Patient Safety in the Office Setting

In-Office Procedures

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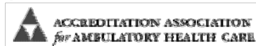
Diclosures

- *No financial relationship to any of the products, devices or procedures discussed*
- *No off-label use discussed*
- *Past President of the AAAHC (voluntary)*
- *Member ACOG TF on PS in the Office Setting*

Objectives – To Learn:

- about the migration of surgical procedures from the hospital and ASC to the office
- about relative risk of adverse events in office surgery
- why these procedures are moving to the office
- how to implement these procedures safely
- how to track outcomes and establish a QA program



- The AAAHC was formed in 1979…
  - **to improve the quality of care in ambulatory health care organizations**
  - **Currently accrediting ~5,000 organizations in the USA.***
  - **(ACOG is a member of the AAAHC since 1999)**

*www.aaahc.org

Physicians for Women's Health, LLC

- Largest ObGyn Group in the USA
- 400,000+ patients / 175+ Ob/Gyns
- Contracting and other economies of scale
- Medical Quality Management
- Clinical Guidelines
- Lobbying
- EMR
- Malpractice Insurance Captive

Physicians for Women's Health, LLC (PWH)

- We began bringing these procedures into our offices about 3 years ago.
- Will discuss how we did it …and what we've learned.

Background – Scope of the Issue

- Outpatient Encounters (Office, Clinics, ERs)
  - **More than 1.2 Billion**
  - **82.4% of these (over 980 Million) in "Doctor Offices"***
    - PCP offices
    - Medical Specialty offices
    - Surgical Specialty offices

***Stumpf, Obstet Gynecol Clin N Am 35 (2008) 19-35**

Background – Scope of the Issue

- Little formal oversight of safety and quality in the office setting
  - **AAAHC and JC have accreditation programs**
  - **Usually voluntary**
  - **In some states, only triggered by deeper levels of anesthesia**

Office Based Surgery Accreditation

- Now that we are moving so much to the office the potential for harm is higher than ever
- We have to develop a culture of safety in the office too, not just in the hospital and surgicenter

Background – Where is Surgery Performed?

- Over the past 20 years:
  - **Explosion of Ambulatory Surgery Centers**
  - **Move of surgery from hospitals to ASCs**

Where is Surgery Performed?

- **Now moving to the office…**

Where is Surgery Performed?

- Of more than 32 million surgical procedures performed in 2006, approx 75% were out-patient*
  - **Mostly ASC or "same day" surgery centers**

***Stumpf, Obstet Gynecol Clin N Am 35 (2008) 19-35**

Background – Adverse Events R. R.

- FLA Board of Medicine 2 Yr Study*:
  - More than ten-fold increase in AEs and Deaths

	AEs/100,000	*Deaths/100,000*
ASC's	**5.3**	**0.78**
Office Setting	**66.0**	**9.2**

***Stumpf, Obstet Gynecol Clin N Am 35 (2008) 19-35**

Adverse Events – Relative Risk

- Often same doctor / same procedure
- Not a board certification issue
- Some think the study is flawed
- Presence of anesthesiologist lowered ASC death rate?
- Regardless, risk higher in office setting

Adverse Events – Relative Risk

- Difference may be lack of a "system" in the office
  - **Less "teamwork"**
  - **Less clearly defined roles**
  - **Less safety equipment and "back-up" systems**

What do we do in the office?

More "Traditional" Office Procedures

- Endometrial Biopsies / Polypectomies
- Bartholin's Abscess I&D
- Vulvar Biopsies
- Colposcopies
- LEEPs
- Breast Cyst aspirations

Recently Added Procedures

- Global Endometrial Ablations
  - **ThermaChoice®**
  - **NovaSure®**
  - **HerOption®**
  - **Etc.**
- Hysteroscopic Tubal Occlusions
  - **Essure®**
  - **Adiana®**

Coming Soon to an Office Near You:

- TVTs
- TOTs

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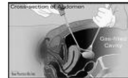
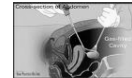


Coming Soon to an Office Near You:

- TVTs
- TOTs
- