

Every year, I like writing a column in which I answer reader questions. It is an opportunity to interact with many readers and to help with important issues. Here is a sample of some recent reader questions I have received:

Question: *"We have been approached by a group of cardiologists to perform some procedures for them at our ASC. We are meeting with them next week and wanted to know what we can do in our center with them."*

Answer: Cardiology is going to be the next big opportunity in non-hospital surgery centers. There are pacemaker implants, electronic leads, changing pacemakers, replacing batteries, replacing stents, and several other procedures you can perform in an ASC. Reimbursement is high — but then again, so are the costs of the devices. Do your homework on costs before jumping into it.

Question: *"Our surgery center's growth is hampered by the anesthesia group. We are a relatively new ASC with four "Class C" operating rooms. We are ready to work, but the group selected by the doctors will only let us open one or two rooms per day. They also make us cluster the cases together so they can be 'efficient' in the use of their staff. Apparently, they do not have enough staff to cover all the rooms. They told our surgeons that they could recruit new CRNAs, but the doctors would have to pay the group a stipend to cover that cost. I sure hope no one else has to deal with this because it is infuriating all of us."*

Answer: Surprisingly, you are not alone. This is a known issue, not only in ASCs but in hospitals, too. First, the Centers for Medicare & Medicaid Services (CMS) requires that you enter into a performance-based contract with an anesthesia provider. You may enter into as many of those contracts as you want. We once worked with a facility that partnered with 15 different anesthesia providers, sort of a nightmare in pairing the surgeon with the anesthesia personnel, but it worked for them. Unless you have an exclusive contract with your anesthesia group, bring in another group or individuals to cover the rooms your current group cannot. If you are locked in an exclusive agreement, let the group know they are not providing services based on your initial criteria for coverage. You cannot be held hostage to restricting the surgeons' investment and all the efforts that went into your facility because anesthesia cannot or will not expand their services. It is kind of like going to a restaurant with empty tables but the wait time to be seated is long because the restaurant does not want to hire more waiters.

> CARDIOLOGY IS GOING TO BE THE NEXT BIG OPPORTUNITY IN NON-HOSPITAL SURGERY CENTERS.

Question: *"What do you see as the best type of cases to handle in a surgery center?"*

Answer: By "best," I assume you mean the most profitable. You can make money on just about any procedures you perform in an ASC. It depends on the number of those cases and your ability to cost your overhead.

If I was running a surgery center today, I would focus on total joints (hips, knees, shoulders), cardiology via a hybrid surgery center with a cath lab and ASC, bundling everything, and spine. There is nothing wrong with other specialties, but you asked.

Question: *"What is the most inexpensive way to expand your facility?"*

Answer: Add a Saturday schedule and one or two evenings per week. It is absolutely the least expensive way to expand. ■

(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. Instagram: Earnhart.associates.)

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **What was the opioid prescription rate in 2017?**

   a. 56.3 prescriptions per 100 persons
   b. 43.2 prescriptions per 100 persons
   c. 58.5 prescriptions per 100 persons
   d. 69.7 prescriptions per 100 persons

2. **Which of the following are side effects of opioids?**

   a. Nausea, vomiting, lightheadedness
   b. Neuropathy
   c. Uneven gait, hyperactivity, hair loss
   d. Increase in urinary tract infections, paranoia, delusions

3. **If a surgery center has an aging accounts receivable (AR) older than 60 days at more than 25% of the AR, there are questions that should be asked to better understand the trend. Which of the following two questions should be asked?**

   a. Is the center performing too many complicated surgeries? Are more difficult cases funneled to the center?
   b. Are you experiencing issues with payers? Are you spending time to conduct quality follow-up on your count?
   c. Is your region typically slower than the expected range? Should the AR older than 60 days expectation be reset to greater than 35% of the AR?
   d. Are too many patients on self-pay? Have payers gone out of business?

