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January 2014: Vol. 38, No. 1
Pages 1-12

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Your patients are taking supplements, but will they stop before surgery?

Clinicians concerned about bleeding and other complications

By **Joy Daughtery Dickinson**, Executive Editor

Herbal supplements are falling under increased scrutiny. In the fall, The Children's Hospital of Philadelphia (CHOP) became the first hospital in the United States to enact a policy to discourage patients from using dietary supplements without a doctor's provision.

CHOP announced that it no longer will include most dietary supplements on its formulary. The hospital explained that the Food and Drug Administration (FDA) does not routinely review the manufacturing of dietary supplements, and therefore cannot guarantee their safety and effectiveness. Potential risks include contamination, mislabeling, interactions with medications, or potential unforeseen adverse effects, CHOP said in a released statement.[1] The policy does acknowledge that certain medical conditions might require vitamin or nutrient supplements, and a very limited number of acceptable products are listed, said **Sarah Erush**, PharmD, BCPS, pharmacy clinical manager and a member of the hospital's Therapeutic Standards Committee.

Such a strong stand against supplements has caught the attention of outpatient surgery managers, particularly since so many surgery patients take supplements. In fact, a recent study reported that about half of patients having facial cosmetic surgery are taking herbal and other supplements.[2]

The researchers analyzed 200 patients undergoing cosmetic facial surgery, and 49% were using at least one type of supplement. The average number of supplements was 2.8 per patient, although one patient was taking 28 supplements. In the general surgery patient population, are half of patients taking supplements? **Alan Matarasso**, MD, attending surgeon at Manhattan Eye, Ear, and Throat Institute/Lenox Hill Hospital/Long Island Jewish Medical Center in New York City, said the percentage at his practice is at least that high. "It's a $30 billion industry," Matarasso said.

In the study mentioned above, 35 patients were taking supplements that have

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been linked to an increased risk of bleeding, such as bilberry, bromelain, fish oil, flaxseed oil, garlic, methylsulfonylmethane (MSM), selenium, and vitamin E.

"In their report, I was surprised to learn that bromelain, a supplement that I have used in my practice, increased the risk of bleeding, just as I was by their previous report that Arnica montana caused hypertension," Matarasso wrote in a discussion of the study.[3] Those two supplements are the most commonly recommended herbals, he said.

"The most common adverse event from many supplements is excessive bleeding and hematoma formation," Matarasso wrote. "I adhere to the concept that a second operation, for example evacuating a hematoma, can take longer and have a more adverse impact than the initial operation."

Dry eyes also can be a side effect of supplements, which can be a particular concern for patients having eyelid surgery, says **Bahman Guyuron**, MD, chairman of the Department of Plastic Surgery at University Hospital and Case Medical Center, Cleveland, OH. Guyuron was a co-author of the study mentioned previously.

Concerns with herbal supplements and general surgery include the fact that they can raise blood pressure and can prolong the effects of anesthesia, according to the American Society of Anesthesiologists (ASA).

John Dombrowski, MD, chair of the ASA Communications Committee and director of the Washington (DC) Pain Center said of supplements, "How your body reacts to that medication can affect that anesthetic."

Take these steps to avoid problems

Patients often think of supplements as safe and natural products, so they often don't think to list these products when their physicians ask what medications or drugs they're taking.

"A lot of people don't recognize that what they buy in a health food store and another store is a medication, even though taking that, they want a medical benefit," Matarasso says. "We specifically advise about health food stores."

He asks patients about their use of prescriptions, over-the-counter medications, and dietary supplements. "We want to know anything they put in their mouth that they consider helpful to their health," he says.

Guyuron uses a questionnaire that asks patients what they are taking, including pharmaceutical products and herbal medications. *(See an ASA questionnaire listed in the resources at the end of this story.)* He specifically asks, "What herbal supplements do you consume?"

"Otherwise, it's not on their radar," he says. They don't consider the herbal product to be a medication, so unless you ask for that information specifically, they won't volunteer that they take some herbal products, Guyuron says.

Dombrowski asks the question in an even more general manner. "I always ask my patients, cosmetic surgery or just outpatient surgery, what pills do you take? Pills. Then I also remind them: This is what I mean: vitamin, supplement, and any medication you

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry Road, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Same-Day Surgery®, P.O. Box 550669, Atlanta, GA 30355.

AHC Media, LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

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get from your doctor."

Guyuron advises that you ensure the patient is questioned multiple times: by the physician, nurse during initial consultation, and at the preop visit. Patients also can be reminded at the preoperative call, Dombrowski says.

Explain to patients why

Patients today are much more likely to question healthcare providers about their instructions, so be prepared to address their questions about why they need to stop taking supplements.

"If you tell them, `you have to stop herbal medications,' they might think you don't want them to take them because you're a doctor," Guyuron says. He discusses specific conditions, consequences, or risks, rather than leading the patient to the assumption that he dislikes herbal medications. *(See list of risks, right.)*

CHOP created an education sheet that can be used to discuss prior medication/supplement use with patients and their families. (The forms that CHOP uses are included in the online issue of Same-Day Surgery. Go to www.ahcmedia.com and select "Access your newsletters." For assistance, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.)

Matarasso tells patients that calcium or vitamin D are fine, but fish oils and supplements that begin with "G" (garlic, ginko, etc.) are not OK. "They finally understand: Supplements can be in the same category as taking an aspirin, which is not advised," he says. He provides patients with a three-page list of medications and tells them to stop taking them two weeks before surgery. (See list with the online issue of Same-Day Surgery.) He tells patients if there is any question about whether to take their supplement, don't take it. He says they should consult the list or call him. Matarasso tells them: "Unless you can tell me these things are essential, don't take them." Patients normally are allowed to keep taking medication for hypertension and thyroid disease.

By taking these steps to stop supplement use before surgery, the patient is less likely to develop problems with bleeding, which is the number one complication from surgery, or other complications. "Controlling every step of the operation and the perioperative period is essential to achieving a safe and satisfying outcome," Matarasso wrote.[3]

Supplements and Surgical Impact

Supplements that are known or suspected to increase bleeding risk include:

- Gingko biloba
- Garlic
- Ginseng
- Fish oil
- Dong quai
- Feverfew

Supplements associated with cardiovascular risk include:

- Ephedra
- Garlic

Supplements with sedating effects that may prolong the effects of anesthesia include:

- Kava
- St. John's wort
- Valerian root

Source: WebMD.com. ■

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$276 million case holds many lessons

Physician arrangement leads to violations

In what is thought to be the largest judgment of its kind against a community hospital in U.S. history, a federal district judge in South Carolina has ordered Tuomey Healthcare System (THS) to pay $238 million for violations of the Stark Law and False Claims Act (FCA). Legal analysts say Tuomey's missteps before and after the fraud accusations hold many lessons for managers.

The Tuomey saga began eight years ago in 2005 when **Michael Drakeford**, MD, filed a *qui tam* lawsuit

against Tuomey alleging that the Sumter, SC-based hospital system violated the Stark Law and the FCA by entering into prohibited contractual relationships with 19 physicians that required the physicians to perform all their outpatient surgeries at Tuomey's outpatient surgery center.

In the arrangement that later led to so much trouble, Tuomey agreed to pay each physician an annual base salary that fluctuated dependent on Tuomey's net cash collections for the outpatient procedures, plus a "productivity bonus" equal to 80% of the net collections. Physicians also could earn incentive bonuses of up to 7% of the productivity bonus. Physicians agreed not to compete with Tuomey during the 10-year term of the contract and for two years after.

The federal government attorneys joined the case after Drakeford made his allegations and said that because Tuomey performed the billing for the services provided at its outpatient center, the claims THS submitted to Medicare and Medicaid were the result of prohibited contractual relationships and thus were false claims. Prosecutors also accused Tuomey of making false statements in its certificates of cost reports.

Tuomey might not end up paying the entire $238 million, notes **Thomas E. Bartrum**, JD, a shareholder with Baker Donelson in Nashville, TN. The system has tried to settle the case earlier but would not accept the government's offer, he says, and it now might end up settling for even more because the verdict came in so high. Years of legal fees must make the total burden on Tuomey enormous, Bartrum says.

"If I were on the board of directors at this system, I would have asked for the resignation of this counsel and started the process for settling the matter much earlier," he says. "At this point their top priority must be putting this behind them and stopping the bleeding."

Managers should study the Tuomey case to see where the mistakes were made, suggests **Alan H. Rumph**, JD, an attorney with the law firm of Baker Donelson in Atlanta. The lucrative physician arrangement apparently misled Tuomey leaders who should have put the brakes on the deal, he says.

"When a hospital is considering relationships with physicians, the number one priority should be compliance," Rumph says. "I know the economics are important and hospitals have to have relationships with physicians in order to survive, but compliance should be the first objective and everything else should flow from that."

The purpose of a physician arrangement should be providing better quality care to more patients, Rumph says. It is dangerous for the hospital or health system to openly discuss the potential financial benefits to the hospital, he cautions.

