

Patient Safety Summit Conference

2007



Patient Safety in Office-Based Surgery Conference January 26th, 2007

SUMMARY REPORT



Highlights included leaders of the four accrediting agencies and the American College of Surgeons speaking at the plenary session.

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Patient Safety Summit Conference

Summary Report

Introduction and Overview

The 2007 Patient Safety Summit Conference convened on January 26th, 2007 in Chicago at the Westin O'Hare Hotel.

Conference sponsors were:

Accreditation Association for Ambulatory Health Care (AAAHC)
American Association for the Accreditation of Ambulatory Surgical Facilities
Educational Foundation (AAAASFEF)
Healthcare Facilities Accreditation Program of the American Osteopathic
Association (AOA)
The Joint Commission

The conference was funded in part by a grant awarded to the American Association for Accreditation of Ambulatory Surgical Facilities Educational Foundation (AAAASFEF) by the Agency for Healthcare Research and Quality (AHRQ). AAAASFEF provided additional "in kind" support services to the conference.

The following professional and regulatory organizations endorsed the conference:

American College of Surgeons (ACS)
American Society of Plastic Surgeons (ASPS)
American College of Foot and Ankle Surgeons (ACFAS)
Federation of State Medical Boards (FSMB)

There were 76 participants in attendance representing 32 different organizations. A detailed list of conference attendees and organizations represented is in Appendix B of this report.

The moderators of the conference were Thomas R. Russell, MD, Executive Director of the American College of Surgeons (ACS) and Robert Singer, MD, President of the American Association for Accreditation of Ambulatory Surgery Facilities Educational Foundation (AAAASFEF).

The conference goals as articulated in the Conference Resource Book are as follows:

1. Establish baseline information on the status of accreditation as a strategy by which to improve the level of patient safety in office based surgical settings.
2. Creation of a series of initiatives that the accrediting agencies can collaborate on a continuing basis that will improve patient safety in the office based surgery (OBS) setting.
3. Provide evidence and a value equation that accreditation of OBS practices enhances patient safety.

The Conference consisted of three major sessions:

1. A Plenary Session opened the conference with invited speakers from the medical community addressing the conference attendees on key topics specific to office based surgery.
2. An Action Planning Session followed, building upon the direction and consensus developed from the plenary session. All attendees participated in this session through breakout groups that were each assigned a specific charge to discuss. The groups were instructed to develop an initial action plan that the four accrediting agencies would review collectively subsequent to the Conference.
3. Conference Wrap-Up and Next Steps summarized what was learned and accomplished during the conference. It concluded with a synopsis of the steps necessary to further utilize accreditation as a strategy to improve patient safety in the office and ambulatory surgical setting.

Plenary Session

The Session consisted of a series of presentations that centered on the following topics:

1. General Medicine View of Accreditation and Patient Safety.
2. Construction of an Evidence-Based Reporting System.
3. Current State regulatory environment and views of accreditation as a strategy to improve levels of patient safety in the office based surgery setting (OBS).
4. The accrediting agencies view of accreditation as a strategy for improving patient safety.

Invited speakers for each of the above sessions were asked to address their remarks to specific focus questions. These questions were as follows:

General Medicine View of Accreditation and Patient Safety

1. What is the current level and impact of patient safety initiatives in medicine today?
2. What data exists on the impact of accreditation on matters of patient safety?
3. What legislation or regulations exist or will exist that will protect data on adverse events, sentinel events or complications reporting from litigation discovery?

Construction of an Evidence-Based Reporting System

1. In what manner will the necessary data be gathered and analyzed so that evidence-based decisions can be made to set directions for increasing the level of patient safety in the OBS practice setting?
2. What organizations are eligible to collect the data?
3. How can competitive advantage be prevented from becoming a factor?
4. How will this help to improve the level of patient safety in the OBS setting?

Current state regulatory environment and views of accreditation as a strategy to improve levels of patient safety in the office based surgery setting (OBS).

1. What have been the successes? What have been the failures?
2. What has been the impact of these initiatives?
3. What are the hurdles and obstacles in achieving greater acceptance of a formalized program of improvement of the level of patient safety in the OBS setting through accreditation?

