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Briefings on
Ambulatory Accreditation

New AAAHC standards hold patients accountable for their care and compliance

Scores of revised standards for organizations accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) take effect this month, including one that calls on patients to bear some responsibility for their own care.

Nearly every chapter of the 2008 AAAHC handbook contains revisions, some intended to keep pace with technological changes, others to clarify existing standards. (See "AAAHC revises light-based, radiation tech standards" on p. 3.)

The first significant change starts in Chapter 1. Previously "Patient Rights," the chapter is now "Patient Rights and Responsibilities." It says that patients are required to give their providers a comprehensive list of their medications, including herbal supplements, and asks patients to respect staff members.

"From my own experience in outpatient healthcare, it is very apparent that from time to time, any physician office will accept the care of a patient who is very difficult to manage," says **Marsha Wallander, RN,** assistant director for accreditation services at AAAHC. "Perhaps the patient is noncompliant with the treatment plan or is disruptive in a personal way and using foul language in the waiting room. Those kind of issues need to be managed."

> **"What we found was we needed to add language specifying that organizations that were closing for 30 days or more needed to notify us."**
>
> *—Marsha Wallander, RN*

Specifically, Standard 1G says that before patients receive care, they must get information about their responsibilities. In addition to providing a complete medical history and treating staff members with respect, the standard requires patients to:

- Adhere to the treatment plans recommended by their doctor
- Arrange for a responsible adult to take them home and remain with them for 24 hours if required by their physician
- Tell their doctor about any living will, power of attorney, or other advance directives
- Agree to pay any expenses not covered by their insurance

"The revisions for 2008 also include some clarifying language on patient procedures for expressing complaints or grievances," Wallander says. "Many of those revolve around billing issues because of the complexity of insurance and managed care. We wanted to make certain patients had the opportunity to make a suggestion."

Ambulatory surgery centers (ASC), she adds, should make sure those rights and responsibilities are posted

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in public areas so patients and clinicians are on the same page.

Protecting healthcare workers

In another important change, Chapter 19, an adjunct chapter, was split in two, and the standard protecting healthcare workers was moved to Chapter 3, which is a core chapter. Chapter 19 reverts back to its original theme dealing with occupational health services.

"I think that's very key because we always tell people the core chapters apply to every organization undergoing accreditation," says **Barbara Ann Harmer, RN, BSN, MHA,** senior consultant at Healthcare Consultants International, Inc., in Skokie, IL. "Healthcare organizations have employees, so saying it might be applicable to organizations doesn't make sense because we all have employees," says Harmer. "So moving it to the core was an excellent move and makes so much sense."

The new standards, now 3.C–3.F, say facilities have to protect their staff members by having:

- An effective program addressing bloodborne pathogens
- An immunization program for other infectious agents of risk to healthcare workers and their patients
- A tuberculosis respiratory protection program
- Programs addressing other relevant biological hazards, such as bioterrorism, as needed for employee safety and health
- A program to assess and reduce risks associated with occupational chemical exposures
- A program to assess and, where necessary, reduce risks associated with physical hazards, such as ergonomic exposures, violence in the workplace, and external physical threats such as terrorism

The change also gives occupational health its own stand-alone adjunct chapter. "Organizations providing occupational health services now have a very clean set of accreditation standards," says Wallander.

Elevating requirements to standard level

Another revision includes the elevation of two requirements to the standards level because of their importance. They require ASCs to:

- Notify AAAHC within 30 days of any significant organizational, operational, or financial changes. An addition to this standard requires organizations to notify AAAHC of any major renovation or interruption of services that lasts for more than 30 days (Standard 2.I.C).

"What we found was we needed to add language specifying that organizations that were closing for 30 days or more needed to notify us," Wallander says. The 30-day closing may not require a new inspection, she adds, but AAAHC wants to make note of it.

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"My counsel to organizations is if they have any concerns, notify AAAHC and ask if this in fact is considered a significant change for their organization," Harmer says. She suggests ASCs do this in writing and to send a second request if they don't hear back from AAAHC.

➤ Admit or discharge a patient only upon the order of a physician who is responsible for the medical care of that patient (Standard 11.B). "There's a difference that folks need to understand," Wallander says. "A medical discharge is when the physician says the patient has recovered from the medical procedure, which is different from physical discharge from the facility."

