

Briefings on

Ambulatory Accreditation

Medication reconciliation, reducing safety risks among top compliance challenges

Medication reconciliation, reducing patient safety risks, and ensuring the competence of healthcare practitioners were the three top compliance challenges in ambulatory centers from January 2006 to July 2006, according to the February *Joint Commission Perspectives*. Specifically, the troublesome measures were the following:

- **Goal 8:** Reconcile medications through the continuum of care—35% noncompliance
- **PI.3.20:** Identify and reduce potential adverse and patient safety risks—33%
- **HR.4.10:** Guarantee the competence of all practitioners—30%
- **Goal 2:** Improve communication among caregivers—29%
- **PC.16.10:** Establish policies that detail the context in which waived test results are used in patient care—28%



IN THIS ISSUE

p. 4 Physicians to receive bonuses for quality reporting

For the first time in U.S. history, the government will start paying bonuses to healthcare practitioners who report on quality measures.

p. 7 Accrediting panels unite to promote patient safety

Competing organizations have joined forces to promote patient safety in office-based surgical settings by creating an action plan to advocate the importance of accreditation to physicians, payers, the public, and regulators.

p. 8 Questions abound on who marks surgical sites

A seemingly straightforward standard has healthcare professionals still contacting the AAAHC asking for guidance.

p. 12 Accreditation spotlight focuses on seamless surveys

Don't panic, take things one step at a time, and prepare well in advance, advises a facility director who underwent her first AAAHC survey this past summer.

- **UP 1:** Meet the expectations of the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™—24%
- **PI.2.10:** Collect and analyze data—22%
- **MM.2.20:** Store medications safely and properly—22%
- **EC.4.10:** Address emergency management—19%
- **PC.6.10:** Educate and train patients about their care and treatment—18%

“People do what we call incident reports on falls and medication errors, but we all know that [not all of them] get reported.”

—Karen Griffin, RN, MSN, CNAA

Karen Griffin, RN, MSN, CNAA, a director of the American Academy of Ambulatory Care Nursing, says her organization, the South Texas VA Health Care System in San Antonio, is doing pretty well with medication reconciliation because it uses electronic medical records (EMR). But Griffin, who is also the associate chief of nursing services for the South Texas VA system, says that paper-based facilities struggle with this goal.

Griffin, who is an adviser to **BOAA**, provided her thoughts on the measures with which most ambulatory centers struggle. Her comments are as follows.

Medication reconciliation

“In a physician’s office, I think they do a pretty good job of keeping a medication list and reviewing it each time the patient comes in,” Griffin says. “The issue is when you have to send or fax that list to the next level of care, whether it is a hospital or nursing home.”

Even though both the outpatient and inpatient units of her healthcare system have EMRs, physicians are still

Accrediting panels unite to promote patient safety

For the first time ever, competing organizations have joined forces to promote patient safety in office-based surgical settings by creating an action plan to advocate the importance of accreditation to physicians, payers, the public, and regulators.

“Yes, it was a first,” says **Alan Gold, MD**, president of the American Association for Accreditation of Ambulatory Surgery Facilities, which worked with the AAAHC and The Joint Commission to convene a patient safety summit in January. “We thought it was long overdue.”

How to proceed?

Specifically, representatives from those organizations and other accrediting bodies, including the American Osteopathic Association, met in four separate work groups to tackle some of the following questions:

- ▶ What cooperative efforts can agencies undertake to advocate for accreditation at the state and federal levels?
- ▶ What is the best way to educate physicians, patients, payers, legislative and regulatory bodies, and the insurance industry about the value of accreditation?
- ▶ How do you make data collection part of the accreditation process?
- ▶ Who are the positive and negative stakeholders of accreditation?

“We need to work together, not at cross-purposes,” Gold says.

Data collection

Many of those who attended the summit spoke about the importance of collecting data on patient safety.

“All accrediting organizations are in favor of health-care organizations very systematically looking at near-misses and adverse events as part of a larger system that would allow them to share information in a protected manner,” says **Naomi Kuznets, PhD**, managing direc-

tor of AAAHC’s Institute for Quality Improvement.

“I think for the most part the work groups supported a system where information would be gathered in a protected manner . . . It would really be used for educational purposes.”

Gold also stresses that data on individual physicians would be blinded in any sort of national database to alleviate fears of doctors who worry they might not compare favorably to their peers.

Little motivation for accreditation

Only about 2,000 of the 40,000 office-based surgical settings are accredited, according to Gold.

Both he and Kuznets say that’s because there’s little motivation for office-based surgical centers to seek accreditation right now.

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—*Naomi Kuznets, PhD*

Roy Grekin, MD, AAAHC president, pointed out during his presentation to summit attendees that studies conducted in 2001 and 2005 by the AAAHC Institute for Quality Improvement found that office-based surgical organizations are more likely to indicate that there is nothing that would motivate them to be involved in a medical event reporting system.

“With most aesthetic surgery being paid for by the patient, there is not necessarily a payer out there to say, ‘Hey you need to do some of these quality and patient safety activities,’ ” Kuznets says.

“Add this to fearing that you may be the one pinpointed [as the only physician in the practice], as well as having to do so much other work with a small staff, and it makes you less likely to be involved in a medical event reporting system or seek accreditation.”

> *continued on p. 8*

Patient safety

< continued from p. 7

That's one reason why one of the goals of the patient summit work groups is to get insurers to support accreditation for office-based surgical settings.

Goals for the future

Other goals the patient safety summit work groups came up with include

- ▶ working to overcome physician skepticism about the value of accreditation
- ▶ educating providers, specialty medical societies, and insurers about accreditation
- ▶ building a strong coalition of accrediting organizations and other stakeholders to lobby at the state level
- ▶ getting anesthesiology associations, insurance carriers,

and malpractice insurers in the coalition

- ▶ developing a national public relations campaign to educate legislators, regulators, and patients on the value of accreditation

Gold praises the accrediting organizations that came together at the summit to work toward the common goal of increasing patient safety in office-based surgical practices.

But he said the summit was only just the beginning. Meetings are scheduled in the following months to build on the progress made at the summit.

"Hopefully, we'll move forward in the same spirit of that meeting," he says. ■

Standard of the month

Questions abound on who marks surgical sites

A seemingly straightforward standard has healthcare professionals contacting the AAAHC asking for guidance. The standard is 10R and reads as follows:

The organization utilizes a process to identify and/or designate the surgical procedure to be performed and the surgical site, and involves the patient in the process. The person performing the procedure marks the site. For dental procedures, the operative tooth may be marked on a radiograph or a dental diagram.

Even though the standard has been in effect for the past two years, calls have been coming in to the AAAHC ever since the beginning of the year. "The standard specifically says that the person performing the procedure marks the site," says **Michon Villanueva**, assistant director of accreditation services for AAAHC. Before it was revised in 2005, the standard read as follows:

The organization utilizes a process to identify and/or designate the surgical site and involves the patient in that process.

Plenty of calls came in right after that change, but then they dropped off. It's only recently has generated interest again. "There have been questions from organizations where the surgeon doesn't come into the case until the person is already under anesthesia," Villanueva says. "I think that's where some of the confusion lies."

Questions have also come in about whether a nurse can mark the site and the surgeon can verify it by placing another mark over the nurse's.

"The standard requires that the person performing the procedure take the responsibility and ensure that the appropriate site being operated on is marked," Villanueva says. "The organization has to be able to demonstrate that the person performing the procedure is marking the site immediately before the operation."

Most of the calls seem to be to affirm the physician's role and responsibility in the site marking procedure.

"I think it's worth highlighting because it's very important that the question continues to be asked. ■