The accrediting agencies view of accreditation as a strategy for improving patient safety

1. What have been the successes? What have been the failures?
2. What has been the impact of these initiatives?
3. What are the hurdles and obstacles in achieving greater acceptance of a formalized program of improvement of the level of patient safety in the OBS setting?

The culminating portion of the Plenary Session involved all conference attendees participating in addressing the question of:

What types of collaborative efforts can the accrediting agencies undertake in the following areas which will advance the level of patient safety in the office based surgical setting and to make fuller use of accreditation as a strategy by which to improve the levels of patient safety in the OBS?

The complexity and scope of the question required that specific areas of activity be identified and initiatives defined. The four areas of activity identified were:

1) Research

- a) Identify “good practice” approaches for safety, outcomes and processes.
- b) Develop an evidence-based approach for all information developed by the coalition of the accrediting organizations. If this is not possible than make use of “Expert Opinion Panels.”
- c) Evaluate “team oriented surgical approach” in terms of performance, communication and improvement of patient safety in OBS.
- d) Track and report on costs and benefits analysis of accreditation.
- e) Develop a common, standardized, protected and mandatory database that all parties will use for purposes of detailed and aggregated reporting of incidents or “near incidents.”
- f) Standardize areas of measure and variable definitions.
- g) Evaluate the differences between accredited and non-accredited environments within hospitals and outside of hospitals.
- h) Develop common benchmarking studies.
- i) Develop methods by which to identify and assess risk.
- j) Explore ways in which to make data reporting mandatory.
- k) Develop the methodology for aggregating standardized data.
- l) Develop multiple pathways by which standardized data can be gathered.
- m) Define the manner in which aggregate data will be reported.

2) Education

- a) Demonstrate the advantage of accreditation to surgeons. Address and answer the question of “what’s in it for me?”
- b) Provide information on how the structured process of accreditation can be linked to future “pay for performance” reimbursement models.
- c) Develop educational programs that deliver the message that this is a way for physician groups to “take back” the leadership role regarding quality and safety.

3) Advocacy

- a) Develop a coalition of the accrediting agencies and professional organizations that would advocate at the state level for mandatory accreditation of all out of hospital surgical facilities
- b) Incorporate in the advocacy programs patient safety standards designed to protect patients. Go beyond mere facility accreditation.
- c) Develop a PR campaign with a non-lobbying focus that will educate legislators, regulators, government agencies, consumer groups and professional associations as a means to advance the role of accreditation as a strategy to improve patient safety.

- d) Include in the advocacy program the promotion of state and national reporting of OBS safety data.
- 4) Promotion of the value and benefits of accreditation as a patient safety strategy
- a) Formalize what was accomplished at the Conference.
 - b) Create a summary so that each of the organizations at the Conference can take it back with a recommendation to their parent organizations for adoption and support.
 - c) Follow up would include soliciting and inviting other societies and organizations to join, and then formally announcing the member organizations and activities that the coalition intended to proceed with on behalf of public patient safety.
 - d) A press release will announce the coalition's activity to the media and public having a positive impact on all the medical societies, and draw national attention to the value and benefits of accreditation for patient safety issues in office based surgery.

Action Planning Session

The intent and purpose of this session was to build upon the suggested initiatives developed in the last segment of the Plenary Session. The intended outcome was the development of action plans that the accrediting agencies could execute in the months following the conference.

The conference attendees and speakers were divided into four breakout groups and were given the charge to focus on one of the four activities listed above. The breakout groups were instructed to prioritize the items listed under their activity and develop initiatives beginning in order of highest priority due to conference time constraints.

The following are the results of deliberations by each of the breakout groups.

Research Action Planning

There was broad agreement that there was the need to establish a standardized mandatory reporting system for patient safety that protected patient identity and discoverability. The aggregate data collected would be used for research purposes to support studies on patient safety in accredited facilities. Specifically, studies that would support the argument that accreditation does have a direct impact on patient safety and that mandatory reporting requirements can identify the practices and processes that serve to improve patient safety.

The group agreed the following initiatives should be recommended:

1. Study data that has been collected to determine the overlap between the different accrediting organizations, state organizations, and others currently collecting data about office-based surgery.
2. Create a data table and consensus process where all the stakeholders could develop a common set of data points.
3. Implement a data collection process based on the stakeholders' common data points by beta testing on an existing system, with the National Quality Forum or similar entity that already has a reporting mechanism being used for data collection.