In other words, the physician needs to say the patient is medically able to be discharged. But the patient may not be physically able to leave the facility because he or she may still be recovering from the effects of anesthesia or is perhaps suffering from nausea. An anesthesiologist or a nurse in the postoperative area could then see the patient through the physical discharge. "It has to be a professional person," Wallander says.

Changing reconciliation requirement

Other key changes, says Harmer, include:

- **Chapter 4: "Quality of Care Provided."** Standard 4.D-4 is a new element that requires review and reconciliation of all medications, including over-the-counter products and dietary supplements. "This brings the standard up to date with items that are taken and can affect care and clinical decisions," she says.
- **Chapter 5: "Quality Management and Improvement."** The following note has been added after the chapter introduction: "The intent of this chapter is that administrative and clinical personnel are to be involved in the quality management and improvement activities of the organization." Harmer says "this makes it clear to organizations that it needs to be a team approach, including both sides of the organization—administrative and clinical."
- **Chapter 15: "Pharmaceutical Services."** Standard, 15.D. was revised to include samples, which historically have not been accounted for.

All AAAHC-accredited facilities are expected to know and comply with the new 2008 standards, Wallander says. "We hold organizations accountable for meeting the standards every day," she adds. The new standards are located in Appendix A of the handbook. ■

Editor's note: For more information or to buy the 2008 handbook, go to www.aaahc.org.

AAAHC revises light-based, radiation tech standards

The 2008 Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) handbook contains new standards in Chapter 10 regarding laser and light-based technology, and in Chapter 19, which covers radiation oncology. Standards applicable to laser technology have been expanded to include all light-based technology.

A number of the additions to the standards for radiation oncology include teletherapy and brachytherapy, according to a press release on the AAAHC's Web site, as well as:

- The designation of a radiation safety officer and committee that shall meet on a periodic basis
- A program to maintain personnel exposure records
- Annual calibration of teletherapy units
- Annual review of the radiation safety program by a qualified medical physicist
- A program to inspect interlock systems of all treatment units
- Maintenance of the records of machine performance, malfunction, and upkeep
- Periodic testing of all sealed sources, satisfying all pertinent radiation regulations
- A program for maintenance and repair of equipment
- Quality control procedures for all therapeutic equipment
- Regulation of the acquisition, use, removal, handling, and storage of potentially hazardous materials
- Personal immobilization devices with procedures to ensure proper identification to match each device to the proper patient
- Shielding available with established procedures for identification, handling, storage, and removal of devices made of lead or other hazardous materials

Proposed goals confuse some, please others

The Joint Commission's proposed 2009 National Patient Safety Goal (NPSG) requirements and expectations have left some pleased, others worried, and many baffled.

"I think Requirement 8B is very confusing," says **Nancy Burden, RN, MS, CPAN, CAPA,** director of outpatient surgery at BayCare Health System in Tampa Bay, FL. "All of Goal #8, really, is very confusing. I read it several times and I thought, 'Well, I'm not exactly sure where they see an ambulatory surgery center [ASC] in all of this.' "

"I totally believe in medication reconciliation. But if they're asking us to create this list when the patient comes to the preop at the admitting desk, that could be a burden."

—Anne Dean, RN, BSN

"I totally believe in medication reconciliation," says healthcare consultant **Anne Dean, RN, BSN,** founder of the ADA Group in Deland, FL. "But if they're asking us to create this list when the patient comes to the preop at the admitting desk, that could be a burden."

The Joint Commission (formerly JCAHO), which announced the proposed NPSGs in January, closed the field review period February 27. They focus on the following:

➤ **Goal #1:** Under the proposed revisions, Requirement 1A would be expanded to include an implementation expectation (IE) requiring that the patient is actively involved in the identification process, when possible, before any venipuncture, arterial puncture, or capillary blood collection procedure. Proposed Requirement 1C aims to eliminate transfusion errors related to patient misidentification.

➤ **Goal #7:** Perhaps most newsworthy is the inclusion of a new proposed requirement aimed to stop drug-resistant organism infections in hospitals. Specifically, proposed Requirement 7C targets Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*–associated disease (CDAD). Among its 16 IEs, 7C requires education for healthcare workers, patients, and their families, as well as the measurement and monitoring of infection rates. It also requires lab-based alert systems when MRSA patients are detected and a surveillance system for CDAD. Requirement 7D proposes 13 IEs, including IEs for before and after insertion of the catheter. Requirement 7E has both general and specific IEs, seven in total, for the prevention of surgical site infections.

