The AANA Supports the FTC’s Letter to the Alabama Medical Board

On Feb. 18, 2011, AANA President Paul Santoro, CRNA, MS, sent a letter to the Federal Trade Commission (FTC) expressing support for the FTC’s comments and analysis submitted to the Alabama State Board of Medical Examiners (medical board) dated Nov. 3, 2010. Significantly, the FTC’s Office of Policy Planning, Bureau of Economics, and Bureau of Competition urged the medical board to reconsider the proposed rule that would have prohibited all interventional pain management services by all healthcare professionals who are not medical doctors or doctors of osteopathy. The FTC stated, "Unnecessary restrictions on the ability of physicians to provide pain management services in collaboration with CRNAs are likely to reduce the availability, and raise the prices, of pain management services in Alabama." The medical board ultimately tabled the rule after receiving numerous letters of opposition, including the FTC’s letter. For additional information click here.

February 28, 2011

Upcoming Events

For the latest AANA News, visit the AANA Facebook page and follow "aanawebupdates" on Twitter

April 10-13, 2011: Mid-Year Assembly
August 6-10, 2011: AANA 78th Annual Meeting

Dates to Remember

March 15, 2011: Agatha Hodgins Award for Outstanding Accomplishment Deadline
March 15, 2011: Helen Lamb Outstanding Educator Award Deadline
March 15, 2011: Alice Magaw Outstanding Clinician Practitioner Award Deadline
March 15, 2011: The Ira P. Gunn Award for Outstanding Professional Advocacy Deadline
March 15, 2011: Clinical Instructor of the Year Award Deadline
March 15, 2011: Didactic

Healthcare Headlines

Healthcare Headlines is for informational purposes, and its content should not be interpreted as endorsements, standards of care, or position statements of the American Association of Nurse Anesthetists.

- Research Yields Potential Breakthrough in Local Anesthesia
- Study Shows Extended-Release Anesthetic Is Safe, Effective
Inside the Association

Hot Topics

COA to Begin Major Revision of Accreditation Standards

The Council on Accreditation of Nurse Anesthesia Educational Programs (COA) will begin a major revision of the Standards for Accreditation of Nurse Anesthesia Educational Programs in 2011. A major revision of the Standards is a multiyear process. There are several opportunities for the community of interest to review and comment on the draft Standards during development through hearings and calls for comment. The community of interest is composed of individuals directly affected by nurse anesthesia education and/or practice, including nurse anesthesia students, faculty, practitioners, patients, employers, institutions, the public, and the higher education community. Notices of hearings and calls for comment will be published in the AANA NewsBulletin and posted on the COA website. Questions may be directed to the COA at accreditation@aana.com or (847) 655-1160. COA accreditation supports high-quality nurse anesthesia educational programs through quality assessment and improvement.

AANA® Continuing Education Course Renewed

“Neuroimmune Activation and Chronic Pain,” one of the most popular AANA® courses, has been renewed and is now available for a limited time in the Sales Catalog at the special reintroduction price of $14 for AANA members. Prepared by Charles Griffis, CRNA, PhD, the content complements his February 2011 AANA Journal article [2011; 79(1):31-37]. As always, the course requires completion of content, exam, and evaluation to receive the CE credit. Visit www.aanalearn.com and start preparing now for your 2011 recertification. Earn your credits where you want, when you want, and have them ready for you when you need them!