Bartrum concedes that hospitals will make that calculation, at least to ensure that the arrangement is economically feasible. "But what is really damning is when that calculation drives the whole transaction," he says. "If you say you can't let the doctors leave because you will lose $18 million a year, and that's the motivation for the arrangement, that gives the government a lot of ammunition to say that your compensation arrangements were driven by volume and value of referrals rather than a fair market value arrangement."

Fair market valuation turned out to be a key issue in the Tuomey case, and Bartrum says the case will lead to much closer scrutiny of valuation in similar arrangements.

"Hospital leaders try to be compliant, I really believe that. But they often don't fully understand what they can and can't do in terms of Stark and the False Claims Act," Bartrum says. "A lot of times risk managers and lawyers are not brought to the table until all this background has been done. The incriminating e-mails are already circulating before we ever get involved in it."

Bartrum also cites what he calls "opinion shopping" by Tuomey when consulting with attorneys about the physician arrangement. Tuomey had attorneys warn them that the plan could be problematic, but they dismissed those opinions in favor others that said it was acceptable, Bartrum explains.

Rumph suggests that the Tuomey case might prompt similar allegations against hospitals and health systems. "With all this publicity and the financial windfall for this whistleblower physician, you're going to see more whistleblowers," Rumph says. "They're in a position to produce more of the facts than anyone else, after you've pitched the deal to them, and particularly if they are jealous that their competitors got in on the deal they didn't."

In addition to the lessons about how to avoid a Tuomey-like arrangement with physicians, the experience of the healthcare system also shows how not to handle such allegations once they hit the court sys-

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The multi-million dollar award against the Tuomey Healthcare system holds important lessons regarding a hospital's business relationship with physicians performing outpatient surgery. The case involved allegations of improper referrals and payment to physicians.

- Unlike many fraud cases, overbilling was not alleged by prosecutors.
- A jury determined that 21,000 Medicare claims were "tainted."
- The government sought and received more than the actual damages.

tem, says **David M. Walsh** IV, JD, a shareholder with the law firm of Chamblee Ryan in Dallas. Tuomey's troubles, and the magnitude of the judgment against it, could have been prevented by taking a more critical approaching to assessing the legality of the physician arrangement, he says.

"The evidence established that Tuomey ignored legal advice that it received that did not support the arrangement and instead chose to listen just to the legal advice that supported the arrangement," Walsh says. "In this example, the contrarians were obviously right, and following that advice would have avoided Tuomey's problems." ■

ECRI releases top 10 list of technology hazards

Reprocessing, retained items, robotic surgery listed

Several areas of outpatient surgery practices were included in this year's Top 10 Health Technology Hazards from Plymouth Meeting, PA-based ECRI Institute. ECRI Institute is an independent nonprofit that researches approaches to improving patient care. New topics on this year's list include hazards related to radiation exposure in hybrid operating rooms and complications arising from insufficient training in the application of robotic surgery.

This year's top 10 list include:

6. Inadequate reprocessing of endoscopes and surgical instruments.

Reprocessing staff may be pressured to take shortcuts, warns **Chris Lavanchy**, engineering director, Health Devices Group at ECRI. "Facilities may not have enough instruments for demand, which puts even more pressure on processing folks to turn around and make sure everything is in shape for the next patient," Lavanchy says.

Communication also is a key factor, he says. "What we've seen, at accident investigations in hospitals or other facilities, that when there is good communication between reprocessing and surgical staff, it is less likely that problems can exist for long period of time and not be discovered," Lavanchy says. "When a good partnership exists between the surgical and reprocessing staff, and there's a more seamless operation, it is less likely that instruments not being properly reprocessed is going to be a problem."

No instrument should ever be reused without proper cleaning, says **Steve Trosty**, JD, MHA, CPHRM, ARM, president of Risk Management Consulting Corp. in Haslett, MI. "This should be in the policy and procedure manual, included in training for all staff involved in surgery or procedures, and be part of what all physicians are told is required for all surgeries and procedures," Trosty says.

Single-use instruments should be used only the one time, he says. "This should be contained in appropriate policies and procedures, included in training for staff, and clearly told to all physicians," Trosty says. "Reusing single-use instruments can increase liability to the clinic and negate any warranty that comes with the instruments, since they would not be used as intended and not in conformity with instructions for their use that would have been provided by the manufacturer."

Also, items that can be reprocessed should be sent to a reprocessor approved by the Food and Drug Administration that is insured, says Mark Mayo, executive director of the ASC Association of Illinois and principal in Mark Mayo Health Care Consultants in Round Lake, IL.

9. Robotic surgery complications due to insufficient training.

There are major concerns due to an increase in the number of adverse events from robotic surgery reported to the Manufacturer and User Facility Device Experience Database (MAUDE), says **Christopher Schabowsky**, PhD, senior project officer, Health devices Group, ECRI. However, the Food and Drug Administration (FDA) doesn't validate the accuracy of those reports, Schawbowsky says.

"Although there are increases in voluntary reports, it's harder to determine if root cause is the robotic system, surgical team training issues, or hospitals that have more robust adverse event and near miss reporting," he says. Another variable is the increase in the number of robotic procedures performed worldwide, Schabowsky says.

There should be an established strict credentialing and privileging program for surgical staff who use the

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Regarding ECRI Institute's list of Top 10 Health Technology Hazards, the following is advised:

- Focus on good communication between surgeons and reprocessing staff, as well as policies and procedures. Use single-use instruments once.
- Have an established strict credentialing and privileging program for robotic surgery. Have annual skill audits. Create a surgical robotic safety committee. Establish a centralized incident reporting and investigating system.
- Scan patients before closing for retained devices. Examine instruments before and after the procedure. Take an X-ray if there is serious concern regarding a potential item left inside.

robotic systems, he says. For example, the program should include observing robotic surgery cases, participating in dry surgery runs, and undergoing a competency exam by a skilled proctor. Also have annual skill audits, he says.

Create a multidisciplinary, leadership level, surgical robotic safety committee, Schabowsky advises. Include senior clinical and technical staff from each service line and risk management staff, he says. "This committee should be tasked with developing and reviewing and updating robotic surgery safety policy and procedures," he says.

Establish a centralized incident reporting and investigating system for robotic surgery, Schabowsky says. "This system should encourage reporting of near misses and incidents to assess the root causes of these problems and educate staff about these issues," he says.

10. Retained devices and unretrieved fragments.

Scan patients using radiofrequency detection systems before closing to ensure you removed all sponges, says Lavanchy.

To avoid unretrieved fragments, surgeons should examine instruments briefly before using them, he says. At the end of the surgery, a staff person should examine them again to ensure there is no obvious component missing, Lavanchy says. Take an X-ray if there is any serious concern regarding a potential item left inside the patient, Trosty adds.

The other items in the top 10 list include:

1. Alarm hazards.
2. Infusion pump medication errors.
3. CT radiation exposure in pediatric patients.
4. Data integrity failures in EHRs and other health IT systems.
5. Occupational radiation hazards in hybrid ORs.
7. Neglecting change management for networked devices and systems.
8. Risks to pediatric patients from "adult" technologies.

Clinical alarm hazards remain at the top of the list due to their prevalence, their potential to result in serious patient harm, and the increased attention they will receive from The Joint Commission this year. In an April 2013 *Sentinel Event Alert,* The Joint Commission cited 98 alarm-related events over three and one-half years, with 80 of those events resulting in death and 13 resulting in permanent loss of function. *(For more information, see "Teen's death, $6 million settlement put the spotlight on alarm fatigue – The Joint Commission issues `Sentinel Event Alert,' considers NPSG," Same-Day Surgery, June 2013, p. 61.)*

The executive brief version of ECRI Institute's annual Top 10 list of health technology hazards is free at www.ecri.org/2014hazards. ■

Healthcare facilities rely on credentialing companies

Outside firms ensures sales reps are ready for OR

(Editor's note: This is the second part of a two-part series on sales reps in the OR. This month, we discuss how to use an outside company to credential sales reps and how to inform patients that reps will be in the OR. Last month we gave you an overview of how outpatient surgery providers are addressing the issue.)

Most hospital systems are using an outside credentialing company to verify that the vendor is safe to allow on-site and in certain situations, such as surgery, says **Dan Flynn**, a surgical instrument sales representative with K&D Medical in Columbus, OH. The hospitals are turning to these outside companies to do all the verification, which frees them of that administrative burden but still gives them assurance that the vendor has been properly vetted.

To be credentialed by these companies, the salespeople and other vendors often are required to complete courses in specific areas of study, such as infection control. Two of the most prominent companies offering vendor credentialing are IntelliCentrics in Flower Mound, TX, which provides the Reptrax vendor credentialing service, and Vendormate in Atlanta.

Relying on those companies can be a practical solution, Hoffman says, because the third party might do a more thorough job of checking the person's background and training him or her than the healthcare facility would. However, she points out that handing the responsibility over to a third party works only if you know that party's stamp of approval is meaningful. To find out, delve into exactly what the company requires and how it trains people.

