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$19 million judgment highlights need to monitor for post-op complications

Here's how to identify problems after laparoscopic cases

An Illinois woman recently was awarded $19 million after her bladder was punctured during surgery to remove an ovarian cyst and went undiagnosed for nearly two days, according to a news report.[1] She subsequently suffered a stroke, necrotizing fasciitis (a flesh-eating infection), and amputation of some fingers and toes, the report said.

After the stroke, the patient was given medication to increase her blood pressure, the report said. A side effect of the medication reduced the flow of blood to her extremities, which led to the amputations, the report said. She underwent nine surgical procedures in two weeks, it said.

The inadvertent puncturing of her bladder was not a violation of medical care standards, the patient's lawyer maintained. However, failing to see it, during the operation and later when the patient complained of pain, was negligent, he said in the news report. The patient reported intense pain in her abdomen the day after surgery. She was

EXECUTIVE SUMMARY

An Illinois woman was given a $19 million award after her bladder was punctured during surgery, went unidentified initially, and led to severe complications.

- Give patients written post-op instructions that list complications and include around-the-clock contact information.
- Ask the physicians to also make post-op calls. Look for symptoms of complications, such as fever, nausea, and trouble voiding. After lap surgery, patients should be feeling better every day, at least after the first 24 hours.
- Overmedication with pain prescriptions can cause side effects and/or mask problems. Physicians should examine patients with significant post-op pain.

advised to take medication, but when the pain intensified, she went to the emergency department, her lawyer said. The severity of her condition was not recognized, he added.

The following morning, her husband walked into her hospital room and found her motionless after a stroke. Tests later showed that it was caused by urine leaking from the bladder, the report said. That led to an infection, decreased blood pressure, and other complications, her lawyer related.

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To avoid similar problems in your program, consider these suggestions:

• Look for signs of puncture in the OR.

If an organ is punctured in the OR, you may see bleeding or some leak of the enteric contents, which may show up as murky irrigation fluid, says **Paula R. Graling**, RN, MSN, CNS, CNOR, clinical nurse specialist in perioperative services at Inova Fairfax Hospital in Falls Church, VA.

"If you puncture into a vessel, you may have frank bleeding and problems with blood pressure," Graling says.

Although such complications are rare, they should be discussed initially when the patient is trying to decide whether to have a laparoscopic procedure, she emphasizes.

• Be alert for excessive pain in the recovery room.

Keep alert for unstable vital signs, continued restlessness, excessive pain, and distention of the patient's abdomen in the recovery room, sources advise.

"The caveat is that the patient has been inflated with CO_2, so that gives you pain, particularly in the shoulder," Graling says.

One way to know there's a complication is when the patient has pain that's unrelieved with normal pain medication, she says.

• Send patients home with written postoperative instructions.

It is essential that the recovery room nurses and any other nurses providing post-op instructions offer written instructions, says **Wendy Winer**, RN, BSN, CNOR, endoscopic surgery specialist at the Center for Women's Care and Reproductive Surgery in Atlanta. "Always remember that whatever you tell patients or family members or whoever is with them, when they get home, they forget all of that," she says. "It's imperative that they have something written to look at."

The key is that the written instructions including warning signs for complications, such as a temperature above 100.5° F, heavy bleeding, severe pain, difficulty urinating, and difficulty having a bowel movement, Winer says. If patients experience any of these problems, they should contact their provider immediately, she adds. Phone numbers should be provided that allow contact 24 hours a day, seven days a week, Winer says.

• Have the physician and facility make postoperative calls.

In the surgeries that Winer participates in, the patients receives a post-op call the first day home from the physician's staff and the facility staff.

SOURCES

For more information on diagnosing punctured organs, contact:

- **William Parker**, MD, 1450 10th St., Santa Monica, CA 90401. Telephone: (310) 451-8144. Fax: (310) 451-3414.
- **Wendy Winer**, RN, BSN, CNOR, Endoscopic Surgery Specialist, Center for Women's Care and Reproductive Surgery, Atlanta. E-mail: wwiner@mindspring.com.

"It's not absolutely imperative that you have both, but it's good continuity of care," she says. "In this day and age, when patients are going home so quickly, we really have to be careful, extra careful, of the potential of post-op complications being undiagnosed." The sooner complications are identified, the more quickly they can be addressed, Winer points out.

• Keep an eye on symptoms of complications.

When urine leaks into the abdomen, it can cause symptoms of irritation, such as a low-grade fever, pain, and sometimes nausea and vomiting, says **William Parker**, MD, clinical professor of obstetrics and gynecology and the University of California, Los Angeles School of Medicine and author of *A Gynecologists' Second Opinion* (Penguin Plume, New York City).