➤ **Goal #8:** Proposed revisions to Goal #8 are composed of new and revised requirements and IEs intended for clarification, not alteration, of previous requirements. Revisions have been made to Requirements 8A, 8B, and 8C for the reconciliation of patient medication across the continuum of care. Requirement 8D has been added requiring modified medication reconciliation processes in settings where medications are not used, used minimally, or prescribed for short durations, such as outpatient radiology, ambulatory care, and behavioral healthcare.

➤ **Goal #13:** Two IEs have been proposed to Goal #13, which targets increasing patient involvement in their own care. The first new IE would require facilities to provide patients with information regarding infection control (e.g., hand hygiene or respiratory hygiene practices), whereas the latter requires facilities to provide surgical patients with information about preventing adverse events during surgery (such as patient identification or surgical site–marking processes).

➤ **Universal Protocol:** Proposed changes to the Universal Protocol, like those made to Goal #8, are not meant to change the overall concept of the goal but rather to clarify existing requirements. According to the draft 2009 NPSGs, the Universal Protocol contains the same concepts as it has in previous iterations.

Extensive clarifications have been proposed for Requirements 1A, 1B, and 1C, including four rewritten IEs under 1B (surgical site marking), and six rewritten IEs under 1C (time-out verifications).

"There are some components that are straightforward and can easily be assimilated into regular quality improvement processes within healthcare organizations," says **Elizabeth Zhani,** spokesperson for The Joint Commission. "There are other components that will create reaction from the field due to the complexity of how to best manage healthcare-associated infections."

Dean says there is confusion about the applicability of catheter-associated bloodstream infections in ambulatory settings. "I've been polling my clients," she says, "and we just do not get catheter-associated infections."

Even in urology, where a Foley catheter might be used, the patient may get a bladder infection but not a bloodstream-associated infection, she says.

Dean did applaud the proposed expectation that antibiotics be started within one hour of incision. Many plastic surgeons, she says, have been starting patients on a 10-day antibiotic regimen before they come in for surgery—a practice that will have to stop.

"I personally think that most of the plastic surgeons are going to fall in line with that because of the studies that have come out about it," Dean says.

However, she adds, requiring the antibiotic to be discontinued within 24 hours is an unreasonable expectation.

"How is the surgery center going to make that happen?" Dean says. "The physician is going to write the prescription, and we can encourage the patient to discontinue it, but once they're discharged, they're discharged from our care. . . How are we going to enforce that?"

The expectation that the surgery center send a list of medications to the patient's primary care provider also calls for more clarity, Dean says.

"Does that mean the surgery center has to send the list to the patient's family practitioner?" she asks. "That's a real burden and cost . . . I think that needs greater clarification, because if that's what they're expecting us to do, it's too much."

Burden says she's worried about the expectation requiring a licensed independent practitioner to mark the procedure site.

"Many, many surgery centers do things like cataract procedures, where they're doing 16 of them in three hours," she says. "Having the surgeon come and mark every eye would be horrific as far as the patient flow."

Burden and Dean laud the intent behind the expectations and say they like some of the proposals. "I think many of them are good," says Burden, who also belongs to The Joint Commission's Standards Improvement Initiative.

She notes that The Joint Commission is very receptive to the feedback it gets. "The Joint Commission really, really relies on hearing from the healthcare world," she says.

Although the review period has closed, the proposed revisions are available on The Joint Commission's Web site at *www.jointcommission.org/Standards/FieldReviews/09_npsg_fr.htm.* ■

Staff engagement critical to survey success

Make your staff members comfortable. That's how the administrator of Shawnee Mission (KS) Surgery Center helped her facility pass The Joint Commission's unannounced survey.

Cindy Ladner, BSN, administrator at Shawnee Mission, involves her staff members in the accreditation process. They help enforce and review regulations, as well as conduct audits.

"I think what helped us significantly [was] looking at each of the Joint Commission [formerly JCAHO] standards chapters and assigning staff accountability for those chapters," says Ladner. "Staff involvement and physician involvement—that was key."

Ladner assigns different chapters to various members of her staff and holds them responsible for education.