Federal Government Affairs and PAC

House OKs Spending Cuts Package, Including Title 8 Nurse Workforce Cuts

A package to continue funding the federal government beyond the March 4 expiration of the current “continuing resolution,” packaged with $62 billion in spending cuts including a one-fifth reduction in funding for health professions and nurse workforce programs, cleared the U.S. House of Representatives on a 235-189 party-line vote. The House package would reduce many programs to FY 2008 levels and would cut Title 7 health professions and Title 8 nurse workforce funding by $145.1 million in the current FY 2011, compared with the president’s FY 2011 budget request of $386.1 million. Nurse anesthesia educational...
programs apply to Title 8 nurse workforce development grant programs to help support program establishment and expansion and nurse anesthetist traineeships. The AANA joined the broad-based Nursing Community in writing to the bipartisan House leadership, urging against cutting nurse workforce development and nurse anesthesia educational program faculty members called their U.S. representatives, urging opposition to Title 8 program cuts. To be enacted into law, the bill (H.R.1) must also be cleared by the U.S. Senate. Ultimately, both chambers of Congress must agree on a package of budget extensions for President Obama to sign into law for federal services to continue uninterrupted. Read the House-passed bill at http://thomas.loc.gov/cgi-bin/bdquery/z?d112:h.r.00001. See how U.S. Representatives voted at http://clerk.house.gov/evs/2011/roll147.xml.

Committee Clears Medical Liability Reforms for House Floor Action

On Feb. 16, the House Judiciary Committee approved comprehensive medical liability reform legislation that caps noneconomic damages at $250,000. Sponsored by Rep. Phil Gingrey (R-GA), an obstetrician-gynecologist, H.R.5 (the HEALTH Act) awaits action on the floor of the U.S. House of Representatives, likely in March. Knowing the importance of medical liability coverage to CRNAs, the AANA has supported medical liability reform in the past and continues to monitor the issue closely. Adopted on a party-line 18-15 vote in committee, H.R.5 was the subject of some amendments. One amendment to repeal the McCarran-Ferguson antitrust exemption for health insurers failed on a 13-13 tie vote. An amendment by Rep. Bobby Scott (D-VA) striking the collateral source rule provision (regarding other sources of liability coverage) from the bill (Sec. 6 of H.R.5) was accepted by voice vote. An amendment by Rep. Bobby Scott (D-VA) striking the collateral source rule provision (regarding other sources of liability coverage) from the bill (Sec. 6 of H.R.5) was accepted by voice vote. Read H.R. 5 at http://thomas.loc.gov/cgi-bin/query/z?c112:H.R.5:

AANA Completes Federal Political Leadership Conference

At the semiannual Federal Political Leadership conference, held Feb. 18-20 in Phoenix, Ariz., AANA federal political directors (FPDs) learned about current federal issues in nurse anesthesia and developed plans to spur federal advocacy organization of the profession of nurse anesthesia in every state. Each state association of nurse anesthetists names an FPD, whose primary volunteer duty is to coordinate and activate effective relationships between AANA members in each congressional district with their members of the U.S. House of Representatives and the U.S. Senate. With more than 90 new U.S. representatives and more than a dozen new U.S. senators taking office in 2011, the FPDs' role in identifying and mobilizing CRNAs to build and sustain these critical professional relationships takes on new importance this year. Between now and the AANA Mid-Year Assembly in April, FPDs will be coordinating AANA members' meetings with members of Congress in Washington, D.C. Speakers at the conference included Patti Bright, CRNA, MS (Va.); Sarah Figueroa, CRNA, DNAP (Colo.); Andrew Griffin, CRNA, PhD (III.); Keith Mackssoud, CRNA, MA (R.I.); Steven Mund, CRNA, MS, MAJ, USAR (Minn.), on behalf of the CRNA-PAC Committee; Brad Fitch of the Congressional Management Foundation; Bruce Merrill, PhD, from Arizona State; and members of the AANA Federal Government Affairs staff.

HHS Announces $225 Million Medicare Anti-Fraud Sweep

The Department of Health and Human Services (HHS) announced on Feb. 17 that the Medicare Fraud Strike Force charged 111 defendants in nine cities, including doctors, nurses, healthcare company owners and executives, and others, for alleged participation in Medicare fraud schemes involving more than $225 million in false billing. The joint Department of Justice (DOJ)-HHS Medicare Fraud Strike Force is a multi-agency team of federal, state, and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques. In addition to making arrests, agents also executed 16 search warrants in various states in connection with ongoing Medicare fraud investigations. Since its creation in 2007, the Medicare Strike Force operations have charged close to 1,000 people with falsely billing the Medicare program for more than $2.3 billion. In many of the most recent cases, indictments and complaints allege that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or never provided. For more information, read the HHS press release.
Budget Proposal Provides Two Years of Relief from Medicare Cuts

President Obama’s 2012 budget proposal issued Feb. 14 totals $3.7 trillion, including a deficit of $1.1 trillion, provides two years of relief from huge Medicare Part B payment cuts to CRNA and physician payment, and modestly boosts Title 8 nurse workforce development programs. Congress determines actual government spending through FY 2012 through enactment of appropriations and other legislation. Thus far the administration’s proposals have received a chillier welcome in the GOP-controlled House than in the Democratic-majority Senate. Of specific interest to CRNAs:

- **Medicare Part B CRNA and physician payment.** According to the administration’s Department of Health and Human Services budget documents, the administration proposes reversing an estimated 30 percent Medicare Part B payment cut taking place Jan. 1, 2012, and additional cuts the following year, "with $62 billion in new, specific healthcare savings, including recommendations from the Fiscal Commission and recent bipartisan proposals, that will strengthen program integrity and increase efficiency and accountability."

- **Title 8 nurse workforce development programs** would receive $333 million in FY 2012, up $43 million from current levels, though total funding for the Health Resources and Services Administration is proposed to be reduced by $685 million. The president’s budget proposes $104.4 million for Advanced Education Nursing, the federal program that helps fund nurse anesthesia educational program establishments and expansions and nurse anesthetist traineeships.

- **Medical liability reforms** are proposed in the President’s FY 2012 budget, as they were indicated in his January State of the Union address. Details of the reforms will come later.

- **Safe injection practice proposals** that the AANA has supported in the past get attention in the president’s FY 2012 budget for the Centers for Disease Control and Prevention (CDC). According to the budget proposal, the CDC will “(s)upport the Health Care Infection Control Practices Advisory Committee Federal Advisory Committee Act; HAI disease outbreak and epidemiological investigations; HAI disease epidemiology and laboratory programs; safety of blood, organ, and other tissues; patient safety; and injection safety.”

House and Senate budget and appropriations committees have begun holding hearings on the President’s budget. For more information on the President’s FY 2012 Budget Request see: http://www.whitehouse.gov/omb/budget, the health budget, more about the health budget, and the HRSA budget (see page 19 for nurse workforce development).

FDA Seeking a Sodium Thiopental Source

In a reply to the AANA on Feb. 11, the Food and Drug Administration (FDA) said that it notes the Association’s concerns with the supply of sodium thiopental but has not yet found a new manufacturer to make the drug available in the United States. CRNAs and other anesthesia professionals use sodium thiopental for the induction of general anesthesia, and the shortage of propofol has driven recent increases in its use. In its response, the FDA noted that it agrees that sodium thiopental is a medically necessary drug, and it shares the AANA’s concern about the unavailability of sodium thiopental for anesthesia use. The agency said it had been working with Hospira to return as a supplier of the drug to the U.S. market, but the agency has “not been able to find a manufacturer willing and able to import this drug for medical use.” "If there does become a manufacturer interested in making sodium thiopental available for the anesthesia use, the FDA will be glad to work with the manufacturer on making a safe, effective, and quality drug available so that U.S. patients are not put at risk,” the agency stated to the AANA in response to the Association’s Jan. 31 request. For more information, read the AANA’s Jan. 31 letter to FDA and FDA Drug Shortage and Medical Device Recall Information (both links require AANA login and password).