When you operate in the abdominal cavity or pelvis, look for any signs of perforation of the bowel, any signs of injury to the ureter, a hole in the bladder, any signs of bleeding, or any signs of post-op infection, Winer advises. Determine if patients are having any trouble voiding, she says.

• Look for patients to improve.

One rule about laparoscopic surgery is that patients should get better every day after the first 24 hours, Winer says. Parker adds, "If they're not getting better, a problem should be looked for."

Complications can be difficult to pinpoint, Winer acknowledges. "The patient may just not be feeling great and may not be getting better," she says. Also be alert if a patients feels fairly good initially, but starts to worsen a couple of days later and continues to feel bad. "That always sends up a red flag that something's going on," Winer says.

• Ensure patients don't overmedicate with pain drugs.

If patients are uncomfortable the first or second post-op day, they have a tendency to take more pain medicine, Winer says. "I think you have to be careful with that, because a lot of times, even taking pain medicine can cause other side effects," she says. For example, patients can become severely constipated or nauseated, she says. "At the same time, taking too much pain medicine post-op can camouflage a more serious problem that would imply something more than normal post-op pain," Winer warns.

• Have the physician examine patients with significant degree of pain.

While some patients feel fairly good the day after surgery, others feel sore for a couple of days, Winer says. "The trick is to differentiate between what's normal post-op discomfort and when something really going on," she says. "For that reason, it's important, in my opinion, that whenever a patient complains of significant post-op discomfort the first post-op day, you take every complaint seriously."

If the patient is having a significant degree of pain, the physician should examine the patient, Parker says. The determination is difficult to make over the phone, he acknowledges. "If patient is saying, 'Oh, I'm having some cramping, but it goes away when I take pain medication,' that's one thing," Parker says. "But if the patient is saying, 'I can't keep pain medication down; the pain is getting worse,' I think they should be examined. That's the thing to do."

Physicians can get into the mindset that if they didn't note any complications during the surgery, there weren't any, he says. "I think sometimes doctors put their heads a bit in the sand," Parker says. "When a patient does start to complain, they miss the fact that complications can occur. They should be looking for that."

Reference

1. Ciokajlo M. Injured woman gets $19 million — Surgical error led to loss of digits, stroke, infection. *Chicago Tribune*, Oct. 2, 2003. Web: www.chicagotribune.com. ■

Place anesthetic in wound during recovery to cut pain

Fewer narcotics needed, patients' ambulation easier

Post-surgical pain control has come a long way since the days when patients were sent home with oral narcotics and no other way to control pain. One method of pain control that has been in use by orthopedists for several years, and now is

EXECUTIVE SUMMARY

In-the-wound pain control relies upon a small pump worn home by the patient placing anesthetic directly into the surgical incision for up to two days. Benefits of the in-the-wound pain pump include:

- faster discharge from recovery unit;
- movement of inpatient procedures, such as abdominal hysterectomies, into the outpatient or 23-hour stay unit;
- reduction in the amount of narcotic medication needed to control pain.

being used by other specialists, is in-the-wound pain control.

"It is important to control pain because post-surgical pain is a physical and psychological risk factor that interferes with healing and delays the patient's recovery," says **June L. Dahl**, PhD, professor of pharmacology and pain specialist at the University of Wisconsin in Madison.

The advances in pain control such as the use of COX-2 inhibitors, spinal opiates, and long-acting oral narcotics such as oxycodone have made it possible for more surgical procedures to move into the outpatient arena, Dahl says. "Because patients don't have to remain in the hospital for intravenous narcotics, orthopedic procedures such an anterior cruciate ligament [ACL] repair, abdominal hysterectomies, C-sections, and hernia repairs now can be done on an outpatient basis," she explains.

Although orthopedists have used in-the-wound pain control for several years, other specialists are seeing the value of nontraditional pain control for incisions. **(See "Put medication directly into surgical sites," *Same-Day Surgery*, February 2001, p. 17.)** By using a pain pump that places an anesthetic directly into the incision site, **Stephen E. Zimberg**, MD, gynecological surgeon at the Cleveland Clinic in Fort Lauderdale, FL, has been able to handle all of his abdominal hysterectomy patients as 23-hour stay patients rather than inpatients. "By converting all of these patients from inpatients to outpatients, we cut the hospital's expense of providing care by 30%," he explains.

Although laparoscopic hysterectomy patients usually are handled in same-day surgery, the ability to use in-the-wound pain control to move abdominal hysterectomy patients out of the inpatient surgery unit is important for surgeons who are not as adept at laparoscopic procedures, Zimberg says. "This can be an advantage to the same-day surgery program because abdominal hysterectomies require fewer costly disposable supplies than a laparoscopic procedure," he adds.

A small catheter that is similar to a soaker hose with small holes along it is placed directly under the incision site, explains Zimberg. "For hysterectomies, I close the peritoneum and place the catheter between the peritoneum and fascia before I close," he says. "This allows the anesthetic to pool in the area of the incision without going into the abdominal cavity."