Other high priority projects discussed included the study of state reporting processes currently in use to help advance the stakeholder agreement by identifying what processes best serve patient safety.

Education Action Planning

The action steps developed were as follows:

1. Educate specialty societies of the impact that mandated accreditation for their members would have on patient safety.
2. Focus on state medical boards, particularly using existing tools such as the FSMB Guiding Principles and the AMA Principles that call for accreditation in lieu of regulation in the office based setting.
3. Focus on culture change in the physician community through residency programs, fellowship programs, and medical schools.
4. Educate physicians on the positive impact on their practice of medicine supporting that the accreditation process gives them the ability to respond to future requirements for performance measurement in a Pay for Performance environment.
5. Educate both physicians and liability insurers that one way to obtain better data is to have each accrediting body mandate data collection as part of the accreditation process.
6. Target liability insurance companies, as specified in some of the other initiatives listed above.

The initiatives previously listed should dispel some of the myths about the accreditation process. We suggest an approach that models current successful examples. A physician education model should focus on the following aspects:

1. Improved physician image.
2. Accreditation as a more cost effective approach than liability and malpractice insurance.
3. The value of self-regulation versus government mandate.
4. The AMA core principles for office-based surgery facilities.

Advocacy Action Planning

Discussion began with a quote that lobbying and advocacy may be an agency's best service to its constituency. That being said, there was considerable discussion on the proper role of accrediting bodies in lobbying and advocacy. There was general agreement that it would be in the best interest of our respective missions to advocate and lobby, when appropriate, on behalf of accreditation and patient safety. The group also agreed that more research and available data at the national level is required to reinforce the important role of accreditation in patient safety.

The group's recommendation is to form a coalition involving the accrediting organizations and other stakeholders committed to advance the role of accreditation in patient safety.

The coalition should explore the following two strategies:

1. Establish a rapid strike force that would actively pursue a combination of both lobbying and public policy activities on specific issues, particularly focusing on the state government.
2. Explore a national public policy PR campaign with a non-lobbying focus to educate legislators, regulators, government agencies, and perhaps consumer groups, as well as medical professionals on the value of accreditation and patient safety.

One platform in this campaign would be to encourage the promotion of state and national reporting of OBS safety data. And another platform may be to advocate for formation of a taskforce or a subgroup to look specifically at the economic impact of patient safety issues. (i.e., the cost of complications)

Promotion of the value and benefits of accreditation as a patient safety strategy

The guiding words established during group discussion were "cooperation, collaboration and coalition."

A coalition would work with positive stakeholders, who included the four accreditation organizations and every organization that is represented at the conference and expand outreach activities to other groups.

In addition to the accrediting agencies, other positive stakeholders in this initiative could include the anesthesiology associations, SOHN, ACR, CRNA, the ASPN group, insurance carriers, malpractice carriers, and all the other groups of interest. The goal would be an expanding coalition.

The group agreed that the coalition should have a name. One suggested name was the Accreditation Consortium Team, or ACT.

Negative stakeholders might include state medical associations, and approximately 38,000 non-accredited physicians around the country, and perhaps some insurance carriers. The following were the action steps that the group agreed could be undertaken:

1. Formalize what was accomplished at the conference.
2. Create a summary so that each of the organizations at the conference can take it back with a recommendation to their parent organizations for adoption and support.
3. Follow up would include soliciting and inviting other societies and organizations to join, and then formally announcing the member organizations and activities that the coalition intended to proceed with on behalf of public patient safety.

A press release will announce the coalition's activity to the media and public having a positive impact on all the medical societies, and draw national attention to the value and benefits of accreditation for patient safety issues in office based surgery.

Next Steps

1. Submit Conference Report (Full and Summary) to the governing Boards of each of the four accrediting agencies.
2. Secure approval in concept from the Boards to move forward with the collaborative efforts recommended by the Conference participants in the areas of:
 - Research
 - Education
 - Advocacy
 - Promotion of the value and benefits of accreditation as a patient safety strategy
3. Subsequent to such approvals, convene a follow up meeting of the four accrediting agencies and the American College of Surgeons to begin the development of detailed action plans for the recommendations of the conference.