"For instance, I have a nurse on the 'Provisions of Care' chapter, and then a nurse on the National Patient Safety Goals [NPSG]. Those are our team leaders who not only look at our monthly audits, but they do the one-on-one teaching with some staff," says Ladner. Having staff members explain the standards to other staff members is helpful because they are more likely to be engaged, she adds.

"Having it come from a staff nurse, a coworker, on why we're doing it—rather than just saying, 'This is a standard, we have to do it'—helps," says Ladner. She says staff members are included in the facility's audit results and are involved in the future goals of the surgery center. Nurses with previous experience on certain committees or as a unit educator were assigned to certain sections of The Joint Commission's requirements for ambulatory surgery centers (ASC).

The survey was Shawnee Mission Surgery Center's first since becoming an ASC in 2002 when it was decided the center needed to be surveyed separately from the Shawnee Mission Medical Center. The multispecialty center, which has four ORs and two minor procedure rooms, sees about 7,000 cases per year and specializes in orthopedic; ophthalmology; plastic; gynecological; ear, nose, and throat; dermatology; urology; and lithotripsy services.

An educational experience

Ladner says the three-day survey by a physician surveyor went smoothly and was educational.

"There was a sense of two-way communication [with the surveyor], which was very helpful with the staff," she says, adding that the survey went smoothly because of training practices such as mock surveys. The surveyor suggested the center implement a system for identifying medications with short expiration dates by labeling them with a sticker. He also noted that verbal orders weren't always documented correctly.

To help correct these and other small compliance issues, a one-page form was created for staff members to review. The document summarizes compliance areas needing improvement—including verbal orders, medication reconciliation, and physician postop notes—to ensure that staff members understand compliance measures. It's a quick outline of what is expected in each area, as well as where hospital policies about the topics can be found.

Better compliance on postop notes

Physicians perform chart audits quarterly, which has helped Shawnee Mission see an increase in compliance for physician postoperative notes.

Ladner recently submitted Shawnee Mission's periodic performance review (PPR) for the survey, which took place in December 2006.

In summer 2007, meetings were scheduled around particular compliance topics in which Ladner and a consultant met to discuss the ongoing action plan in that area. Ladner says these meetings were helpful in cutting down action plans until the PPR action plan was much shorter than originally anticipated.

Nurse leaders are essential in keeping up compliance, says Ladner. She suggests other ASCs who wish to keep constant survey readiness maintain organized files, involve the staff, and focus on NPSGs. Postsurvey, Ladner found the PPR process a good way to stick with action plans and audits and stay focused on compliance year-round. ■

Accreditation corner

Learn five ways you can cut infections in your ASC

Editor's note: The following is an article from a series about accreditation by Troy Lair, CEO of Los Angeles–based consulting company The Compliance Doctor, LLC.

Proper terminal cleaning is critical to protecting your patients from infections, but confusion abounds at many ambulatory surgery centers (ASC) about reducing microbial loads.

Incorporate the following guidelines to keep your patients safe and your facility free from infectious agents:

1. Never use the same cleaning device for the OR to clean any other room.

For example, if you have two ORs, each OR should have its own device. The recovery room should have its own, and so forth. When you use the device in multiple locations, you have essentially cross-contaminated the entire space.

2. If you have an infectious or potentially infectious patient, perform his or her surgery at the end of the day. This gives your staff members time to perform deep terminal cleaning versus the lighter cleaning done between noninfectious cases. (*Note:* This is not to say that all patients should not be treated as though they are infectious, as the Occupational Safety & Health Administration teaches us to do.)

3. Use appropriate cleaning devices for the OR floor, such as devices that are disposable or easily disinfected. Never use a mop or mop head unless it can be replaced each week.

The preferred tool is a device much like a wet/dry vacuum that is easily cleaned and can reduce your microbial loads by 50%, according to the Centers for Disease Control and Prevention.

4. Direct staff members cleaning the ORs to wear scrubs or scrub-like clothing that can be changed and placed in the soiled linen receptacles.

Staff members should never wear the same clothes to clean areas such as the recovery room as they wear to clean the OR. To clean separate areas in the same clothing permits cross-contamination and increases your patients' risk of contracting a hospital–acquired infection.