4. **A spine fusion patient study, presented at the March 2019 annual meeting of the American Academy of Orthopaedic Surgeons, revealed that what percentage of patients were diagnosed with osteopenia and osteoporosis, using criteria from the American College of Radiology?**

   a. 25% had osteopenia, 4% had osteoporosis
   b. 51% had osteopenia, 24% had osteoporosis
   c. 43.6% had osteopenia, 14.9% had osteoporosis
   d. 35.6% had osteopenia, 11.4% had osteoporosis

SDS ACCREDITATION UPDATE

Covering Compliance with TJC, AAAHC, AAAASF, and Medicare Standards

OSHA/HIPAA Compliance Best Practices

Employees in the healthcare sector, particularly in nursing care, are involved in more accidents, contract more illnesses, and sustain more injuries than workers in any other industry, according to 2017 data from the Bureau of Labor Statistics. *(Editor's Note: See many more related statistics at: http://bit.ly/2ZD9plg.)*

The cost of making a mistake that imperils employees' safety, under rules created by the U.S. Occupational Safety and Health Administration (OSHA), has increased. Starting in January, healthcare organizations and other employers now pay more in fines when investigators find they are not protecting their employees' safety.[1]

"The increased fines pertain to everybody across the board," says **Kelly Ogle**, MS, CMPM, CHOP, director of OSHA and HIPAA services, DoctorsManagement LLC in Knoxville, TN. "We'll have larger fines based on what we didn't do or aren't doing right. They'll start with the maximum amount they can fine you and then determine how many people will be affected."

The increase was mandated in the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 as an inflationary rate adjustment, which occurs annually.[1] A violation can range from not emptying a sharps container and causing an accident to not giving staff required training or maintaining proper documentation of that training, Ogle says.

"When OSHA goes in and fines a facility, they write somebody up and give them the maximum amount of a fine," she explains. "If they're doing everything else good, and are making sure their compliance program is good, and training is what it's supposed to be, OSHA will look at that, and reduce the fine amount." To avoid hefty fines, make sure to take the following steps to stay in compliance with current regulations:

• Conduct employee safety check annually. "Determine the hazards in your office, like not having a sign with radiation symbols in the X-ray area," Ogle suggests. "Use a checklist to see what you need to fix." The annual assessment should address staff training, ensuring every employee is up to date.

OSHA provides a compliance assistance quick start guide that includes eight steps and OSHA requirements, available online at: http://bit.ly/2ICpkuG.

• Ask for an OSHA consultation. A surgery center's designated compliance officer or a compliance consultant can conduct an OSHA walk-through, looking for examples of noncompliance with federal workplace safety regulations.

"You make an appointment, and consultants come out and inspect and let you know what to do to fix any problems they find," Ogle says. "They can write up citations like those you would have gotten and explain to you how to fix them."

The walk-through might help uncover instances of workers not wearing personal protective equipment when it is needed or employees not washing their hands correctly. These types of findings might suggest the need for additional training, such as directing employees to watch a handwashing video, Ogle says.

Surgery center staff might think this level of compliance detail is trivial. But it is important to show regulators that the center held training and documented it, she adds.

HEALTHCARE ORGANIZATIONS AND OTHER EMPLOYERS NOW PAY MORE IN FINES WHEN INVESTIGATORS FIND THEY ARE NOT PROTECTING THEIR EMPLOYEES' SAFETY.

• **Think outside the compliance box.** Sometimes, healthcare organizations receive OSHA citations that blindside them. There are some daily activities that a site assumes is fine (but actually are not acceptable).

For instance, Ogle once worked with a physician-owned anesthesiology group in a children's hospital. The group's nurses were not hospital employees, but they had to walk through the hospital to see patients. If one of the anesthesiology group's employees was injured while walking in the hospital (outside of their employer's offices), then the injury would have to be reported to the hospital and to their employer, the physician-owned anesthesia group.

"If OSHA investigated the injury, then the doctor would get part of the fine because he's supposed to make certain the working environment is safe for them," Ogle explains. "The main person that would be responsible is the actual employer."

The entity that owns the setting where the injury occurred also shares some of the responsibility, she adds. "If an employee has to make a stop at the drugstore for items to stock carts, and then the person falls, it's partially the drugstore's fault," Ogle says. "But if the employee files a claim with the employer and the insurance company and complains to OSHA, then everyone gets involved in the investigation."

This means that surgery centers should be cautious about sending employees out on work-related errands. "If I'm an employer, and I want to make sure my employees are as safe as they can be, I may not send them out to run errands if I know they're bad drivers," Ogle says. "I might pick up the items myself."

