January 31, 2013

Oregon State Legislature Senate Bill 163 (Improving access for patients in pre-medicine)

As an orthopedic surgeon in Salem, Oregon, for 37 years I have been instrumental in putting together a Center for Excellence which has gained national recognition in the care of hip and knee replacement surgery. You can get information regarding that from Salem Hospital. Certainly there are rated agencies that can confirm the fact that we are functioning in the 95th to 98th percentile of all hospitals in the care of hip and knee replacement surgery based on the multiple factors of care, the admission, the complications, etc.

We have systematized the care so that there is preoperative medicines, a program that we are following out the Mayo Clinic, and also a protocol of medicines that are changed from day to day based on the patient's pain rating scale. At the time of discharge the same systematized medication approach is used. With that the amount of narcotics along with the intensity of narcotics, has been tailored to the patient's need using initially an injectable anti-inflammatory in the postoperative period followed by an oral anti-inflammatory. This roughly halves the amount of narcotic required, and intravenous narcotics are rarely used.

In the office we are encouraged by Medicare policies to write these prescriptions for postoperative care and keep records of that in our office. Typically we will write for the blood thinning medications which is given in our protocol along with the anti-inflammatories, and about half of the narcotics postoperatively are used.

Patients preoperatively receive an oral anti-inflammatory along with Tylenol, a narcotic, and a neuroleptic. These are done always under a spinal anesthetic.

This approach is validated by other centers in the United States and the example of this systemized approach is the Mayo Clinic in Minnesota.

With that background we have a constant problem of getting medicines authorized. It is in the best interest of the patient that the minimum amount of narcotics are used, that anti-inflammatories be used appropriately, and a decreasing amount in the total amount of both products are minimal.

The problem is that insurance entities have protocols treating this preoperative and postoperative pain medicine anti-inflammatory approach as an ordinary prescription, it is not.

It is our very strong opinion that being credentialed and re-credentialed at our hospital, being Board certified and recertified, being a member in good standing of the Oregon Medical Board, along with credentialing from the insurance companies **must mean something.**

Rather than having an obstructive approach from the insurance entities creating unnecessary phone calls and increased overhead demands administratively in our office, a sophisticated systematic approach like this needs to be applauded and supported administratively. We strongly support Senate Bill 163.

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