CONNECTION

November/December, 2010

In This Issue

2011 Handbooks

Appendix A of the 2011 Handbook, which describes all of the changes from the previous year, will be posted to www.aaahc.org by mid-December. Additionally, all publications will be available for pre-sale around this time. Please continue to monitor our website as information becomes available.

Additionally, in order to best serve the needs of all of our accredited organizations, AAAHC has changed the way our publications are written in terms of the audiences they are geared towards.

The **2011 *Accreditation Handbook for Ambulatory Health Care*** will mirror the check-list format of the 2010 book. Ambulatory care organizations seeking AAAHC accreditation will benefit from having this Handbook close at hand before, after and during an accreditation survey. This handbook is suitable for ambulatory organizations seeking AAAHC accreditation. All organizations not seeking or currently withholding Medicare Deemed Status, regardless of specialty, will be using this Handbook to prepare for their accreditation survey.

The **2011 *Accreditation Handbook for Ambulatory Surgery Centers Seeking Medicare Deemed Status*** will also closely resemble the 2010 Handbook. This book is essential for ambulatory surgery centers (ASCs) seeking AAAHC accreditation in addition to Medicare Deemed Status, or those interested in reviewing the Medicare certification process and requirements as well as the AAAHC standards. The internal layout and design will remain consistent with the check-list format implemented in the 2010 book. This Handbook helps walk organizations through the entire Medicare process, including obtaining a National Provider Identifier (NPI) and enrolling in the 855B process.

Both books contain many valuable resources such as references, a comprehensive glossary, interactive forms and worksheets for self-audit, a step-by-step guide to writing a QI study, and more tools to aid in achieving accreditation.

2011 Achieving Accreditation Dates and Locations

Miami, FL
March 18-19, 2011
Miami Marriott Biscayne Bay

San Diego, CA
June 10-11, 2011
San Diego Marriott Hotel and Marina

Boston, MA
Sept. 23-24, 2011
Seaport Boston

Las Vegas, NV
December 2-3, 2011
Bellagio

AAAHC Contact Information

Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road, Suite 200
Skokie, IL 60077

P: 847.853.6060
F: 847.853.9028
info@aaahc.org
www.aaahc.org

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In addition, CMS adopted the 2000 edition of the Life Safety Code (LSC). All ASCs opting to complete a Medicare Deemed Status survey through AAAHC (combined accreditation/Medicare on-site survey) will be surveyed for compliance with the CMS Conditions of Coverage, including the requirement for compliance with the LSC 2000®. The *Physical Environment Checklist* provides a framework for organizations to use to assess whether they meet the requirements of the LSC 2000®. All ASCs seeking Medicare Deemed Status must complete the AAAHC *Physical Environment Checklist for Ambulatory Surgical Centers*. This publication was last updated in May 2010. Organizations that have an earlier edition must purchase the latest version to become compliant. This product is available on CD-ROM only.

As a result of the new changes, there will be no *Accreditation Guidebook for Office-Based Surgery* available. Organizations that previously purchased this publication should now use the *Accreditation Handbook for Ambulatory Health Care*. It is important to note that the standards contained within the Guidebook have always been the same as those contained within the Handbook.

Should you have any question about which book to choose, or how this affects your accreditation preparation, please contact Alison Solway, Marketing and Communications Manager, at asolway@aaahc.org or 847/853.6060.

Medical Home Certification Pilot Program

AAAHC is seeking a limited number of primary care organizations to participate in a new pilot program focused on Medical Home On-Site Certification. The program will use the newly developed AAAHC *Medical Home On-site Certification Handbook*.

Organizations participating in the pilot program will work with a team of two AAAHC surveyors to complete a pre- and post-survey phone call with surveyors, a one day on-site survey, and are asked to provide feedback to AAAHC staff regarding their experiences. The fee for organizations seeking to participate is $1000. At the end of the program, a certificate will be issued to organizations who have earned it.