"When they say training, do they mean a five-minute video or something more substantive?" Hoffman says. "You have to know exactly what it means when they say someone is credentialed."

Companies offer free services

Reptrax and Vendormate services are provided to facilities at no cost, with the salesperson or the employer paying for the credentialing, explain **Greg Goyne**, vice president of marketing at IntelliCentrics,

and **Gary Johnson**, chief marketing officer at Vendormate. About 5,000 facilities in the United States use the Reptrax system, with about 400,000 vendors credentialed. Vendormate has about 1,900 facilities using its system and 63,000 companies credentialed. The services can credential individuals and companies.

"The hospital has a way of verifying credentials that is more complete and more efficient than trying to collect paperwork from each visitor," Goyne says. "If The Joint Commission audits you, the credentials are available right away."

The credentialing companies can help a facility achieve the level of scrutiny that most managers say they want of vendors, but which can be too much work for the staff, Johnson says. "We see our job as making that process work as easily and effectively as we can for both parties, the healthcare provider and the vendor," Johnson says.

From a salesperson's perspective, the vendor credentialing can be a valuable service, Flynn says. He cautions managers, however, not to depend entirely on the word of an outside company when vetting a salesperson or other vendor.

"The credentialing they offer is trustworthy, but remember that they're also in the business of making money by requiring coursework and giving us the blessing that we need to get in the hospital and do our jobs," Flynn says. "The documentation shows that you took the courses, but it doesn't necessarily show that you understand what goes on in the OR and how to conduct yourself. That comes from experience."

What the services offer

Facilities that designate Reptrax as their credentialing service can determine what qualifications they require for salespeople or other vendors, and then the service will take responsibility for verifying that those standards are met, Goyne says.

Reptrax and Vendormate keep on file all the records showing the person's credentials. Those records might include training courses completed, immunizations, criminal background checks, and whether the person is on any healthcare-related watch lists for exclusion related to fraud. Both companies check for updates to the exclusion lists every month.

Once the vendor is credentialed by one of the companies, that information is available to all facilities that use that company for verification. The vendor only has to provide the credentials once rather than doing it for each facility visited. Information is updated in real time, but it is posted in the system only after an employee of the verification company has seen the document and confirmed it is legitimate.

When a facility decides to use one of the companies, it makes credentialing by that company a requirement for access to the facility. Both companies provide kiosks in the facility where salespeople and other vendors can check in and print a document showing they are approved by the credentialing company. The kiosks can print identification badges denoting what area of the facility the person is allowed to visit. "If the person tries to check in, and the credentials do not meet the requirements of this hospital, access will be denied and an alert will be sent to an administrator," Goyne says.

The healthcare facility can drive the credentialing process, Johnson says. By declaring that all vendors must be credentialed and have a badge for each visit, the vendors will respond by seeking the proper credentialing from the company specified, he says. The key, however, is that the staff must enforce the facility's own policies regarding vendors on site.

"If the OR staff says this is a salesperson who's been here every Tuesday for five years and we know him, so it's OK if he doesn't have a badge, everything falls apart. That can be the weak point," Johnson says. "You need to push for 100% compliance for any non-employee walking your hallways." *(For information on how to inform patients, see story, below.)*

SOURCES

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Inform patients: Sales rep might be in the OR

In addition to concerns over patient safety when salespeople are allowed in the OR, managers should consider requiring that patients be notified of the person's presence, says **Sharona Hoffman**, JD, professor of law and bioethics, Edgar A. Hahn professor of jurisprudence, and co-director of the Law-Medicine Center at Case Western Reserve University School of Law in Cleveland, OH.

"I think most patients would be pretty surprised to learn that there were people in the OR who were not doctors or nurses," she says. "It would be prudent to include that in the informed consent documents, and that would have to include giving the

patient the opportunity to say no, to opt out of having outsiders in the OR during the procedure."

Informing the patient is not required by law, and some would argue that it's not even necessary in terms of ethical concerns. However, Hoffman says facilities take a significant risk by allowing vendors in the OR without telling the patient. If the salesperson somehow contributed to an adverse event — by compromising a sterile field, for example, or distracting the surgeon — the facility could be accused of negligence for allowing that person in the room. That liability is especially the case if the facility could not prove that it adequately vetted the vendor.

Also, a plaintiff's attorney could make much of the revelation that a salesperson was present even if the vendor had nothing to do with the adverse outcome or even if the procedure went well, Hoffman says.

"Patients could just be upset that there are people there who are not directly involved in their medical care," she says. "This is the kind of issue that can lead to lot of ill will, bad publicity, once the patient makes his or her dissatisfaction public. The patient may have no damages and no real lawsuit to pursue, but you could still suffer bad press from allegations that you did not respect the patient's privacy." ■

First virtual surgery with VIPAAR, Google Glass

A University of Alabama at Birmingham (UAB) surgical team has performed the first surgery using a virtual augmented reality technology called VIPAAR with Google Glass, a wearable computer with an optical head-mounted display. The combination of the two technologies could be an important step toward the development of useful, practical telemedicine.

VIPAAR, which stands for Virtual Interactive Presence in Augmented Reality, is a UAB-developed technology that provides real time, two-way interactive video conferencing.

UAB orthopedic surgeon **Brent Ponce**, MD, performed a shoulder replacement surgery on Sept. 12, 2013, at UAB Highlands Hospital in Birmingham. Watching and interacting with Ponce via VIPAAR was **Phani Dantuluri**, MD, from his office in Atlanta.

Ponce wore Google Glass during the operation. The built-in camera transmitted the image of the surgical field to Dantuluri. Dantuluri saw on his computer monitor exactly what Ponce saw in the operating room. VIPAAR allowed Dantuluri to introduce his hands into the virtual surgical field. Ponce saw Dantuluri's hands as a ghostly image in his heads-up display.

"It's not unlike the line marking a first down that a television broadcast adds to the screen while televising a football game," said Ponce. "You see the line, although it's not really on the field. Using VIPAAR, a remote surgeon is able to put his or her hands into the surgical field and provide collaboration and assistance."

The two surgeons were able to discuss the case in a truly interactive fashion because Dantuluri could watch Ponce perform the surgery yet could introduce his hands into Ponce's view as if they were standing next to each other. "It's real time, real life, right there, as opposed to a Skype or video conference call which allows for dialogue back and forth, but is not really interactive," said Ponce.

This kind of technology could greatly enhance patient care by allowing a veteran surgeon to remotely provide valuable expertise to less experienced surgeons, according to UAB physicians. VIPAAR owes its origins to UAB neurosurgeon **Barton Guthrie**, MD, who some 10 years ago grew dissatisfied with the current state of telemedicine.

Guthrie described telemedicine as basically just a little more than a phone call between physicians. "A surgeon in a small, regional hospital might call looking for guidance on a difficult procedure — one that perhaps I'd done a hundred times, but he'd only done once or twice," he said. It offers an advantage to the patient if physicians can get virtual hands and instruments into the field of a trained, skillful surgeon who lacks only experience, Guthrie said.

"The paradigm of the telephone consultation is, 'Do the best you can and send the patient to me when stable,' while the paradigm with VIPAAR is 'Get me to the patient,'" he said. "Let's get my expertise and experience to the physician on the frontline, and I think we can implement that concept with these technologies."

Ponce says VIPAAR allows the remote physician to point out anatomy, provide guidance, or even demonstrate the proper positioning of instruments. He says it could be an invaluable tool for teaching residents or helping surgeons first learning a new procedure.

"This system is able to provide that help from an expert who is not on site, guiding and teaching new skills while enhancing patient safety and outcomes," he said. "It provides a safety net to improve patient care by having that assistance from an expert who is not in the room."

In 2003, Guthrie approached the Enabling Technology Laboratory in UAB's Mechanical

Engineering Department, which already was at work on virtual, interactive technologies, with the idea of using two-way video to enhance surgery. The resulting technology became VIPAAR, now a start-up company at Innovation Depot, a technology business incubator partnered with UAB.

Drew Deaton, CEO of VIPAAR, said, "VIPAAR brings experts or collaborators to the site of need, in any field where a visual collaboration would be beneficial. VIPAAR uses video on mobile devices to allow experts or collaborators to connect in real time and not only see what might need to be fixed, corrected or solved, but also be able to reach in, using tools or just their hands, and demonstrate. It's like being there, side by side, with someone when you might be a thousand miles or 10,000 miles away."

Ponce and Dantuluri were pleased with the results of their interactive collaboration. Adjustments will be needed to fine tune the marriage between VIPAAR and Google Glass, but the promise of useful, practical telemedicine is drawing ever closer. Deaton calls it one more step on the technology evolutionary ladder.