AANA Seeks Examples of Innovative Practice Models

The AANA Federal Government Affairs Division seeks your help in identifying innovative models of care where CRNAs have participated in change processes that have proven to reduce costs and improve quality. Your involvement may have ranged from participant to lead investigator. We are looking for examples that address:
• Improving transition of care from one setting to another (e.g., early discharge following ambulatory surgery; reduced hospital readmission or emergency room visits due to reduction in postoperative pain or nausea).
• Improving coordination of care (e.g., medication reconciliation; coordination of care between operating room and intensive care unit).
• Reducing the incidence of hospital-acquired conditions (e.g., manifestations of poor glycemic control, surgical site infections following coronary artery bypass grafting, orthopedic procedures, or bariatric surgery).
• Preventing hospital readmissions (e.g., reduced hospital readmission or ER visits due to reduction in postoperative pain or nausea).

We will share this information with the Center for Medicare and Medicaid Innovation (CMMI), which at a recent meeting had urged the AANA to provide examples of innovative care models. Created under Section of 3021 of the Affordable Care Act, the CMMI is charged to develop, deploy, evaluate, and scale up healthcare payment models and delivery care models that ultimately reduce costs and improve quality of care. We encourage you to submit your projects regardless of size and scope, and would appreciate any data that you could share with us. Please send your information to info@aanadc.com with the subject line: CMMI Innovative Models of Care.

Court Decisions on Health Reform’s Constitutionality Headed for Appeals; Implementation Continues

U.S. District Court Judge Roger Vinson of the Northern District of Florida ruled on Jan. 31 that the entire healthcare overhaul is unconstitutional, but he stopped short of ordering the federal government to stop implementing it. He ruled that Congress overstepped its legal bounds when it included the provision requiring nearly all Americans to buy insurance. Because the individual mandate provision is key to the rest of the law, he declared the whole law unconstitutional. In his ruling, Judge Vinson said that the law's requirement to carry insurance or pay a fee "is outside Congress' Commerce Clause power, and it cannot be otherwise authorized by an assertion of power under the Necessary and Proper Clause. It is not constitutional." The ruling also said that entire law "must be declared void," because the mandate to carry insurance is "not severable" from the rest of the law. The Vinson ruling differs from an earlier ruling against the law by U.S. District Judge Henry E. Hudson in Virginia. Judge Hudson found that the individual mandate was unconstitutional, but said his ruling applied only to the part of the law that established the mandate and any directly dependent provisions that refer to that part. The ruling is the fourth federal court ruling on health reform; two federal courts have ruled the law is constitutional. These federal cases, including the Florida case, which consolidates 26 states’ challenges to the law, are headed to appeals and will probably land in the U.S. Supreme Court. In the meantime, the administration will continue implementing the law. For more information, read a link to the ruling, an article from The Washington Post, and an article from Politico.

AANA Advises FDA How to Evaluate Sedation Drugs and Devices

In response to the Food and Drug Administration's (FDA's) Request for Assistance (RFA) published in the Federal Register the AANA submitted comments on Jan. 28 regarding how the agency evaluates sedation drugs and devices. As part of the RFA, the FDA "is inviting any interested party, or parties, to facilitate an evaluation of critical fundamentals of the science related to sedation products by conducting and managing a coordination of activities that will bring together experts in the field, including from academia, patient organizations, and industry," and requesting that these parties hold public meetings to discuss these issues. The AANA responded in its comment letter that it is discussing the development of such a forum with the American Society of Anesthesiologists. In the letter signed by President Paul Santoro, CRNA, MS, the AANA also recommended that "the FDA remove MAC [monitored anesthesia care] from the concept of sedation so that the terms are not used interchangeably."

AANA Participates in AARP Champion Nursing Council Conference on Implementing IOM “Future of Nursing” Recommendations

Members of the AANA Federal Government Affairs team participated in the AARP...
**Champion Nursing Council** and **Champion Nursing Coalition** meetings on Jan. 31 in Washington with an eye toward promoting implementation of the recent Institute of Medicine (IOM) report, “**The Future of Nursing: Leading Change, Advancing Health**.” Represented by AANA Deputy Executive Director Christine Zambricki, CRNA, MS, FAAN, and Associate Director, Federal Government Affairs Ann Walker-Jenkins, the Association participated in discussions with consumer groups, health industry representatives, and employer organizations, to see how promotion and adoption of the IOM’s recommendations could improve healthcare and help decrease costs.