Zimberg typically uses Marcaine, but other surgeons have used lidocaine.

"I use a two-day pump that contains 100 cc of anesthetic and injects 2 cc per hour," Zimberg says. This is sufficient to eliminate the incisional site pain and enables the patient to get up and move around more quickly, he adds. In yet-to-be-published studies that Zimberg and his colleagues have conducted, anesthetic levels never go higher than 50% of the level considered toxic, he says.

Because there are no moving parts and the flow restrictor keeps the level of medication constant, the pump is very safe, Zimberg points out. "The only caution I can offer is to pay attention to the connector between the pump and the catheter," he says. "There is an air filter in the connector that should not be covered with a bandage."

Making sure that this point is taught in staff and patient education ensures that the filter is not covered, he adds.

Pain control is more effective because there is a consistent level of medication, according to **Sharon Schwartz**, RN, administrator at Wausau (WI) Surgery Center. "We've been using the pain pumps for two years on a regular basis," she says. "Our orthopedic surgeons use it for procedures such as ACL repairs, but our plastic surgeons also use it for pain control after breast augmentation."

The actual implantation of the catheter does not add time in the operating room, but because the anesthetic starts to work on the incisional pain within the hour, patients usually can leave the post-anesthesia care unit more quickly and more comfortably, Schwartz explains.

No matter how effective in-the-wound pain control can be, it's essential that surgeons and same-day surgery staff realize that no single therapy can effectively control pain, Dahl says. "Multimodal therapy, such as the use of a pain pump and oral narcotics, will give the patient the most effective pain control," she suggests.

Zimberg does prescribe oral narcotics for his patients, but he points out that in-the-wound pain control has eliminated the need for patient

SOURCES AND RESOURCES

For more information about pain control, contact:

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- **Sharon Schwartz**, RN, Administrator, Wausau Surgery center, 2809 Westhill Drive, Wausau, WI 54401. Telephone: (715) 842-4490. E-mail: Sharon.Schwartz@healthsouth.com.
- **Stephen E. Zimberg**, MD, Department of Gynecology, Cleveland Clinic, 2950 Cleveland Clinic Blvd., Fort Lauderdale, FL 33331. Telephone: (954) 659-5565. Fax: (954) 659-5560. E-mail: zimbers@ccf.org.

The following companies offer in-the-wound pain control pumps:

- **Breg**, 2611 Commerce Way, Vista, CA 92083. Telephone: (800) 321-0607 or (760) 599-3000. Fax: (800) 329-2734. Web: www.breg.com.
- **dj Orthopedics**, 2985 Scott St., Vista, CA 92081. Telephone: (800) 321-9549 or (760) 727-1280. Fax: (760) 734-3595. Web: www.djortho.com.
- **I-Flow Corp.**, 20202 Windrow Drive, Lake Forest, CA 92630. Telephone: (800) 448-3569 or (949) 206-2700. Fax: (949) 206-2600. Web: www.i-flowcorp.com.
- **Sgarlato Laboratories**, 130-C Knowles Drive, Los Gatos, CA 95032. Telephone: (800) 421-5303 or (408) 374-9901. Fax: (408) 374-9924. Web: www.sgarlatolabs.com.
- **Stryker Instruments**, 4100 E. Milham Ave., Kalamazoo, MI 49001. Telephone: (800) 253-3210 or (269) 323-7700. Web: www.stryker corp.com.

controlled analgesia pumps. "We also find that patients use less narcotic medication when the incisional pain is controlled by the pain pump," he adds.

Staff education related to the pain pump is essential, but not overwhelming, Schwartz says. "The operating room staff must understand the implantation of the catheter and how to fill the pump, but it is not a complicated procedure," she says. Patient education prior to the procedure and in the recovery room also is needed, but pain pump manufacturers provide patient education material, she adds. **(For names of manufacturers, see resource box, above.)**

Physicians play an important part in patient education because it is up to them to set realistic expectations, Schwartz points out. "Our physicians discuss different pain control and offer the pain pump as an option before the patient is scheduled for surgery," she says. "They explain the pain pump addresses incisional pain and oral medications will be available for other pain," she explains.

Because of the amount of education prior to surgery and in the recovery room, patients have been very comfortable with the pain pumps and have expressed great satisfaction with the results, she adds.

Removal of the catheter is simple, Zimberg says. "My patients just pull it out themselves," he says. Other physicians may have the patient come to their office in for their postoperative visit and to remove the catheter, he says.