It is also important for surgery centers to think like OSHA does: If a disgruntled employee complains about practices at the surgery center, then OSHA might investigate, Ogle adds. "OSHA can walk in tomorrow for no reason," she warns. "But, generally, they find out about violations because of a complaint."

When OSHA investigates a surgery center, the investigators will not look at just the area of the complaint. "They'll walk through every step, check documentation, look through the sharps container, and write their final information down on what's going wrong," Ogle explains.

"They'll dig through everything to make their visit worthwhile. And the fines are per violation. If you have overfilled a sharps container, that's one violation. If you are not disposing of them properly, that's two." ■

REFERENCE

1. *Federal Register*. Department of Labor Federal Civil Penalties Inflation Adjustment Act Annual Adjustments for 2019. Published Jan. 23, 2019. Available at: http://bit.ly/2IRDqHU. Accessed April 25, 2019.

The Joint Commission's Pain Assessment Standards Explained

The Joint Commission's new and revised pain assessment and management standards went into effect in 2019, covering all Joint Commission-accredited ambulatory care, including surgery centers and office-based surgery organizations. **Natalya Rosenberg**, PhD, RN, project director, standards and survey methods for The Joint Commission, answered *Same-Day Surgery*'s questions about the revised standards.

SDS: *The updated standards require organizations to maintain a leadership team that is responsible for pain management and opioid prescribing and developing and monitoring performance improvement activities. In an ambulatory surgery center (ASC), which leader(s) might be best suited to take on this role? What would be an example of how ASCs could monitor performance improvement activities?*

Rosenberg: Each organization will need to determine whether an individual leader will be assigned this responsibility or if a team model is used. The scope of organization services and patient populations served will help determine which model would be most appropriate and who will best fulfill this role (e.g., a nurse, a physician leader, etc.). The role of leader is to ensure there is an alignment in the organization's approach to safe pain management and oversee implementation of this approach. The ASC setting has evolved and serves an increasingly complex patient population. Evidence and guidance on postoperative pain management are emerging. Having a leader or several leaders is necessary to help organizations rise to these challenges.

Regarding performance improvement metrics, organizations should choose the ones that are more meaningful or practical for them. Generally, in existing guidelines, there is support for monitoring adherence to an organization's post-procedural pain management guidelines, monitoring duration of

opioid prescriptions at discharge, and ensuring that patient and family receive education on safe storage and disposal of opioids to prevent misuse and diversion. Some organizations track naloxone administration as a safety indicator to identify patients who may have been prescribed too high a dose of opioids or who may have comorbid conditions that were not recognized or addressed.

SDS: *How might surgery centers fulfill the requirement (LD.04.03.13, EP 3) to provide staff and physicians with educational resources on improving pain management and safe use of opioids?*

Rosenberg: Organizations have flexibility in determining the methods for education, as well as content and frequency. Topics for education should be guided by the identified needs of the patient populations. A relevant topic may be perioperative pain management for patients with complex needs (i.e., receiving long-term opioid therapy or presenting with a history of substance use disorder). Providers also may benefit from education on recommended nonpharmacologic, pharmacologic, multimodal pain management strategies.

SDS: *For small surgery centers, what type of consultation services would be feasible to provide staff for patients with complex pain management needs?*

Rosenberg: Consultation or referral to a specialist (e.g., pharmacists and pain management specialists) is advised when it is necessary to develop a perioperative pain management plan for the patient with a history of substance abuse or for the patient on long-term opioid therapy ... Making sure access to internal or external resources for consultation is available and utilized to support safe practice could be one of the priority areas that pain management leaders could focus on.

SDS: *How can surgery centers use the prescription drug monitoring program (PDMP) database to improve patient safety related to opioid prescriptions?*

Rosenberg: ASCs are not required to facilitate access to the PDMP databases, and The Joint Commission does not mandate PDMP use, but will survey to the local state law and regulations that govern PDMP use. PDMP is an important tool that allows a clinician to assess pre-existing controlled substance use. This information could impact post-discharge management or could indicate the need to educate the patient and family on proper disposal of opioids.