**Return to Headlines**

**AANA Foundation and Research**

**Friends for Life Deadline – June 15, 2011**

Friends for Life help support the future of the nurse anesthesia profession through meaningful, lasting gifts. Gifts through Friends for Life help fund and sustain programs that further research and education in anesthesia. Members of Friends for Life receive a medallion at the Annual Meeting Opening Ceremonies, an engraved plaque in the AANA Park Ridge office, and an invitation to the Annual Awards and Recognition Dinner. The minimum gift commitment to join Friends for Life is $25,000. Members may fulfill this commitment through a cash gift, but there are many other ways to meet the commitment through planned gifts. Some of the most popular planned gift options for becoming a Friend for Life include:

- A gift (bequest) in the will for a specific amount or a percentage of the total estate
- Gift of personal property or real estate
- Including the Foundation as a beneficiary on a retirement plan or a whole life insurance policy

For further information, please contact Nat Carmichael at (847) 655-1175 or by email at ncarmichael@aana.com. The Friends for Life submission deadline for recognition at this year’s Annual Meeting in Boston is June 15, 2011.

**Return to Headlines**

**News from the NBCRNA**

**NBCRNA Item Writer Workshop – Practitioners Wanted!**

The National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA) is hosting the next Item Writer Workshop in Chicago, Ill., on June 24-25, 2011. This workshop provides information that will help item writers and reviewers develop sound test items. The interactive format allows participants to learn item writing techniques from experienced examination committee members and to practice writing questions in small-group sessions. Nurse anesthetists who write questions for the National Certification (NCE) and Self-Evaluation (SEE) examinations will help facilitate the work of the groups.

Traditionally, this workshop has been offered to educator members every other year at the Assembly of School Faculty. While the NBCRNA welcomes educators for the June 2011 workshop, practitioner members are also encouraged to apply. The item writer workshop has traditionally been a prerequisite for membership on the NCE or SEE examination committees. Those interested in serving the profession in this capacity are encouraged to attend while having the opportunity to earn CE credits.

Visit the NBCRNA website at [www.nbcrna.com](http://www.nbcrna.com) to submit an application. Space is limited to 25 attendees. Application deadline: March 31, 2011. Contact the NBCRNA with questions at (866) 894-3908.

**Ohio Board of Nursing Policy Changes**
The National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA) is aware of the changes in Ohio Board of Nursing (OBN) policy regarding primary source verification for advanced practice nurse national recertification. As a result, the NBCRNA will provide this information to the OBN automatically during the recertification period. Contact the NBCRNA at (866) 894-3908 with questions.

Jobs

Visit the CRNA Career Center.

Healthcare Headlines

Research Yields Potential Breakthrough in Local Anesthesia

A collaborative effort between U.S. and Chilean researchers promises to provide relief to surgical patients through the use of a new, longer-acting local anesthetic. Children's Hospital Boston has teamed up with Proteus, a biotech startup in Chile, to help advance the drug—known as neosaxitoxin (neoSTX)—toward the market. The hospital was a co-investigator in a double-blind, randomized trial that demonstrated that patients experienced notably less pain and faster recovery when administered neosaxitoxin, which is derived from algae. Currently, local anesthetics last only about eight hours or less; and patients typically need opioid analgesics once they wear off. Because the analgesics have side effects such as sedation, nausea, shallow breathing, constipation, itching, and sleepiness, recovery sometimes is delayed and can result in a longer hospital stay. The trial included 137 patients in Chile who were having laparoscopic removal of their gallbladders. At both 12 hours and 24 hours, significantly fewer patients in the neoSTX group reported severe postoperative pain at the incision site. Patients in the neoSTX group also reported full functional recovery about two days earlier than in the control group. The trial will be published in the March-April issue of *Regional Anesthesia and Pain Medicine*.