With the importance of pain control a focus of accreditation organizations, medical associations, and same-day surgery staff themselves, the variety of pain control methods that are now available are exciting, says Dahl. "It's critical that we recognize the importance of evaluating the use all modalities such as in-the-wound pain pumps and oral medications in the best way possible to control pain and improve patients' recoveries," she says. ■

Outpatient mastectomies are under fire again

Millions back petition delivered to Congress

In the last several years, seven bills have been introduced in Congress to ban outpatient mastectomies but have not passed. The Breast Cancer Patient Protection Act, introduced in the House and Senate this year, may have new strength thanks to 5 million signatures on a petition delivered by Lifetime Television's web site and the support of Tami Agassi, who is the sister of tennis star Andre Agassi and a breast cancer survivor.

The legislation would require insurance companies to cover a 48-hour minimum stay for mastectomy patients and a 24-hour stay for women undergoing lymph-node dissections. At press time, the bill had been referred to committees in both houses.

"A mastectomy is not an outpatient procedure in any civilized country in the world, except, perhaps, ours," said Sen. **Mary Landrieu** (D-LA).[1]

In 1997, the Department of Health and Human Services sent a policy letter prohibiting Medicare managed care plans from requiring that breast

EXECUTIVE SUMMARY

With a petition signed by 5 million and the endorsement of a celebrity's sister, the Breast Cancer Patient Protection Act has new life in Congress. The legislation would require insurance companies to cover a 48-hour minimum stay for mastectomy patients and a 24-hour stay for women undergoing lymph-node dissections. Providers, however, speak highly of outpatient mastectomies and point to patient preference.

- When performing the procedure outpatient, provide thorough education and include the at-home caregiver.
- Use medication to address pain and nausea.
- Home health nurses and volunteers who have undergone the same procedure can provide care and reassurance after the patient is home.

cancer surgeries be performed on an outpatient basis or from limiting hospitals stays. However, insurance companies have not followed suit, according to Rep. **Rosa DeLauro** (D-CT), one of the sponsors of the legislation.

For their part, many health care providers support mastectomy stays of less than 24 hours for most patients. They point to patient preference as one reason.

"For a significant majority of my patients, who are young — less than 45 years old, same-day mastectomy is an option that is offered to them, and most are pleased with going home prior to the [end of the] 23-hour observation time," says **Lee Gravatt Wilke**, MD, assistant professor of surgery at Duke University Health System in Durham, NC, and medical officer of the American College of Surgeons Oncology Group.

At The Johns Hopkins Breast Center in Baltimore, patients who are not having reconstructive surgery are given the option of staying overnight or going home, but they are asked to make that decision in the recovery room based on how they feel after the surgery.

"In the last eight years, we have only had three patients request to spend the night," says **Lillie Shockney**, RN, MAS, director of education and outreach. "All three in retrospect said on their surveys that they wish they had gone home, as they felt fine once they re-evaluated themselves when they got to an inpatient bed."

However, providers are quick to point out that outpatient mastectomies are not for every patient. Patients who have comorbid conditions including cardiac dysfunction, pulmonary impairment, or renal insufficiency usually warrant overnight hospitalization for monitoring of their cardiac or respiratory systems, for example, providers say.

For those providers who want to provide outpatients mastectomies, consider these suggestions:

• Provide thorough education.

Patients are educated on the procedure, any reconstruction, such as expander or implant placement, and the postoperative pain, wound, and drain care requirements, Wilke says.

"The physicians and nurses work to ensure that the patients who are discharged on the same day or the next morning before 7 a.m., if they had a late surgery start, are very comfortable with this plan," she says.

At Johns Hopkins, the pre-op educational process is conducted by a nurse practitioner who specializes in this type of education, Shockney says. "The educational program is about 90 minutes and includes a review of drain management, wound care, showing photographs of what to expect, details of how she will feel, and what will happen step by step, so that she is empowered with information and can feel confident in her care," she says.

It also includes education on exercises for the arm and sexuality issues, she says. Shockney and the nurse practitioner involve the person caring for the patient after she returns home in the education, she says.

• Provide adequate pain control and antiemetics.

At Duke, the majority of the patient's receive a "paravertebral block" as a component of their anesthesia, Wilke says. "This provides a 12-24 hour window of excellent pain control in the immediate postoperative period," she says.

Johns Hopkins uses propofol for an anesthetic, and uses Decadron (Merck & Co., Whitehouse Station, NJ) and Zofran (GlaxoSmithKline, Boston)

SOURCES

For more information on outpatient mastectomy, contact:

- **Lillie Shockney**, RN, MAS, Director of Education and Outreach, The Johns Hopkins Breast Center, 601 N. Caroline St., Room 8031A, Baltimore, MD 21287. Telephone: (410) 614-2853. Fax: (410) 614-1947. E-Mail: shockli@jhmi.edu.
- **Lee Gravatt Wilke**, MD, Assistant Professor of Surgery, Duke University Health System, Medical Officer, American College of Surgeons Oncology Group. Telephone: (919) 660-2244. Fax: (919) 660-2255. E-mail: wilke031@mc.duke.edu.

intraoperatively, which reduces post-surgical nausea rates, Shockney says.