"Today, you can't imagine having a phone without the capability to take picture or a video," he said. "I can't imagine, five years from now, not being able to use a smartphone to connect to an expert to solve my problem and have that person reach in and show me how to solve that problem, because the technology is advancing rapidly, and we're bringing this technology to market today." ■

Ex-doc gets life sentence for HCV outbreak

Patient: 'He has to answer to his God'

By **Gary Evans**, Executive Editor, *Hospital Infection Control and Prevention*

[Editor's note: This article originally appeared in HICprevent (http://bit.ly/hrg4pA), the blog of Hospital Infection Control & Prevention. *The blog is published by AHC Media, which also publishes* Same-Day Surgery.*]*

In lieu of patient safety signs and infection control reminders, every ambulatory clinic in the country should just post the scowling countenance of one Dipak Desai, defrocked MD, who will spend the rest of his life in prison for practicing in flagrant disregard of injection safety.

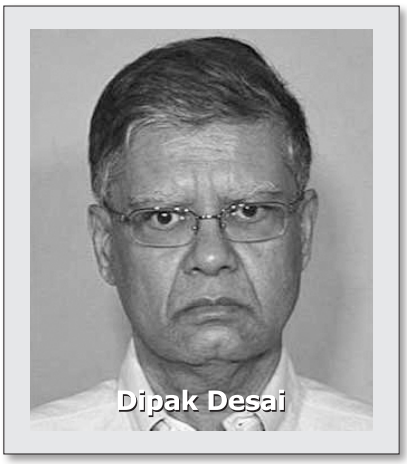

Photo Source: www.fox5vegas.com.

It may well give pause to those who are greedy or ignorant enough to reuse and misuse vials, needles and syringes. Maybe a single outbreak would be averted, perhaps many more, for to look upon that face is to see the "hubris"[1] that a Desai colleague described or know the "chiding"[2] an anesthesiologist faced for suggesting a patient needed more of the precious propofol.

Desai's two endoscopy clinics were in Las Vegas, where patients may fairly expect the gambling to end when they seek health care. In this case, which came to harsh light in 2007 and 2008, nine patients were infected with hepatitis C virus and two died. More than 100 cases of HCV were possibly acquired in the outbreak, which resulted in some 65,000 patients recommended for testing.

On Oct. 24, 2013 the 63-year-old Desai was sentenced to life in prison, having been found guilty of 27 criminal charges including second-degree murder, according to published reports.[3] Prosecutors successfully argued that he oversaw a "penny-pinching" practice where patient safety was trumped by profit. The practices described included using single-dose vials on more than one patient, which can spread blood borne viruses from patient to patient.

Patty Aspinwall, who contracted HCV from a 2007 procedure at one of Desai's now shuttered clinics, had a stoic reaction to the sentencing. "He has to answer to his God, and I have to continue living life the best I can." she told the Las Vegas Review-Journal.

She wears latex gloves when she cooks to protect her family, the newspaper reported.

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3. Associated Press. Ex-doc sentenced to life in Vegas hep C case. Oct. 24, 2103. Accessed at http://bit.ly/HXuIpe. ■

Same-Day Surgery Manager

Need to hire staff or get hired? Read on

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Houston, TX

Hiring staff is one of the most pleasurable and satisfying experience most of us do. It can also be one of the most frustrating. We have several facilities where we need to augment the staff at centers or hire for completely new facilities. I don't know which I enjoy most. I think it is infinitely easier to hire 30 or 40 all new staff than it is to fill one vacant position.

Hiring en masse means you are filling a big bucket that needs to be ready to go by a certain date and you know that not all that are hired will make it. But you have time to make adjustments before you open the doors. The expectations are more realistic than filling a void of one or two individuals at one location. Not a lot of you will be hiring that many people at one time, so I want to spend more time this month on filling that one position in your department or surgery center.

I thought it would be helpful if I gave a few tips on getting hired and to look for when you are hiring. I have hired hundreds, maybe thousands of people in my career. FYI: My techniques are not always orthodox, but I do get results. Here are some insight from a non-professional interviewer and hirer:

• Wages and benefits.

Money isn't everything in a job. It is, however, way ahead of what is in second place. I used to think that discussing wages and benefits at a first interview was inappropriate; now, I start the process with it. "Hi, I'm Steve Earnhart and we are interviewing you for a business office manager for our facility in Chicago. The position pays an annual salary of $42,500 and has full benefits, including a 401K plan. Would you like to continue the interview?"

If you are interviewing them, then they need to know what the job entails and pays. You know they probably are qualified after reading their resume. The only thing dangling is the money. Get it right out there from the start. It saves time and dancing steps.

Note, if you are being interviewed and the issue of money comes up, never, ever say to the person who might hire you that "I have a new car, and I have an apartment that is probably too expensive for me, so I will need a salary of $55,000 to cover my expenses." Don't let the person interviewing you know you have little willpower or fiscal responsibility. They should not have to cover your poor financial decisions. I have never offered to cover someone's debt via their salary. It should never come up.

• How many interviews?

Some managers think they need to have a minimum of two interviews before they hire. I'm not sure why that practice still is breathing. If the candidate presents because they are qualified; you like them, and they seem to like you; you agree on the terms; then make an offer! On the other side, if you are the person being interviewed and that situation happens, and you share their sentiment, take the job!

I don't know why, but I am offended when, after I make an offer that I know they want, they then tell me they have to think about it. It is such a turnoff. That tells me that one, they have to take time to process before they make decisions. Great for some, but for me, not so much. Two, that tells me that they have other interviews, and they want to see what those are like before they make a decision. Turnoff.

In most positions in our field, the benefits are what the benefits are. I always am surprised when an interviewee challenges why an employer, say, doesn't offer a retirement plan the first year. Arguing about it will never change it. Best course for the interviewee who needs a retirement plan is to wait until the end of the interview and thank them for their time. Then turn down the offer, if it is made, and tell them why.

• Tats and new body holes.

Tattoos and armor piercings are OK for some. Visible tattoos and piercings at an interview usually give a very negative first impression. Your works of art and metallurgy are not viewed universally as things of beauty to be shared with everyone you come in contact with. Remove them, cover them up, or don't show up.

• Body language.

Google "body language" and follow these example of positive body language at your interview. Everyone who interviews knows that body language is a good way of judging a candidate's interest or lack thereof in the conversation.

• Grammar.

If you know your grammar is not the best, avoid speaking as much as possible. Bright eyes, nodding, and bobbing are acceptable forms of language to most. Smiling goes a long way with me.

The most glaring grammatical errors I hear are using double negatives in a sentence. Research it if you think you might use them.

• Attitude.

You know what I mean. Lose it for 30 minutes. It will, however, trip you up after you get hired.

• Maturity.

I never hired anyone who has issues with acting mature at an interview. Candidate who share gross jokes, are backstabbing previous positions or coworkers, wear inappropriate attire, or fail to stay focused have short interviews.

• Childcare issues.

No one wants to hear about your difficulties in getting a sitter so you could come in for the interview. That information is a red flag going forward.

• Parting shot.

If you want the job, let them know! This is not the time to try to be cool and detached. There is nothing wrong and everything right about telling the interviewer that you are deserving of the job, can handle it well, and will be successful at it. *[Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates' address is 238 S. Egret Bay Blvd., Suite 285, Houston, TX 77573-2682. Phone: (512) 297.7575. Fax: (512) 233.2979. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.]* ■

TJC tweaks patient safety goal

The Joint Commission has revised one National Patient Safety Goal (NPSG) for 2014 for ambulatory care organizations, office-based surgery practices, hospitals, and critical access hospitals. The revised goal is NPSG.07.05.01 on using proven guidelines to prevent infection after surgery. The new wording below in underlined.

Standard NPSG.07.05.01:

Implement evidence-based practices for preventing surgical site infections.

Element of Performance for NPSG.07.05.01:

A 5. Measure surgical site infection rates for the first 30 **or 90** days following **surgical** procedures ~~that do not involve inserting implantable devices and for the first year following procedures involving implantable devices~~ based on National Healthcare Safety Network (NHSN) procedural codes. The [organization's] measurement strategies follow evidence-based guidelines.

Note 1: Surveillance may be targeted to certain procedures based on the [organization's] risk assessment.

Note 2: *The NHSN is the Centers for Disease Control and Prevention's health care–associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care–associated infections. For more information on NHSN procedural codes, see http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html.*

In addition, hospitals and critical access hospitals have a new NPSG for 2014 to "Reduce the harm associated with clinical alarm systems." Specifically, the goal states that hospitals should "Make improvements to ensure that alarms on medical equipment are heard and responded to on time." The NPSG does not apply to ambulatory care facilities or office-based surgery facilities. *(For more information, see "NPSG on clinical alarms will start with phase one,"* Same-Day Surgery, *September 2013, p. 103.)* ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
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 successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

- Benefits of setting up a foundation, even for ASCs
- You won't believe what these donors agree to pledge
- Should you let patients bid for their surgery?
- Save money by reducing infections

CNE/CME OBJECTIVES

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

CNE/CME QUESTIONS

1. A recent study in Plastic and Reconstructive Surgery (2013; 132:78-82) reported that about what percentage patients having facial cosmetic surgery are taking herbal and other supplements?
   A. 10%
   B. 25%
   C. 35%
   D. 50%

2. How did the Tuomey Healthcare System become embroiled in a lawsuit alleging violations of the Stark law and the False Claims Act?
   A. Michael Drakeford, MD, filed a qui tam lawsuit against Tuomey.
   B. A federal investigator discovered impropriety during an audit.
   C. The problems were discovered during a survey by The Joint Commission.
   D. A recently terminated administrator reported improprieties.