From "Research Yields Potential Breakthrough in Local Anesthesia"
*Nurse.com* (02/23/11)

Study Shows Extended-Release Anesthetic Is Safe, Effective

A phase III clinical trial shows that Exparel, an experimental extended-release version of an approved local anesthetic, is safe and effective for patients recovering from bunion surgery, reports Pacira Pharmaceuticals. This drug candidate combines the anesthetic bupivacaine (Marcaine and Sensorcaine) with DepoFoam, Pacira's product developed to hold medicine inside microscopic chambers for extended release. Patients receiving Exparel required significantly fewer pain pills than patients who received a placebo, researchers reported at the annual meeting of the American Academy of Orthopedic Surgeons in San Diego. The study involved 193 patients who underwent bunion removal from their feet. Those treated with Exparel went an average 7.2 hours before having to take an opioid for pain relief, compared to an average 4.3 hours for those receiving a placebo. The U.S. Food and Drug Administration accepted Exparel for review in December and established a deadline of July 28 for marketing approval.

From "Study Shows Extended-Release Anesthetic Is Safe, Effective"
*Sign-on San Diego* (02/18/11) Darce, Keith

Anesthesia Method Matters for AV Fistula Repair

Early research results suggest that the success rate for arteriovenous fistula repair surgery, which tends to be on the low end, can be improved by using regional anesthesia for the procedure instead of general anesthesia. The team from North Carolina's Duke University School of Medicine determined that patients who received nerve blocks were five times more likely to have their fistula successfully repaired than patients who received general anesthesia. Moreover, they experienced markedly less
pain and required fewer opioid medicines after their operations; they also continued to
outperform the general anesthesia group after six months. Despite the promising
findings, the Duke team and others in the medical community acknowledged that the
small scope of the study—which involved just 16 patients—warrants further research.
"However," noted researcher Tong-Joo Gan, MD, vice chair of anesthesiology and
clinical research at Duke, "the results so far showed a remarkable trend in favor of
regional anesthesia in the success of long-term fistula function. If a similar trend
continues, we are likely to show statistical significance within the scope of the study."

From "Anesthesia Method Matters for AV Fistula Repair"
Anesthesiology News (02/01/11) Vlessides, Michael

Management of ICU Patients' Sedation Could Soon Become Automated

An automated system for the management of sedation in ICUs could be on the
horizon, thanks to work underway by researchers from the Georgia Institute of
Technology and the Northeast Georgia Medical Center. The team hopes to implement
control algorithms that will use clinical data to accurately evaluate a patient's level of
sedation and alert medical staff if there is any change. The technology could greatly
reduce the hardship of ICU nurses, who often care for several patients at once. "If we
can use control system technology to automate the task of sedation, patient safety will
be enhanced and drug delivery will improve in the ICU," according to James Bailey,
chief medical informatics officer at the Northeast Georgia Medical Center. The
researchers presented their analysis at the IEEE Conference on Decision and Control.
The study, to be published in the March issue of IEEE Transactions on Control Systems
Technology, consisted of more than 15,000 clinical measurements from 366 ICU
patients whose level of sedation was classified either as "agitated" or "not agitated."
The findings showed that 92 percent of the time, the algorithm returned the same
results as the hospital staff assessments. "Ultimately, we envision an automated
system in which the ICU nurse evaluates the ICU patient [and] enters the patient's
sedation level into a control, which then adjusts the sedative dosing regimen to
maintain sedation at the desired level by continuously collecting and analyzing
quantitative clinical data on the patient," said Wassim Haddad, a professor at the
Georgia Tech School of Aerospace Engineering.