• **Include home health nursing.**

At Duke, home health nursing follows up with patients in the 48-hour post-op period to ensure proper drain care and pain control, Wilke says.

Johns Hopkins also uses home health nurses, as well as a survivor volunteer who had the same procedure in the past, Shockney says. Volunteers provide one-on-one support emotionally to women from diagnosis through the treatment process, including surgery, she says.

They discuss their own experiences, including their surgery, Shockney says. "Some even come in on the day of surgery to be with the patient," she adds.

Also, a survivor volunteer comes in twice a month on heavy surgery days to help see the patients off to surgery and greet them in the recovery room, Shockney says.

Overall, providers speak highly of outpatient mastectomies. "Through education, accurate patient assessment, and close follow-up, I believe a proportion of the patients receiving mastectomy can be discharged to their own home and environment with family to recover safely," Wilke says.

"Patient safety comes first, and it is the responsibility of the surgeon to accurately assess each patient's capabilities to recover successfully from an operation," she adds. **(For more information, see "Outpatient mastectomy push stirs debate," *Same-Day Surgery*, August 1997, and "Outpatient mastectomies: What makes them work?" *SDS*, September 1997.)**

Reference

1. Press release from Rep. Rosa DeLauro (D-CT). Agassi, Landrieu, and Delauro team up to protect breast cancer patients. Sept. 25, 2003. Web: www.house.gov/delauro/press/2003/Breast_Cancer_9_25_03.html. ■

Same-Day Surgery Manager

Flying first class isn't always an option

By **Stephen W. Earnhart**, MS
President and CEO
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Austin, TX

During a routine process and operational audit of a hospital facility last month, we discovered an interesting situation. The supply cost and personnel cost for most ambulatory surgery cases exceeded the reimbursement by 30%. That did not take into account the fixed or variable expenses and profit margin. The more surgery the hospital did, the more money they lost. This revelation was particularly disturbing to the chief financial officer of the well-known facility who thought there was a significant profit on these cases.

What were the symptoms? A nagging sense of doom by the nurse manager. Her concerns were the increased use of expensive supplies on cases and the increasing use of endoscopies for hernia and carpal tunnel cases. As it turns out, she was right to be concerned. As managers and administrators of health care facilities, we need to realize that no one is going to pay us for the high-tech toys and cool procedures we do anymore. It's sad, but it's just not going to happen. So . . . who is going to tell the surgeon?

The facts are that big business (who pays for all of health care) just isn't willing to pay for all the new technology, regardless of how much better it is for the patient. We can argue the point to death or deal with it. From a practical standpoint, we need to deal with it.

First, it is definitely time to separate inpatient from outpatient services. We cannot afford to have the same staffing levels and mindset that we have for inpatient cases. There are two classes of service now. If you want to fly first class on an airplane, you pay more. Inpatient is now the first-class flyer, and ambulatory is for those flying coach. Consider these specific differences:

• **Technology.** It has to change. We really do not need two or three monitors in each operating room to do an incisional hernia repair.

• **Supply cost.** It's time to sit down with the surgeons and explain that we need to reduce as much as we can on their preference cards. We cannot afford everything listed there. You may be afraid you're going to push them out the door to a freestanding center. However, if they do leave, they are going to find out that everything you are trying to accomplish is what the for-profit centers have been doing for years. Surgeons are going to have to come around and understand that we as

facilities can do only so much.

• **Staffing.** We are treating ASA 1 and 2 patients for the most part. You do not need the same staffing levels for this class of patients. You can be proactive, or let a company like mine come in and tell you to cut back, but someone is going to do it eventually.

• **Contracting.** It's time to "beat up" the people who negotiate your contracts. There's not much you can do about federal programs, but your commercial payers need to come around.

• **Mentality.** I can tell you from experience that the most difficult roadblock ahead will be your own staff. As health care providers, especially not-for-profit hospitals, it is difficult for staff to understand the economics of doing without, especially when it comes to denying the patient. As much as we would all like to fly first class, the fact is, we cannot always afford it.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 8303 MoPac, Suite C–146. Austin, TX 78759. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

HIPAA Q & A

[Editor's note: This column addresses specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to Sheryl Jackson, Same-Day Surgery*, Thomson American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: How should a same-day surgery program proceed if a patient agrees with only portions of the privacy notice?

Answer: "A patient does not agree or disagree with the Notice of Privacy Practices," says **John C. Gilliland II**, an Indianapolis attorney. "It is a notice of the provider's privacy practices, not something to which a patient must agree."