5. Perform periodic cultures of the OR surfaces and floors—areas that patients touch are most important. You can use these cultures to measure the effectiveness of the cleaning that is being provided.

If you are failing to provide a low microbial load, or if you have infectious results as demonstrated by the culture, immediately begin a quality study. Use the cultures as your baseline for determining the problem and then perform a root cause analysis to determine the causes for the infection.

By reculturing the space after you have implemented the changes, you can measure the effectiveness of your quality plan for resolution.

Be sensitive to the vendors who say they are doing this task for you via an outside contract. Cleaning crews sometimes say they do this task but often know little about terminal cleaning or its purpose. ■

Editor's note: Lair has more than 18 years of executive healthcare experience, from running an ICU in a Louisville, KY, hospital to working as the chief nursing officer for a Pasadena, CA–based acute care facility. He entered the ambulatory arena while serving as the corporate director of clinical services for the world's largest plastic and cosmetic surgery company. Visit www.thecompliancedoctor.com *for more information.*

Follow these seven steps for QI study success

Closing the loop is critical for long-term improvement

A robust quality improvement (QI) study for the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)-accredited facilities needs to accomplish seven key tasks, according to longtime surveyor **Dawn Q. McLane, RN, MSA, CASC, CNOR,** chief development officer for Nikitis Resource Group in Broomfield, CO.

They are:

1. Identifying an important problem or concern in patient care
2. Selecting performance measures, goals, and objectives
3. Determining what data will be able to evaluate and analyze the frequency, severity, and source of the problem or concern
4. Implementing corrective actions to resolve problems or concerns
5. Remeasuring the problem to determine whether the changes have achieved and sustained demonstrable improvement
6. Identifying, analyzing, and implementing additional corrective actions if problems remain
7. Communicating the findings of the QI studies to staff members and the governing body (closing the loop)

Many ambulatory surgery centers may put corrective actions in place and do an initial assessment to determine whether they're improving. But they often fail to go back later to see whether the improvement has been sustained, says McLane.

"The first thing that happens when people know they're being watched is that they'll change their behaviors," she says. "You have to look at it for longer than one month or two months . . . Then the next thing is 'Is it going to stay that way?' To find out whether it will be lasting, you need to wait for a little while. Then you restudy it to see if it still works."

"If you don't go back and restudy to make sure the changes you've made are working, you're just spinning your wheels," says **Naomi Kuznets, PhD,** director of AAAHC's Quality Improvement Institute.

The final part of closing the loop is communicating the findings to staff members and the governing body, say McLane and Kuznets.

"Make sure the information isn't put in the circular file," Kuznets notes.

Aside from closing the loop, many surgery centers struggle to determine how many QI studies they should do each year—there is no required number—and what areas they should be looking at, McLane says.

"I got an e-mail from someone a couple of months ago just saying, 'We're reviewing our QI programs for the year and we're trying to decide what studies to do. Do you have any suggestions?' " McLane says. "That's a really hard question. I can't really tell anyone that because it needs to be individualized to their particular center."

QI studies need to stem from peer review, benchmarking, near-misses, or incidents, she adds. They can also come out of quality assurance monitoring if the data indicate your organization is not meeting its goals. (See p. 9 for McLane's sample quality improvement form.)

"Quality assurance [includes] those kinds of things you monitor every day, such as refrigerator temperatures," McLane says. "If you find that something is not at the level that it should be, and you can't just make a simple fix to correct it—it's more complex than that—then it might be a topic for a QI study." ■

Questions? Comments? Ideas?

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Sample form

Any Surgery Center, LLC, medical quality improvement

I. Quality assurance

- Pharmacy and therapeutics
  - Pharmacist consultation report
  - Medication errors and follow-up
  - Quality monitors appropriate to pharmacy topics
- Infection control
  - UP and refrigerator monitors
  - Sterilizer monitors
  - Infection control reports from offices
  - Needlestick reports and follow-up
  - Quality monitors appropriate to infection control
- Safety
  - Disaster drills
  - Monitors—crash cart, malignant hyperthermia cart, intubation cart
  - Laser safety monitors
  - Eye wash station monitors
  - Quality monitors appropriate to safety
- Patient care evaluation
  - Patient satisfaction survey
- Nursing quality improvement
  - Facility assessment
  - Glucometer/Humocue logs
  - Nausea and vomiting survey—PACU
  - Quality monitor review appropriate to nursing care
- Medical records
  - MR consultation report
  - Generic screens of 5% of the medical records for each month
  - Quality monitor review appropriate to medical record policy compliance
- Surgical review
  - Tissue review
  - Utilization review