SDS: *Could you name resources surgery centers could use to find a tool or criteria that would help them screen, assess, and reassess patients' pain?*

Rosenberg: The Joint Commission has published an R3 report, which lists several publications with evidence-based tools that an organization can consider using. *(Editor's Note: This report is available to view online at: http://bit.ly/2W4JP6f.)*

In addition, the Ambulatory Surgery Center Association (ASCA) offers an Opioid Resource Center *(http://bit.ly/2XDWihM)*, [but] The Joint Commission does not endorse any of the materials on the ASCA website.

SDS: *To fulfill the pain treatment plan requirement, which members of staff and outside expertise might be employed to assess evidence-based practices, the patient's condition, and the patient's history to develop a pain treatment plan?*

Rosenberg: In the vast majority of cases, decisions should be up to the treating physician; additional staff and outside expertise are not required. However, in cases where patients have a history of addiction or for patients who want to avoid all narcotics, consultation with pharmacists or pain management specialists might be appropriate.

SDS: *The standards include a requirement to involve patients in pain management treatment. Why is this standard important?*

Rosenberg: It is important to include the patient as part of the development of a treatment plan so that realistic expectations of pain relief can be discussed and agreed upon. In addition, it provides an opportunity for the patient and the care team to have transparent discussions regarding available treatment options and realistic expectations of those treatments. ■

Surgery Center Wins AAAHC Award for Pain Management Quality Improvement Project

An ASC's laparoscopic cholecystectomy patients were prone to pain and nausea after surgery. There had to be a solution that would achieve both effective pain management and less nausea. A quality improvement team gathered to find that solution.

The resulting pain management intervention won a 2018-2019 Innovations in Quality Improvement Award from the Accreditation Association for Ambulatory Health Care (AAAHC) Institute for Quality Improvement in April.

"It seemed the more medication we gave patients for pain, the more the treatment increased their nausea, and they got sick and hurt worse," says **Lisa Leathers**, BSN, RN, administrator and director of nursing at CSA Surgical Center in Columbia, MO.

The quality improvement committee focused on what the scientific literature showed might benefit gallbladder surgery patients. The answer appeared to be IV Tylenol administered preoperatively. But that solution came with logistical problems.

"The problem with IV Tylenol is that it's very expensive," Leathers explains. "In a surgery center, when you're trying to provide patients with a product they can afford to purchase, it's cost-prohibitive." An even bigger obstacle was that IV Tylenol was on backorder and difficult to obtain consistently. "IV Tylenol was not a reliable product available for routine purchase," Leathers laments. "The last thing we wanted to do was to implement something that was available only part of the time."

One of the quality committee's surgeons came up with a solution: Just use oral Tylenol. After obtaining buy-in from anesthesia providers, the surgery center began to administer Tylenol one hour before surgery to patients, except those with liver toxicity or other problems prohibiting the use of Tylenol, Leathers explains.

"We talked about the need to make sure patients received Tylenol within a reasonable interval, meaning not eight hours before surgery or five minutes before surgery," Leathers says. "Patients should be given Tylenol roughly one hour before surgery."

The intervention has worked. Prior to implementing the Tylenol quality project, about 42% of patients had a length of stay (LOS) related to pain that was longer than two hours. When measured after implementation, patients with a pain-related LOS longer than two hours dropped to 7%. Later, the quality committee re-measured the results to make sure the intervention was still working. They found that no patients on the Tylenol regimen stayed longer than two hours.

Another positive outcome was that narcotic usage sharply declined with the intervention. In the six months before implementing the Tylenol intervention, only 7.6% of postanesthetic care unit (PACU) patients required zero narcotic pain medication. In the six months after implementing the intervention, nearly 22% of PACU patients required zero narcotic pain medication.

Nurses at the surgery center were excited with the intervention within weeks of making the change. "They said, 'We can't stop doing this.' They no longer had to manage patients coming out of surgery in pain and nausea," Leathers says.

Gallbladder patients' reported pain scores improved so significantly that the surgery center decided to use the pre-op Tylenol intervention on all general surgery patients that typically experience pain during recovery. They receive two 500 mg tabs of Tylenol one hour before surgery, Leathers says.

AAAHC's accreditation process involves directing surgery centers to undergo improvement projects, measure their quality, and evaluate it through completing 10-step quality studies, Leathers says.

(Editor's Note: For more data and information about the CSA Surgical Center project, please visit this resource: http://bit.ly/2IUvKVr.) ■