The provider must give a copy of its Notice of Privacy Practices to the patient and attempt to obtain the patient's written acknowledgment that he or she received it, he says. If the written acknowledgment cannot be obtained, the provider must document the efforts it made to obtain the patient's acknowledgment and why the acknowledgement was not obtained, he adds. The form that the patient is asked to sign is an acknowledgment of receipt of the privacy notice, not of agreement or understanding, he adds.

Question: When a patient asks a same-day surgery program to restrict the disclosure of information beyond that provided in the program's privacy notice, does the same-day surgery program have to comply?

Answer: "No, the provider does not have to comply," says Gilliland. An individual has the right to request restriction on the use and disclosure of his or her protected health information, he points out. However, the provider does not have to comply, if the patient's request goes beyond the program's normal disclosure restriction, he adds.

Question: Can a same-day surgery program post thank-you letters from patients on a bulletin board that can be seen by staff and other patients?

Answer: "In my opinion, they cannot post the letters unless the letters are de-identified so they no longer constitute protected health information," says Gilliland. "De-identification" is a process under the privacy rule by which health information is made to no longer be individually identifiable, he explains. "Typically, it requires removing all of 18 identifiers stated in the privacy rule including names, geographic subdivisions smaller than a state, most zip codes, telephone numbers, and medical record numbers," he says.

Question: If a same-day surgery program regularly keeps a chart by the patient's bedside during the preoperative period, does that violate HIPAA regulations?

Answer: There is nothing wrong with keeping the chart by the patient's bedside during the preoperative period, but reasonable efforts should be taken to avoid incidental disclosure on information in the chart to nonstaff who might be in the area, Gilliland explains.

"If nonstaff are not in the area, then it's not a problem at all," he points out. "If nonstaff may be in the area, reasonable steps to avoid incidental disclosures could be as simply as having a blank cover sheet over the chart that must be lifted to read information on the chart." ■

SOURCE

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Hospital OPPS receives 4.5% rate increase

Medicare has published a rule for hospital outpatient prospective payment system (OPPS) services that will increase rates in the aggregate by 4.5%, according to an initial analysis by the American Hospital Association. The rule was published in the Nov. 7 *Federal Register* and takes effect Jan. 1.

The changes omit a prorated reduction in pass-through rates for new technology drugs and devices, create two outlier thresholds and two outlier payment pools, and lower the threshold used to determine when drugs are paid separately from $150 to $50, the association said.

In its proposed rule, the agency had projected a 3.8% aggregate increase.

To access the rule, go to: www.cms.gov/regulations/hopps/2004f/. ■

Findings debated from specialty hospital report

The findings of a new report on specialty hospitals are being debated by outpatient surgery experts who are drawing lines in the sand over whether the hospitals are a good idea.

Specialty hospitals, such as surgical hospitals, are controversial because they are often for-profit and sometimes owned, in part, by physicians who work in them, the General Accounting Office (GAO) said in its report, *Specialty Hospitals — Geographic Location, Services Provided, and Financial Performance.* The surgical hospitals studied derived most of their revenues from outpatient services, the agency said.

The report is good news for those facilities and bad news for those lobbying to limit their development, says **Eric Zimmerman**, JD, partner with McDermott, Will & Emery in Washington, DC.

"GAO found insignificant differences — and with respect to some topics, no differences — between specialty hospitals and community hospitals," he says.

Interestingly, the GAO found that average for-profit specialty hospitals have lower profit margins that for-profit general acute care hospitals, Zimmerman says.

"This finding debunks assertions that specialty hospitals are cherry-picking healthy patients or somehow profiting unreasonably off of the Medicare system," he says.

The report found that physicians combined ownership tended to be about 70% at surgical hospitals. The percentage of admitting physicians who were investors was about 44% at surgical hospitals. The GAO found that referral patterns between owners and nonowners were indistinguishable, Zimmerman says.

The American Surgical Hospital Association in San Diego noted the GAO reported more admissions come from physicians who are not investors in specialty hospitals. "This disproves the notion that the only motivation for physicians to use specialized hospitals is financial," the association said in a statement. "This key finding should finally put to rest the overused argument from general hospitals that physicians have a conflict of interest."

The report said Medicare records indicate that there were 16 surgical hospitals in 2001, and 17 surgical hospitals are under development.

"I think that this report should send Congress a message that constraining physician ownership in specialty hospitals at this time would be grossly premature," he says.

At press time, the House and Senate were considering a conditional temporary moratorium on building new specialty hospitals owned by physicians. The moratorium would be in place while the Medicare Payment Advisory Commission (MedPAC) studies the impact of specialty hospitals on community hospitals. Exemptions probably would be provided if the specialty hospitals have an emergency department, the hospital is

EXECUTIVE SUMMARY

The findings in a new report from the General Accounting Office on specialty hospitals are being interpreted in conflicting ways.