II. Quality improvement

- Loop studies—reviewed at least quarterly or as determined per study
- Benchmarking—internal and external reports at least quarterly

III. Risk management

- Quality monitor review—risk management topics
- Liability insurance/litigation update
- Patient accounts—collections
- Patient satisfaction/complaints
- Physician satisfaction/complaints
- Contracts review
- Utilization review

IV. Medical staff peer review

- Performed by medical executive committee as part of credentialing and privileging program

Source: Nikitis Resource Group, Broomfield, CO. Reprinted with permission.

NY offices urged not to delay investigating accreditation

Procrastinators in New York beware: If you don't take action soon, you could get lost in the last-minute crush of office-based surgery practices lining up to be accredited by July 14, 2009. And if that happens, and you continue to perform surgery, you could lose your license and potentially face felony charges.

No one knows the exact number of office-based surgery facilities in New York, although some estimates have placed the number as high as 2,000. But if a preponderance of those practices waits until the final months to seek accreditation, the three accreditors won't be able to accommodate everyone.

"It is not something that you can arrange for and have completed in a matter of days, so now is the time people should be looking," says **Alan Gold, MD,** president of the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). "There are some physical plant modifications that may be necessary. There's certainly equipment that you may not have that may need to be purchased."

Illustration by David Harbaugh

"When the surveyor asked if you had read the AAAHC manual, you said, 'No, but I thought about it'?"

Although the AAAASF has seen an uptick in inquiries about accreditation in the past month, it has not received the numbers of calls it expected.

"Unfortunately, we are not seeing the kind of numbers that we would like to see early enough in this process to be able to accommodate every one," Gold says. Of the 26 states that require accreditation for office-based surgery practices, New York is the one that has the most teeth, he says. "This is not a slap on the wrist if you are not in compliance," Gold says. "You endanger your career because it will be a felony to be in violation of this law. You will get reported to the board of medical misconduct, and you can lose your license."

The first step

In January, the AAAASF, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), and The Joint Commission (formerly JCAHO) were designated as the three accrediting agencies for NY offices that perform procedures requiring conscious sedation.

Investigating which of those organizations is the best fit is the first step facilities should take toward becoming accredited, says **Carolyn Kurtz, JD,** senior counsel and director of government and public affairs at AAAHC.

"Get in touch with all three and get an idea of the approaches different accrediting organizations take," Kurtz says. "If you have any peers who have been through the accreditation process, contact them and see if they were happy with the process they went through."

Practices should also ask for and complete a self-assessment form from one of the accreditors to see how much work it will take to become accredited. For high-quality practices, it may require only a few minor changes; for others, it may be a much bigger task.

"Some may be fairly close," Kurtz says. "The areas we know that organizations that have not been accredited before may have issues with are the quality improvement requirements and things requiring outside peer review—especially the smaller organizations."

Gold says that offices already providing high-quality care should pass the accreditation inspection with little difficulty. "This legislation is not onerous," he says. "It really is one that is directed at patient safety concerns for an arena in which, unfortunately, physicians have sometimes not been operating under the safest of circumstances."

Indeed, several high-profile patient deaths in New York prompted the accreditation law.

"It's my understanding that there were a number of cases that had very, very bad outcomes regarding liposuction, plastic surgical procedures, and bariatric procedures," says **Donna Montalto Williams, MPP,** executive director of the American College of Obstetricians and Gynecologists for district II in New York. "That's why the law came into being." Williams says her group is investigating whether any gynecological procedures performed in office settings require conscious sedation and would therefore acquire accreditation.

Requirements not onerous

"If you're providing care for conscious sedation with a nurse anesthetist or anesthesiologist and providing safe care, you should have no trouble complying with the standards of any of the three accrediting agencies," says Gold.

Unlike most states, procedures in New York are usually performed in office-based settings instead of ambulatory surgery centers (ASC). That's because New York requires ASCs to get a certificate of need—a complicated and costly process.