3. What was one key issue in the Tuomey case?
   A. Overbilling
   B. B. Fair market valuation
   C. C. Denied claims
   D. Time to reimbursement

4. Which of the following is recommended regarding retained items?
   A. Scan patients before closing for retained devices.
   B. Examine instruments before and after the procedure.
   C. Take an X-ray if there is serious concern regarding a potential item left inside.
   D. All of the above

Same-Day Surgery®
Covering Hospitals, Surgery Centers, and Offices for More than 35 Years

Can't find nurses for your program? These surgery programs grow their own

By **Joy Daughtery Dickinson,** Executive Editor

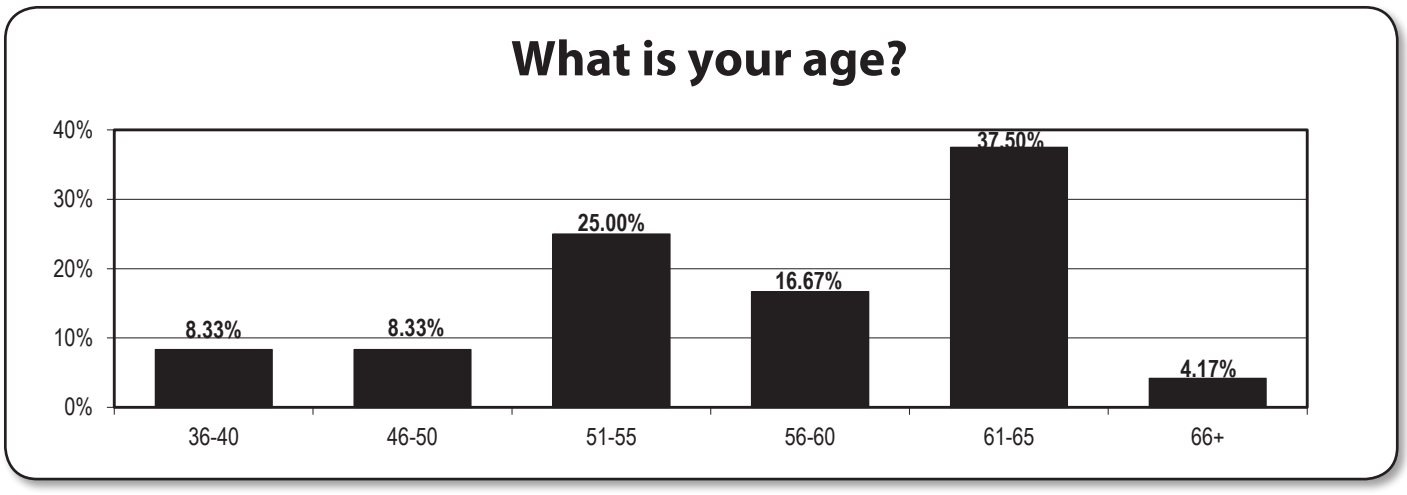
(Editor's note: This is the first part of a two-part series on innovative and cost-effective ways to address the nursing shortage. In this month's issue, we discuss two perioperative courses that are part of nursing curriculums. In next month's issue, we discuss an internship program.)

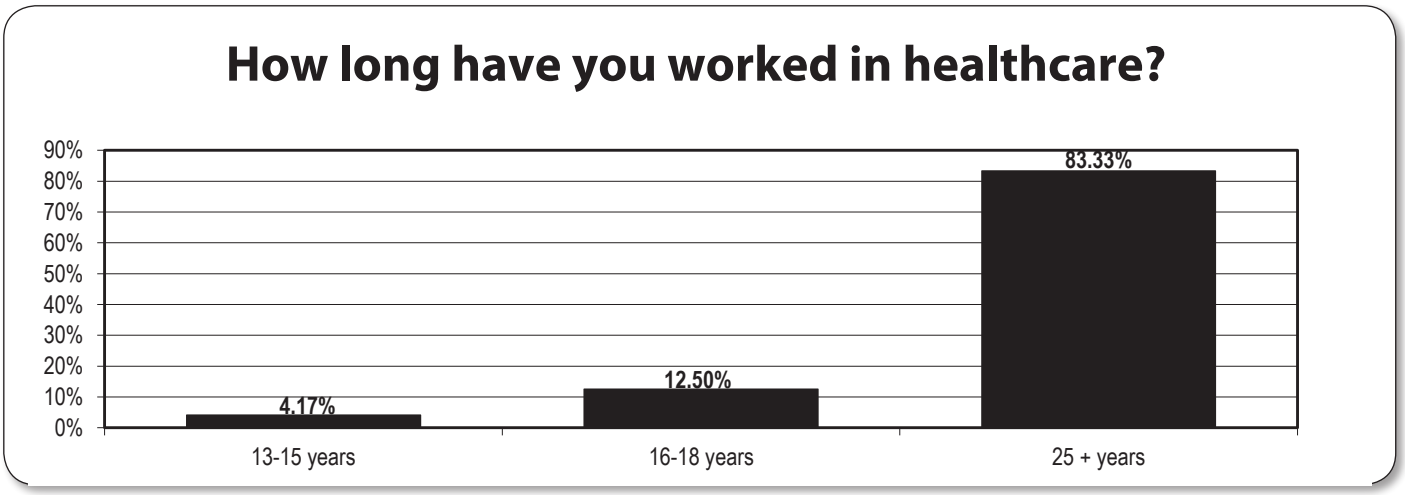
When you look around at your aging nurses and other staff, you realize the nursing shortage can only get worse. The responses to the 2013 *Same-Day Surgery Salary Survey* demonstrate the problem: 83.3% of all persons who responded have worked in healthcare for 25 or more years. *(See graphic, p. 2. For more on the salary survey results, see story, p. 4.)*

More than one-third (37.50%) of all respondents reported that their age is 61-65. One fourth (25%) report that their age is 51-56, and 16.67% report their age is 56-60. More than 4% are older than age 66. *(See graphic, below.)* When their impending retirement is considered, the future can seem dire. In terms of surgical nurses, the problem is made worse by the fact that most nursing programs don't include a perioperative curriculum.

"Since students are not exposed much to perioperative nursing during their ADN or BSN coursework, they don't realize what perioperative nursing is all about," says **Kay Ball**, RN, PhD, CNOR, FAAN, associate professor of nursing at Otterbein University, Westerville, OH. "They are 'imprinted' with other specialties — ICU, ER, etc. — that they get to experience, so they are more apt to go into those specialties after graduation."

Ball and others are addressing this problem head-on. Ball set up an elective perioperative course in the BSN curriculum at Otterbein. Others are setting up intern-





ships and mandated courses. The end result is that more students are choosing to work in the OR after graduation because of these surgical experiences, and they are ready to start work with minimal orientation. The reported savings to facilities for not having to perform a full-blown orientation is $10,000 to $30,000, according to Ball. She will co-lead a presentation on her program at the 2014 AORN Surgical Conference and Expo.

These new nursing programs are getting attention. About 50 persons have expressed interest in the mandated periop course that is part of the BSN curriculum at Case Western Reserve University in Cleveland, OH, says **Rebecca M. Patton**, MSN, RN, CNOR, FAAN, Lucy Jo Atkinson scholar in perioperative nursing at the Frances Payne Bolton School of Nursing and immediate past president of the American Nurses Association.