- Supporters point to the finding that average for-profit specialty hospitals have lower profit margins that for-profit general acute care hospitals. Also, the report says referral patterns between physician owners and nonowners were indistinguishable.
- Critics highlight the report's finding that specialty hospitals locate in areas with the greatest profit and growth potential and they serve significantly fewer Medicaid patients than general hospitals. Also, overall, specialty hospitals enjoy an average margin of 6.4%, more than double that of all general hospitals (3.1%).

SOURCES

For more information on the report, contact:

- **American Surgical Hospital Association**, P.O. Box 23220, San Diego, CA 92193. Telephone: (858) 490-8085. Fax: (858) 490-9016. E-mail: info@surgicalhospital.org.
- **Eric Zimmerman**, McDermott, Will & Emery, 600 13th St. N.W., Washington, DC 20005. Telephone: (202) 756-8148. Fax: (202) 756-8087. E-mail: ezimmerman@mwe.com. Web: www.mwe.com.

accredited by the Joint Commission on Accreditation of Healthcare Organizations, and physician-owners disclose their ownership interest to patients.

For its part, the American Hospital Association (AHA) found some concerns in the report, such as the findings that specialty hospitals locate in areas with the greatest profit and growth potential and they serve significantly fewer Medicaid patients than general hospitals. Also, the AHA story pointed out that comparing all facilities, including not-for-profit, showed that specialty hospitals enjoy an average margin of 6.4%, more than double that of all general hospitals (3.1%).

The report "further confirms that specialty hospitals are a drain on the general hospitals that provide vital patient services to all in their community," said **Rick Pollack**, AHA executive vice president.[1]

He urged Congress to adopt the Breaux-Nickles-Lincoln amendment to the Medicare prescription drug bill that would prohibit physicians from referring patients to specialty hospitals in which they have an ownership interest.

"If left unchecked, the rapid growth of these hospitals will undermine access to a wide array of health services for patients across the country," he said.[1]

[Editor's note: General Accounting Office (GAO) documents are available free at www.gao.gov. Click on "GAO Reports," and "Find GAO Reports." Click on "GAO Reports" and search for "GAO-04-167."]

Reference

1. American Hospital Association. AHA: GAO report 'further confirms' need for Medicare bill amendment. *AHA News Now,* Oct. 22, 2003. ■

Be cautious with SARS, some patients need mask

Draft guidelines address respiratory symptoms

Even if there are no cases in the world of severe acute respiratory syndrome (SARS), you still should encourage patients with respiratory symptoms to wear a surgical mask, according to the Centers for Disease Control and Prevention's draft *Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)*.

Patients with respiratory symptoms should be moved to a private exam room "as soon as feasible," the guidance states. When there are SARS cases worldwide, but no known transmission in your area, screen all patients and visitors with respiratory symptoms for known SARS epidemiologic links, such as travel to endemic areas or contact with known cases, it adds.

The full guidance, dated Oct. 21, 2003, can be downloaded free at www.cdc.gov/ncidod/sars/sarsprepplan.htm. For recommendations specific to outpatient areas, click on "Supplement C: Preparedness and Response in Healthcare Facilities" and scroll down to p. 27: "Matrix 2: Recommendations for Outpatient Facilities/Areas." ■

SARS audio program updates guidelines

Leading epidemiologists say a global return of severe acute respiratory syndrome (SARS) — which wreaked havoc on the health care systems that had to deal with it — is almost inevitable. The current overriding concern is that SARS will resurface as a seasonal illness along with influenza and other respiratory infections.

Indeed, it would be a surprising development if the emerging coronavirus did not return, said **Julie Gerberding**, MD, MPH, director of the Centers for Disease Control and Prevention (CDC).

"As an infectious disease expert, I can say in my experience, I've never seen a pathogen emerge and go away on its own," she said. "I think we have to expect that somewhere, some time, this coronavirus is going to rear its ugly head again; and that's the whole purpose of all this preparedness effort."

What would happen *today* if a patient with suspect or probable SARS showed up at your facility? To help you prepare for the threat, Thomson American Health Consultants offers the upcoming audio conference: **The Resurgence of SARS: Why Your Hospital May Not Be as Prepared as You Think**, on Dec. 9, from 2:30-3:30 p.m. ET. Let our experts help you answer that and many other critical questions with practical tips and solutions to detect first cases and protect other patients and health care workers.

Speakers include **Allison McGeer**, MD, director of infection control at Mount Sinai and Princess Margaret Hospitals in Toronto. A veteran epidemiologist, McGeer dealt firsthand with SARS patients and occupationally infected workers during the prolonged outbreak in Toronto. Hear the lessons learned by somebody who has dealt with this novel emerging pathogen on the front lines.