From "Management of ICU Patients' Sedation Could Soon Become Automated"
Nurse.com (02/14/11)

Comparison Between Balanced Propofol Sedation and Conventional Sedation
for Therapeutic GI Endoscopic Procedures

A team of Korean researchers reports that balanced propofol sedation (BPS) using
propofol, midazolam, and meperidine is associated with higher healthcare provider
satisfaction and better patient cooperation compared to conventional sedation. The
study is published in GIE: Gastrointestinal Endoscopy. The study compared the safety
and efficacy of BPS with conventional sedation (midazolam and meperidine) in patients
who received therapeutic endoscopic procedures. The randomized, single-blinded trial
involved 222 consecutive patients who were referred for therapeutic
esophagogastroduodenoscopy or endoscopic retrograde cholangiopancreatography
between July 2009 and March 2010. Patients were randomly assigned to one of the
two sedation methods used. Between the two groups, there was no significant
difference in mean duration of induction, endoscopic procedures, and recovery, and no
difference in patient assessment and adverse event profiles. BPS, however, had
significantly higher healthcare provider satisfaction compared with conventional
sedation as well as better patient cooperation. Sedation nurses also reported greater
satisfaction with BPS than with conventional sedation.

From "Comparison Between Balanced Propofol Sedation and Conventional Sedation
for Therapeutic GI Endoscopic Procedures"
Medical News Today (02/17/11)

Parental Recall of Anesthesia Information: Informing the Practice of
Informed Consent
In an attempt to assess which information is important to parents with regard to their child’s anesthesia, researchers at the University of Michigan designed a study to find out. The researchers examined which information parents seek in terms of their child's anesthesia, what they were told, who informed them, and how much of the information they remembered later. Two hundred and sixty-three parents of children undergoing a variety of elective surgical procedures were included in the study. They were asked later if they remembered their child's anesthetic plan, postoperative pain management, and the related risks and benefits. In general, the researchers concluded that disclosure was often incomplete and recall by parents was poor—with more than half having no recollection of being told the risks or benefits of anesthesia and nearly 83 percent failing to recall the side effects of their child’s pain medication. When the information was given by anesthesia providers, as opposed to by surgical personnel, there was a higher rate of recall of consent information.

From "Parental Recall of Anesthesia Information: Informing the Practice of Informed Consent"
Anesthesia & Analgesia (02/11) Tait, Alan R.; Voepel-Lewis, Terri; Gauger, Virginia

Laughing Gas Returning as Option for Laboring Moms

Only two U.S. hospitals still offer nitrous oxide, or laughing gas, during childbirth, but interest in the anesthetic is on the rise. Countries such as Britain and Canada offer nitrous oxide during labor, and some other U.S. hospitals may begin to offer it. The use of nitrous oxide in the United States has been abandoned largely in favor of epidurals, which block pain more thoroughly and must be administered by an anesthesia provider. Judith Bishop, a certified nurse midwife at the University of California San Francisco Medical Center, says that the name "nitrous oxide" may put people off, thinking "that it sounds very old-fashioned and they're sure there’s something bad or dangerous about it and we must've chosen to eliminate it." Rather than eliminating pain, nitrous oxide “takes the edge off,” but advocates say it should still be offered as an option for women, especially in small or rural hospitals without readily available anesthesia providers. Nitrous oxide can be self-administered, works quickly, and is safe to use late in labor. The federal Agency for Healthcare Research and Quality is conducting a review of nitrous oxide, comparing its effectiveness and safety with other pain-relief methods.

From "Laughing Gas Returning as Option for Laboring Moms"
USA Today (02/14/11)

Acupressure Helps Reduce Pediatric Postsurgical Vomiting

According to a controlled study performed by researchers at the University of Oslo in Norway, postoperative acupressure helps prevent vomiting following pediatric tonsillectomy or adenoidectomy. The trial included 154 children who were randomized to a control group and received standard treatment. An experimental group of patients, by contrast, received acupuncture during anesthesia and afterwards were given acupressure wristbands for 24 hours in addition to receiving standard treatment. The kids in the experimental group experienced less retching and vomiting than the control group. The research indicated that adding the methods used by the experimental group to the standard treatment was successful and should encourage the implementation of acupressure for postoperative vomiting in children undergoing adenoidectomy or tonsillectomy. The trial was published in the journal Acupuncture in Medicine.