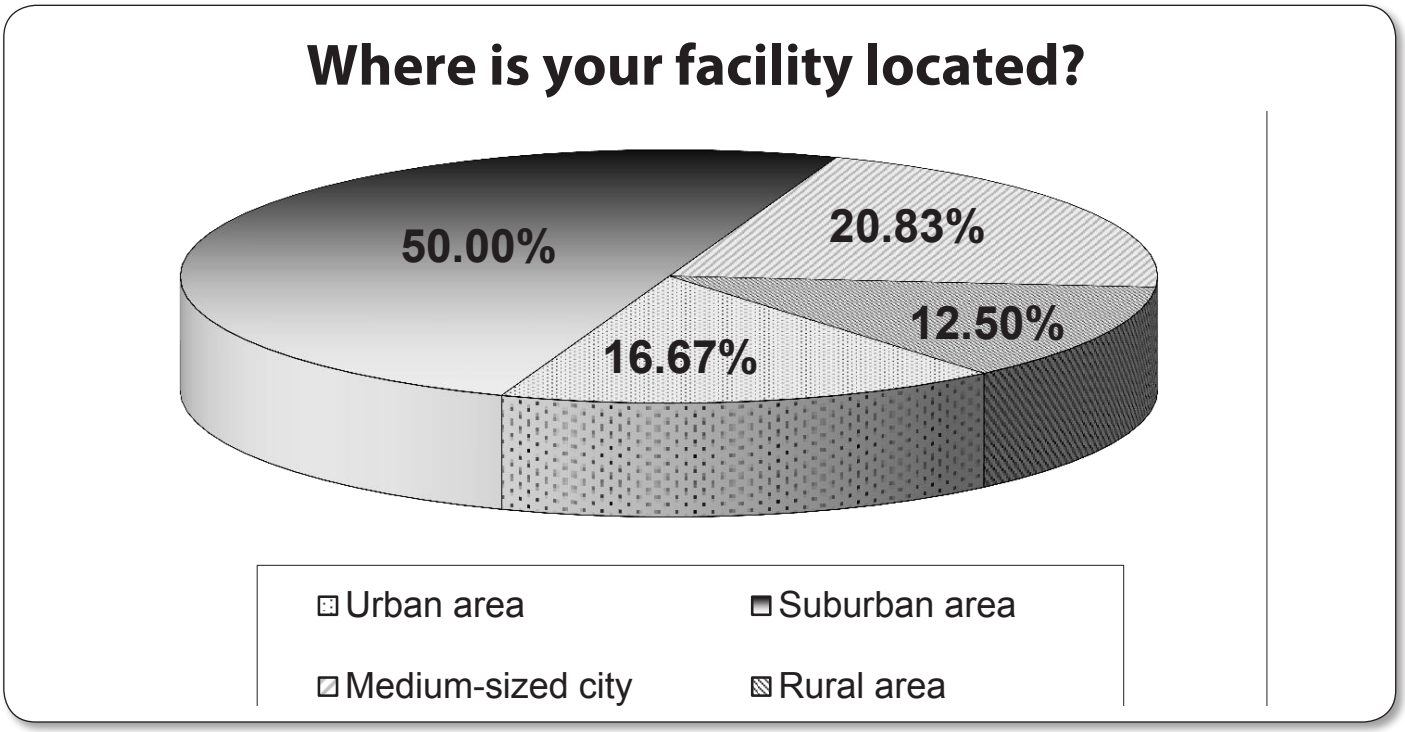
Here's an overview of how some of these programs work:

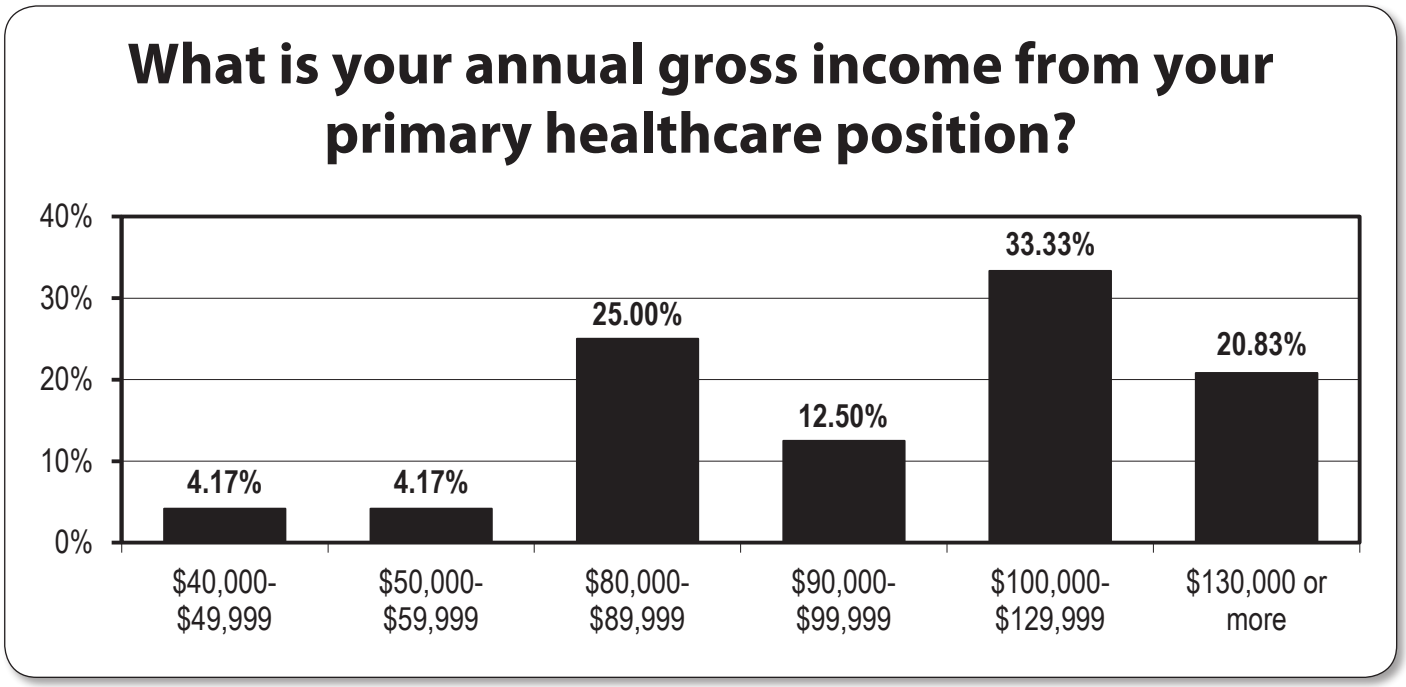
• **Mandated perioperative course in BSN curriculum at Case Western Reserve University.**

The Case Western course is one of the few mandated courses in the country. It is seven weeks long, with clinical instruction twice a week. It offers 3.5 hours of credit. A second 15-week OR course is offered as an elective for the senior year practicum. The course includes a weekly lecture and a weekly lab, with eight hours of clinical instruction twice a week. The clinicals are held at 10 Cleveland hospitals. Each student is paired with a nurse. Students circulate in the OR. Students are encouraged, but not required, to scrub in, Patton says.

"They pass drugs to the field, they do counts, they open sterile supplies to the field," she says.

They spend part of the day in the Central Sterile Processing (CSP) area, and part of the day in preop and





postop. "The whole point is that they see the whole continuum of care for the patient," Patton says.

One of the core lectures is on aseptic technique and sterilization, infection control, and surgical site infections, "but when they spend time in CSP, they have quite a number of 'aha' moments." The benefit is that the students' knowledge of safety is enhanced, Patton says.

Having a mandated periop course has changed the perceptions of students and ignited an interest in working in the OR, Patton says. Before the course, "they didn't see the independent role nurses have in the OR and they did not know how much of an advocate nurses needed to be for patients," Patton says. "They had no concept of the knowledge the nurse needs to have."

Students have realized the OR offers "tremendous" opportunities in terms of new procedures, new equipment, and cutting-edge technology, Patton says. Also, students have been impressed with the family atmosphere, "not just between nurses, but also with the whole team, including physicians."

Patton said students often perceive OR nursing as "technical" nursing in which they're going to be doing what the physician wants them to do, "when in fact, no, no, no, there's so much more to doing it."

Although the program is relatively new, it already is seeing some positive outcomes. Students are developing confidence in core nurse competencies, Patton says. Additionally, four students have been hired by hospitals as perioperative nurses.

To offer such a course, you must have buy-in from the faculty and the clinical sites, and that buy-in might take a bit of time, Patton says. She pulled OR educators and directors into a Perioperative Advisory Council to agree what students would be doing. "With their buy-in to the perioperative program, that helped," Patton says.