If SARS returns, health care providers certainly will be on those front lines. To provide valuable guidance and critical insight, **Susan E. Shapiro**, PhD, RN, MSN, CEN, will outline valuable tips and procedures, in addition to addressing and clarifying recently updated CDC recommendations for SARS. Shapiro is a postdoctoral fellow in risk assessment and intervention research with individuals and families at Oregon Health and Science University School of Nursing in Portland.

A career ED nurse and nurse manager before recently completing a doctoral program, Shapiro is the Emergency Nurses Association's representative to the CDC's SARS task force. Educate your entire staff for one low fee including 1 hour of CE, CME, or critical care credits for all attendees. You may invite as many participants as you wish to listen for the low fee of $249.

Information on obtaining audio conference instructions and continuing education forms will be in the confirmation notice, which will be mailed upon receipt of registration. Your fee also includes access to a 48-hour replay following the conference and a CD recording of the program. For information or to register, call customer service at (800) 688-2421 or contact us via e-mail at customerservice@ahcpub.com. When ordering, please refer to effort code **35281**. ■

Adverse events associated with stent

The Food and Drug Administration (FDA) has received more than 290 reports of thrombosis associated with a drug-coated stent approved in April for angioplasty. The clotting is occurring one to 30 days after implanting the Cypher Coronary Stent, manufactured by Warren, NJ-based Cordis Corp. In more than 60 of the reports, the patient died, according to the FDA. The cause of the adverse events has not been determined.

Also, the FDA has received more than 50 reports, including some deaths, of possible hypersensitivity reactions to the stent. The symptoms include pain, rash, respiratory alterations, hives, itching, fever, and blood pressure changes. The FDA is encouraging clinicians to follow the instructions for use of the stent and urging them to be vigilant for any patient symptom that may be attributed to hypersensitivity. Clinicians who have experienced an adverse event related to the stent are encouraged to report the incident to the FDA.

Reports may be made one of four ways: on-line at www.accessdata. fda.gov/scripts/medwatch/; by telephone at (800) FDA-1088; by fax at (800) FDA-0178; or by mail to MedWatch, FDA, HF-2, 5600 Fishers Lane, Rockville, MD 20857. For more information, go to the web site: www.fda.gov/bbs/topics/ANSWERS/2003/ANS01257.html. ■

CE/CME instructions

Physicians and nurses participate in this CE/ CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. **After completing this semester's activity with this issue,** you must complete the evaluation form provided and return it in the reply envelope. When the evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Tips on improving your procedure times
- Suggestions on designing effective passwords
- Surveyors take close look at endoscopy
- Cost-containment ideas that work
- Innovative staffing ideas for same-day surgery

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management.
- Describe how those issues affect clinical service delivery or management of a facility. (See *"$19 million judgment highlights need to monitor for post-op complications"* and *"Be cautious with SARS, some patients need mask,"* in this issue.)
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts. (See *"Place anesthetic in wound during recovery to cut pain"* and *"HIPAA Q&A."*)

CE/CME *questions*

If you have any questions about this testing method, please contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

21. How can a nurse in the recovery area tell whether a patient's pain is excessive and may be caused by a complication, according to Paula R. Graling, RN, MSN, CNS, CNOR, clinical nurse specialist in perioperative services at Inova Fairfax Hospital?
    A. The patient rates the pain a 10 on a 1-10 scale.
    B. The patient doesn't want to go home.
    C. The patient has pain in his or her shoulder.
    D. The pain is unrelieved with normal pain medication.

22. What has Stephen E. Zimberg, MD, gynecological surgeon at the Cleveland Clinic, discovered about his abdominal hysterectomy patients for whom he used in-the-wound pain control?
    A. They use less narcotic oral medication to control post-surgical pain.
    B. They don't like wearing the pump on their clothing.
    C. The cost of care does not change significantly.
    D. There is no difference in pain control as compared to traditional medications.

23. Which of the following statements is true regarding the Health Insurance Portability and Accountability Act, according to John C. Gilliland II, an attorney?
    A. A patient must agree or disagree with the Notice of Privacy Practices.
    B. A patient must sign a statement saying he or she agrees with the Notice of Privacy Practices.
    C. A patient does not agree or disagree with the Notice of Privacy Practices.

24. Even if there is no cases in the world of severe acute respiratory syndrome (SARS), you still should take what precaution with patients who present with respiratory symptoms, according to the Centers for Disease Control and Prevention's draft *Public Health Guidance for Community-Level Preparedness and Response to SARS?*
    A. Send patient with respiratory symptoms to the nearest emergency department.
    B. Ask every patient if he or she has traveled to an endemic area or had contact with a known case.
    C. Encourage patients with respiratory symptoms to wear a surgical mask.
    D. No precautions are necessary.

Answer Key: 21. D; 22. A; 23. C; 24. C

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