AAAASF currently accredits about 130 practices in New York, Gold says. AAAHC accredits 28 office-based surgery practices and eight endoscopy centers in the Empire State. The Joint Commission media relations department did not respond to questions about the number of facilities it accredits in New York. But a source familiar with The Joint Commission says it now accredits 75 office-based surgery centers.

Kurtz says the number of calls from New York about accreditation have increased since her organization was designated an official accrediting body in January. Likewise, The Joint Commission has seen the volume of calls rising, according to a source.

Application process thorough

Although Kurtz says office-based surgery practices should start the accreditation process as soon as possible, she cautions organizations not to rush through the application process.

"Don't submit the applications until they're complete," she says, because the AAAHC application is fairly rigorous. "But what it means is if you've gone through it, you've done a really good self-assessment of your organization. If you've completed the entire application and then you send it in, things will go much smoother."

Last year, in an unprecedented move, all three accrediting organizations united to advocate for accreditation for office-based surgery practices throughout the United States. In 2007, only about 2,000 of the 40,000 office-based surgical settings were accredited, says Gold.

Gold and Kurtz say the three accrediting organizations need to collaborate again to ensure that everyone who submits an application is accredited by July 14, 2009.

"In all fairness, we will need to work together toward getting all of the facilities accredited by that deadline," Gold says. ■

Editor's note: Go to www.health.state.ny.us/professionals/office-based_surgery *for more information about the new law.*

Adverse reporting required

Physician practices that perform office-based procedures in New York now have to report adverse events to the Department of Health. The law, which took effect January 14, calls on clinicians to report the incident within one business day after learning of the event for:

- Patient death within 30 days
- Unplanned transfer to a hospital (emergency department)
- Unscheduled hospital admission within 72 hours of the office-based surgery for longer than 24 hours
- Any other serious or life-threatening event

Effective data collection needs to bring about change

Editor's note: This is the first article in a series about how to collect and analyze data.

Don't waste your time collecting data unless it's part of a closed control loop that will lead to changes in your organization.

"The reason we measure data is because data is part of a closed loop, and the reason we have a closed loop is that we want to change something," says **Ken Rohde,** a senior consultant for The Greeley Company, a division of HCPro in Marblehead, MA, and author of the new HCPro book *Making Your Data Work: Tools and Templates for Effective Analysis.* "We either want to change behaviors, or we want to say, 'It's exactly at the right point; let's keep it here.' "

A thermostat that is working properly, Rohde says, is an example of a closed control loop. If the temperature falls below a set point, say 70ºF, the thermostat initiates an action, which is to turn on the heaters. The air then warms up, and the thermostat samples the temperature to determine whether the room has reached that set point, or 70ºF mark, and turns off the heater if it has.

"That's a closed control loop, and it's got some key parts: it's got the data; it's got the set point, or the expectation; it's got the action; and it's got the closed feedback loop," says Rohde.

In the example above, a data loop breakdown may mean that either the thermostat or heater is broken, so even if you keep raising the temperature, the room stays cold. A broken data loop might also result if someone has changed the set point, or temperature, to 90ºF. The heater then works to try to reach an expectation that might not be the right one for everyone else in the room.

Similarly, the governing boards might have different expectations, or set points, for medication error rates. Senior leaders need to determine what that expectation is and clearly define it to quality directors, so if the data show performance falling below that set point, the quality department can take action to correct the problem.

"So if we see more falls happening, we make an adjustment in our fall prevention program," Rohde says. "As soon as our fall prevention program is doing what we want, we keep it at that point because it's reached our set point, or our expectation. And that's the key starting point with a control loop; you have to know what your expectations are."

Oscillation problems

A third way control loops fail is by oscillation. For example, you get in your car on a wintry morning and turn up the heat to full blast. Pretty soon, you're boiling hot, so you turn the temperature way down. Not long after, you get cold again, so you turn the heat back up.

Instead of initially setting the heater at a good set point, such as 70ºF, the temperature, or performance, keeps vacillating.

In a healthcare organization, oscillation might involve a quality improvement team starting a performance improvement project, abandoning it two months later, and then starting it again.

"Program-of-the-month problems often are the result of oscillations in our control loops," Rohde writes. "We keep trying different things, never sticking with one long enough to really see whether it works." ■

Editor's note: Go to www.hcmarketplace.com/prod.cfm?id=5970&CFID=4257555&CFTOKEN=26313843 *for more information about Rohde's book.*

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