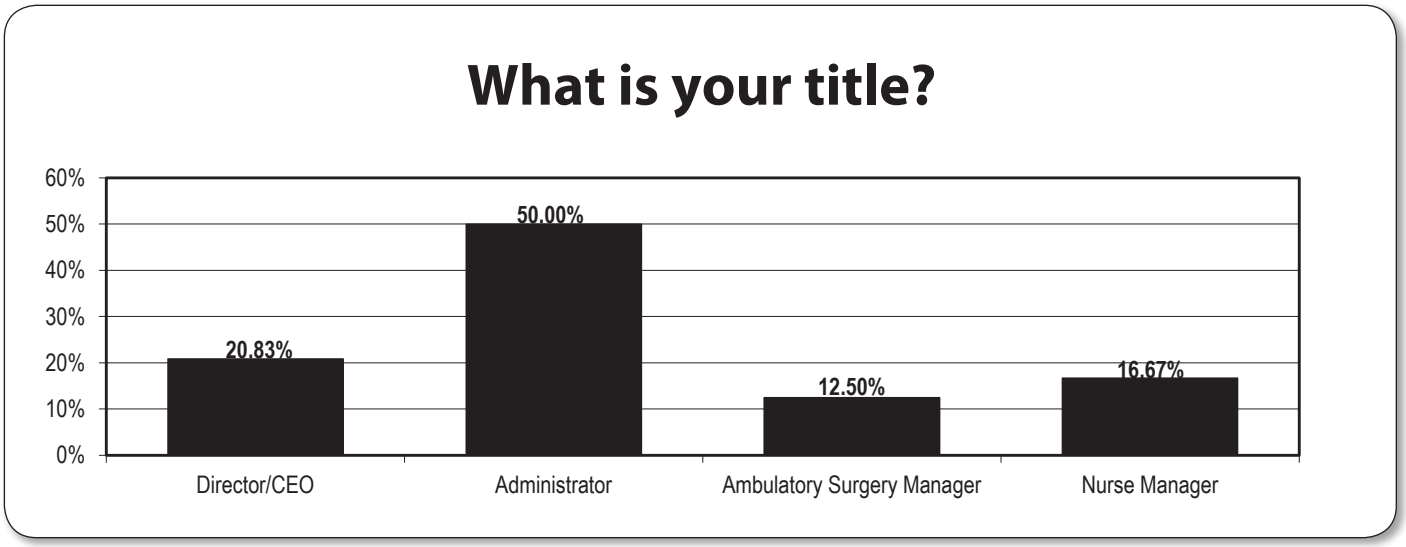
Some nurses are reluctant to give students the opportunity to do things because of the high stakes in the OR, she says. "But I tell you: students have worked in open heart, heart transplants, lung transplants, and less complex places such as endoscopy," Patton says. "For students in endoscopy outpatient surgery centers, they are independent almost by the time they leave there, particularly because staff there allow students to do things."

Provide an orientation for your nursing staff in which you explain that the students are allowed to do anything and everything, she advises.

• Elective perioperative course at Otterbein University.

In setting up the course at Otterbein, a team was assembled in a unique partnership between the university and the Ohio Health hospital system that included university faculty, OR staff and experts from the hospital simulation lab. They designed a curriculum that included clinical instruction, classroom discussions, and online work, as well as a lot of simulation.

The course originally was designed for a small group of senior nursing students during a condensed semester, known as the January term in 2013. The primary instruction was done with simulation for scrubbing, gowning, gloving to patient skin preps and positioning. Other simulation experiences included airway maintenance, maintaining a sterile field, counts, patient preop assessment, energies used during surgery, intubation, and instrumentation. Even the quizzes and final exam were done using simulations to demonstrate the students' understanding and competency of perioperative nurs-



ing skills and knowledge. The course also included the clinical experiences of scrubbing and circulating during surgical procedures with the students being precepted at Columbus-based Ohio Health facilities and also in the simulation lab.

"Simulation is a major part of this course," says Ball, who led the setup. The course also included lectures, reflective discussion, case studies, group presentations, audio-visuals, demonstration, and observation. The outcome of the first course has led to refinement and expansion for the next course offering this month.

Eight students have already signed up for the next course which offers three hours of credit. The course might be considered for expansion to a full semester in 2015.

Two of the four students taking the original course were hired after graduation to work in the periop setting. The managers who hired them reported that their orientation length was reduced by two months, which equals $30,000.

One senior nursing student who couldn't participate in the course was allowed to participate in a practicum of 15 weeks during her final semester. She also was offered an OR position after graduation, and she had a reduced orientation time that saved the hospital system more than $10,000.

The skills these students learn provide a solid foundation for the nursing students, Ball says. "Perioperative nursing should be built into the nursing curriculum at any university because perioperative nursing has been shown to be the foundation of med-surg nursing skills," she says. When perioperative nursing is introduced into the nursing curriculum, students are more apt to want to work in the OR after graduation because they understand and appreciate the unique skills needed to be a successful perioperative nurse.*)* ■

Same-Day Surgery 2013 Salary Survey results

The *Same-Day Surgery 2013 Salary Survey* was mailed in the October 2013 issue to 261 subscribers and had 24 responses, for a response rate of 9.4%.

Most readers (91.6%) have an income of $80,000 or more. *(See graphic, p. 3.)* Respondents reporting a 1-3% salary increase totaled 41.7%. One-third reported no change.

Half of the respondents were administrators. The rest are a mix of titles: director/CEO, nurse manager, and ambulatory surgery manager. One-third have a master's or similar level degree.

More than half of respondents (54.2%) work in freestanding, independent facilities. One-fourth of readers work in hospitals or freestanding, hospital-affiliated facilities. Respondents who work in a freestanding center that is part of a chain total 16.7%. Respondents who work in office-based facilities totaled 4.2%.

Half (50%) reporting living in a suburban area. Those living in a medium-sized city total 20.8%. Those living in an urban area total 16.7%. Only 12.5% report living in a rural area. *(See graphic, p. 2.)*

Fifty percent of readers reported no change in the number of employees. One-fourth had increased employees, and one-fourth had decreased. ■

Dear *Same-Day Surgery* Subscriber:

This issue begins a new continuing education semester.

Here is how you earn credits:

1. Read and study the activity, using the provided references for further research.
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3. Pass the post-test with a score of 100%; you will be allowed to answer the questions as many times as needed to pass.
4. After completing the last test of the semester, complete and submit an evaluation form.
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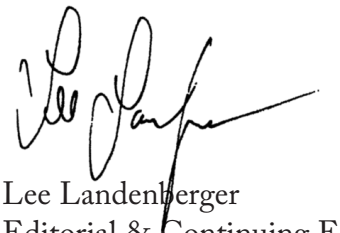

Lee Landenberger
Editorial & Continuing Education Director

The Children's Hospital of Philadelphia®
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12:B:81

Caring for Your Child
Dietary Supplements – What You Should Know

CHOP's Policy on the Use of Dietary Supplements

The Food and Drug Administration (FDA) does not review the manufacturing of dietary supplements and therefore cannot guarantee they are safe or effective. Because safety is a priority at CHOP, we discourage the use of dietary supplements for our hospitalized patients. If your child takes a dietary supplement at home, but it is not approved for use at CHOP, you may be asked to take the supplement home. If you cannot take the supplement home, we can safely store it at CHOP until your child is discharged. If you feel strongly that your child should continue to receive the dietary supplements at CHOP that they are taking at home, you will be asked to review the information in this document and discuss any questions you have with your child's doctor.

If your child's doctor agrees to continue the dietary supplements, you will be responsible for supplying the supplements and giving them to your child. You will also be asked to sign a paper (waiver) that states you are agreeing to do this.

What are Dietary Supplements?

Dietary supplements are vitamins, minerals, and herbs. Other substances such as botanicals, amino acids, enzymes, and animal extracts may also be used. They can come as tablets, capsules, powders and liquids. Dietary supplements are meant to "supplement" the diet, and should never replace the balance of foods that are important for a healthy diet.

Who Should Take Them?

Dietary supplements are not for everyone. Dietary supplements are not medications. They are not intended to treat, diagnose, prevent, or cure diseases. Some patients with certain medical conditions may need to take supplements if their diet does not contain enough of a certain nutrient.

Source: The Children's Hospital of Philadelphia, Philadelphia, PA January 2014 / Online Supplement to SAME-DAY SURGERY

What are the Risks?

Unlike medications, dietary supplements are **not** reviewed by the FDA for safety and effectiveness.

There are risks to taking supplements. Side effects or interactions with other drugs can occur. Prescription medications are thoroughly studied for side effects and effects on other medications. Supplements do not go through this process. We cannot be sure that dietary supplements will not cause harm to your child or affect the safety and effectiveness of his other medications.

Some Tips About Dietary Supplements

- The term "natural" does not necessarily mean that the supplement is safe to use. Without FDA regulation, products may not be pure.
- Do not use supplements to replace poor dietary intake of a nutrient.
- Use caution and think carefully when you see potentially-false claims such as "cure-all," "secret ingredient," or "scientific breakthrough."
- **Always** discuss the use of dietary supplements with your physician or pharmacist before use.

Resources Available

American Academy of Pediatrics: The Use of Complementary and Alternative Medicine in Pediatrics (http://aappolicy.aappublications.org/cgi/content/full/pediatrics;122/6/1374)

KidsHealth: Alternative Medicine and Your Child (http://kidshealth.org/parent/general/sick/alternative_medicine.html)

National Center for Complementary and Alternative Medicine (http://nccam.nih.gov/about/ataglance/index.htm)

U.S. Food and Drug Administration: Dietary Supplements (http://www.fda.gov/Food/DietarySupplements/default.htm)

HPA: Alliance for Holistic Family Health and Wellness (http://hpakids.org/)

The Journal of Chinese Medicine (http://www.jcm.co.uk/). The Journal of Chinese Medicine is the foremost English language journal on all aspects of Chinese medicine including acupuncture, Chinese herbal medicine, dietary medicine and Chinese medical history and philosophy.