From "Acupressure Helps Reduce Pediatric Postsurgical Vomiting"
Massage Mag (02/08/11)

CMS Requires Hospitals to Report Bloodstream Infections in ICUs

On Jan. 1, 2011, a new rule from the Centers for Medicare & Medicaid Services (CMS) took effect, requiring hospitals to report the number and rate of central line-associated bloodstream infections acquired by adult patients in their intensive-care units.
Hospitals that fail to follow this rule could lose 2 percent in Medicare pay. These infections take the lives of as many as 31,000 people annually, and they have prompted the adoption of many statewide infection-control initiatives. Starting in January 2012, hospitals must also begin collecting data on surgical-site infections. The new rules involve reporting with the use of definitions and the data-submission process of the Centers for Disease Control and Prevention (CDC)'s National Healthcare Safety Network, rather than claims information, a move that many healthcare professionals support. Linda Greene, RN, a member of the Association for Professionals in Infection Control and Epidemiology's board of directors, says: "The information that will be entered into Hospital Compare is based on CDC definitions using very objective criteria." More than 3,000 U.S. hospitals participate in the CDC's National Healthcare Safety Network, and 22 states require hospitals to report infections through the network. For many of these hospitals, the new CMS rules do not require any work beyond what they have already been doing. The additional transparency required for some facilities could encourage more funding for infection prevention. Nearly 500 hospitals in 27 states are involved in the "On the CUSP: Stop BSI" project, which hopes to follow the success of Michigan's "Keystone: ICU" collaborative to cut the central-line infection rate. Measures to achieve these goals include improved hand washing, using full-barrier precautions when inserting central venous catheters, use of chlorhexidine to clean skin, avoiding the femoral site for insertion, and removing unnecessary catheters.

From "CMS Requires Hospitals to Report Bloodstream Infections in ICUs"
American Medical News (01/10/11) O'Reilly, Kevin B.


Research suggests that hospital patients are at significant risk of hospital-acquired influenza-like illness (ILI) when they are exposed to both patients and healthcare workers (HCWs) with potentially infectious ILI. Investigators estimated the relative risk (RR) of hospital-acquired ILI at a large hospital during three influenza seasons. The study data included more than 21,500 patients and some 2,100 HCWs from 2004 to 2007. For patients exposed to at least one contagious HCW, compared with those with no documented in-hospital exposure, the RR of hospital-acquired ILI was 5.48. The RR was 17.96 for patients exposed to at least one contagious patient, and it was 34.75 for patients exposed to at least one contagious patient and one contagious HCW. These "results identify priorities regarding preventive measures for seasonal or pandemic influenza," the researchers concluded.

Archives of Internal Medicine (01/24/11) Vol. 171, No. 2, P. 151 Vanhems, Philippe; Voirin, Nicolas; Roche, Sylvain; et al.

Technologies to Battle HAIs

Several technologies are available today to help hospitals better control and reduce the number of hospital acquired infections (HAIs) in their facilities. One popular technology is portable sterilization systems that can be taken to any location to sterilize rooms, surgical suites, and clinics. These devices frequently produce a gas that sterilizes hospital rooms and equipment, and many are even safe to use on electronics. Hospitals that rely on automated surveillance technology may be more likely than those that use manual surveillance to fight HAIs effectively. In findings presented at the 37th Annual Conference and International Meeting of the Association for Professionals in Infection Control and Epidemiology, statistically significant associations were recorded between adoption of automated surveillance technology and the extent to which hospitals implemented tested prevention programs for methicillin-resistant Staphylococcus aureus, ventilator-associated pneumonia, and other HAIs. With automated patient flow, clinicians can enter real-time patient information into a software system that tracks patient progress. If applicable, this could include contracted infection details including infection type, and the need for an isolation room.

From "Technologies to Battle HAIs"
Healthcare Technology Online (01/07/11) Congdon, Ken