If your organization is interested in participating, please contact Ron Smothers for details at 847/853.6067 or at rsmothers@aaahc.org.

AAAHC International

The next AAAHC International education program will take place in San Jose, Costa Rica, on January 27-28, 2011. For more details on how to sign up, please contact Jim Pavletich at jpavletich@aaahc.org.

Ask the Expert

Q. When a Medicare certified ASC and an office practice share the same electronic medical record, how does the ASC meet the Medicare requirement for a separate record?

A. Both AAAHC and CMS require that an individual record be established for each patient. AAAHC Chapter 6 states, "An accreditable organization maintains clinical records and a health information system from which information can be retrieved promptly. Clinical records are complete, comprehensive, legible, documented accurately in a timely manner and readily accessible to health care professionals." Standard 6.B states, "An individual record is established for each person receiving care."

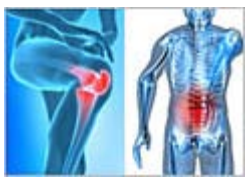
Medicare Conditions for Coverage 416.47 states, "The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care;" and 416.47(b) states, "The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed."

That record can either be a separate, stand alone record, or a tab or section in the practice's office record for an office-based or medical practice based surgery center.

The key is that the surgical episode can be identified from the remainder of the record and that the section of the record designated for the surgical center records can only be accessible to surgery center staff. As many office-based surgery centers migrate from paper records to an electronic medical record (EMR), they find it is more economical to share the EMR between the practice and the surgery center. Many EMRs come formatted with tabs or sections for various items, such as lab tests, EKG and x-ray reports. A separate tab or section for surgical center procedures would satisfy the requirements for both AAAHC and CMS.

— Answered by Ray Grundman, AAAHC Surveyor, AAAHC Senior Director, External Relations

AAAHC Institute New Study Reports: Focus on the Pain Management – Low Back Injection Report



The AAAHC Institute has released the January-July 2010 performance measurement and benchmarking study reports on *Cataract Extraction with Lens Insertion, Colonoscopy, Knee Arthroscopy with Meniscectomy*, and *Pain Management – Low Back Injection*. Visit the AAAHC Institute website and choose 'Order Products' for descriptions of these study reports or to place an order, or click

here.

For the *Pain Management – Low Back Injection* study report, 107 organizations (performing approximately 139,000 low back injections annually) submitted data on a total of 2,227 routine, uncomplicated procedures for inclusion in the study. More than three-fourths (78 percent) of patients reported their pain had improved and 82 percent said they were able to perform their daily activities after undergoing spinal injections for back pain, although only about half (53 percent) said they were able to reduce their pain medications after the procedure. Additional findings include:

The most frequent symptoms for which the procedure was performed were pain (96 percent), limited range of motion (47 percent), spinal tenderness (28 percent), weakness (28 percent) and a positive straight-leg test (21 percent) – a test in which the leg is raised upward with the knee unbent (the test is positive if there is pain down the back of the leg) – and numbness (5 percent). Some patients reported more than one symptom.

- 53 percent of patients rated the severity of their symptoms as greater than 5 on a scale of 0 to 10, with 10 being the most severe.
- 91 percent of patients received three or fewer injections.
- 89 percent of injections included local anesthetics and 95 percent included corticosteroids.
- 63 percent of patients received intravenous sedation.
- 98 percent of injections were guided by X-ray imaging.

Procedure times are the only measures used for benchmarking because the processes involved are not dictated by clinical guidelines and are, for the most part, within the control of the organization. Procedure times also can be an indicator of safety and patient satisfaction. For example, longer discharge times can indicate overuse of medications or other complicating factors. Pre-procedure, procedure, discharge, and facility times were all benchmarked. Following the example above, discharge times – defined as needle out to the time the patient meets discharge criteria – ranged from 2 to 74 minutes (median 29).

If you have questions or comments, please contact Alison Solway at asolway@aaahc.org.