Written 1/11; Revised 3/13

The Children's Hospital of Philadelphia®

RX-010
Rev. 1/13

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USE OF DIETARY SUPPLEMENT(S) NOT ON THE CHOP FORMULARY WAIVER AND RELEASE

At The Children's Hospital of Philadelphia (the "Hospital"), the use of dietary supplements not on the CHOP Formulary (the list of medications the hospital has approved for use) are discouraged during hospitalization based on the following assumptions:

1. A number of patients are using one or more dietary supplements as outpatients to treat a variety of conditions. Some of these agents can have serious adverse effects and most have not been studied sufficiently to determine their effectiveness, safety or their interactions with other medications.

2. The FDA does not oversee the manufacturing of most dietary supplements as they are considered food and nutrition supplements rather than medications. In the absence of reliable controls over labeling and manufacturing, it is not possible to guarantee that product content is accurate or safe.

3. Temporarily stopping these agents is unlikely to adversely affect the long-term outcome of any underlying chronic condition.

4. Use of an agent for which there is no reliable data on toxicity and drug interactions makes it impossible to adequately monitor the patient's acute condition or safely administer medications.

Listed below are the dietary supplements that your child was taking before admission to the hospital and that you wish to continue during this hospitalization. The Hospital is not willing to provide this product due to the lack of information available to support the quality, safety, and effectiveness of use.

_____ _____

_____ _____

You have been advised by your physician of the risks and/or potential risks associated with the continued use of the dietary supplement(s) above which include contamination, mislabeling, or that the supplement contents are not accurately reflected by the label, resulting in potential unforeseen adverse effects. Other concerns with the product[s] you would like your child to receive include the following:

_____.

By signing this release and waiver you agree to be responsible for providing the product, giving it to your child, and advising the nursing staff immediately after you have administered it.

You further agree on the behalf of yourself/or as the patient representative of the patient(s) named below, as well as your agents and assigns, to waive, release and forever discharge The Children's Hospital of Philadelphia, its affiliates, its agents and employees, including your physicians, pharmacists, and nurses, for any harm, injuries, or damages whatsoever, which are directly or indirectly related to the use of your dietary supplements, including but not limited to physical, mental, and emotional harm and/or distress.

_____ _____ _____/_____

Signature of Parent/Guardian Obtaining Waiver | Printed Name | Date | Time

_____ _____/_____ _____/_____

Attending Physician Signature | Printed Name and/or Contact Number | Date | Time

ALAN MATARASSO, M.D., F.A.C.S., P.C.
PLASTIC SURGERY
1009 PARK AVENUE
NEW YORK, N.Y. 10028

APPOINTMENTS
212-249-7500

MEDICATIONS TO BE DISCONTINUED 2 WEEKS BEFORE/2 WEEKS AFTER SURGERY

NOTE: If and MD has prescribed a drug for you that is ON this list, please notify that doctor before stopping your medication.

Please inform Dr. Matarasso or his staff of **any** and **all** medications that you are taking. This includes all vitamins and homeopathic medications.

Discontinue:

1. ALL vitamins, homeopathics and other supplements two weeks before surgery.
2. Take ONLY what is noted on our list.
3. ALL Hormone pills, hormone patches, creams, ointments.
4. Birth Control Pills, Rings, Patches: Use alternative method of birth control.

If you have any questions regarding medications, including over-the-counter products interfering with surgery, please consult our office, your medical doctor or pharmacist.

ASPIRIN COMBINATIONS

Bufferin
Easprin
Ecotrin
Excedrin
Ascriptin
Fiorinol
Darvon
Lortab
Norgesic
Aspergum

ASPIRIN WITH ANTACID

Alka-Seltzer

ANTI-INFLAMMATORY

Advil
Aleve
Anaprox
Cataflam
Clinoril
Dolobid
Feldene
Ibuprofen
Lodine
Ponstel
Vioxx
Anacin
Empirin
Bufferin
Bayer
Entab-650
Indomethacin
Indocin
Midol
Nalfon
Relafen
Celebrex

ANTI-PYRETICS

Aleve,Motril, Advil
Feverall
Trilisate
Naprosyn

ARTHRITIS MEDICATIONS

Aleve
Anaprox
Ansaid
Cataflam
Clinoril
Daypro
Dolobid
Ecotrin
Motrin
Indocin
Orudis
Motrin
Telectin
Vioxx
Tolectin
Voltaren
Mono-gesic
Myochrysine
Ridaura
Solganal
Sal-flex
Feldene
Lodine
Naprosyn
Oruvail
Naprosyn
Toradol
Celebrex

MIGRAINE PREPARATIONS

Imitrex
Blocadren
Ergomar
Ergostat
Cafergot
Midrin
Migrilam
Sansert
Wigraine
Fiorinal
Darvon

TOPICAL PREPARATIONS

Absorbent Rub
Absorbine
Act-on-Rub
Ben Gay
Doan's Rub
Exocaine Plus
Icy Hot
HEET
Neurabain
Sloan's
Metholatum
Infrarub
Solitice
Oil-O-Sol
Panagesic
Stimurub
Surin
Yager's Lin.
Zemo Liquid

PLATELET INHIBITORS

Aspirin
Baby Aspirin
Bufferin
Ecotrin
Halfprin
Persantine
Ticlid
Plavix

COLD MEDICATIONS

4-Way Cold Tabs
Alka-Seltzer
Dristan
Vanquish
Pepto-Bismol
Quiet World Analgesic
Sine-off, Sine-Aid, Sinutab
St. Joseph's for Children
Nyquil Liquid or Nyquil pills
Airborne

OTHER PRODUCTS CONTAINING ASPIRIN

ACA Caps
APAC Acetonyl
Aidant
Alka Seltezer
Allygesic
Apamead
APC
Aphodyne
Aphophen
Arthra-Zene
ASA
Asalco
Ascolco
Ascaphen
As-ca-phen
ACD Acetabar
Acetasem
Alprine
Aluprin
Amsodyne
Amytal
Anacin
Anexsia
Anadynos
Ascodeen
Ascriptin
Aspadine
Aspergum
Asphac
Asphencaf
Asphyte
Aspirbar
Aspir-C
Aspireze
Aspirn (USP)
Aspirin
Aluminum
Aspirin
Children's
Aspirjen
Aspircal
Aspir-phen
Aspodyne
Axotal
Babylove
Ban-o-pain
Bayer
Brogesic
Bufabar
Buff-A
Buffacetin
Buff-a-comp
Buffadyne
Bufferin
Buffinol
Calurin
Cama Inlay
Capron
Causalin
Cephalgesic
Cheracol
Cirin
Clistanal
Codasa
Codempiral
Codesal
Coldate
Colrex
Congesprin
Cope
Coralson
Modified
Cordex
Coricidin
Co-ryd
Counter pain
Covangesic
Darvon
Darvo-Tran
Dasikon
Dasin Caps
Decagesic
Delenar
Derfort
Derfule
Dolcin
Dolene
Dolor
Doloral
Dorodol
Drinacet
Dristan
Drocogesic
Duopac

Dristan
Drocogesic
Duopac
Duradyne
Ecotrin
Empiral
Empirin
Emprazil
Empragen
Equagesic
Excedrin
Fiorinal
Fizrin
Formasal
4-Way Cold Tabs
Gelsodyne
Grillodyne
Hasamal CT
Henasphen
Histadyl
Hypan
I-PAC
Kryl
Liquiprin
Lumasprin
Marnal
Measurin
Medadent
Medaprin
Midol
Multihist
Nembudeine
Nembu-Gesic
Nipirin
Norgesic
Novahistine
Novrad
Opacedrin
Opasal
Paadon
Pabirin
PAC
Palgesic
PC-65
Pedidyne
Pentagesic
Pentagill
Percobarb
Percodan
Persistin
Phac Tab
Phenaphen
Phencaset
Phenergan
Phenodyne
Pheno-Formasal
Phensal
Pirseal
Palygesic
Ponodyne
Predisal
Prolaire-B
Pyrasal
Pyrhist Cold
Pyrroxate
Phinex
Robaxisal
Ryd
Sal-Aceto
Sal-Fayne
Salibar Jr
Salipral
Sarogesic
Sedalgesic
Semaldyne
Sigmagen
Sine-Off
Spirin Buffered
Stanback
Ster-Darvon
St. Joseph
Supac
Super-Anahist
Synalgos
Synirin
Tetrex-APC
Thephorin-AC
Toloxidyne
Trancogesic
Trancoprin
Triaminicin
Trigesic
Triocin
Vanquish
Zactirin

MISC. PREPARATIONS/ FOODS/SPICES TO AVOID:

NO CINAMMON
NO GARLIC
NO ETHNIC FOODS:
NO CHINESE,
NO JAPANESE/SUSHI,
NO HEAVILY SALTED/SPICY FOODS
NO SALMON
NO PROTEIN/ENERGY BARS
NO VITAMINS/HOMEOPATHICS OTHER THAN WHAT IS ON SEPARATE LIST

*Updated on 12/5/2011/ fpo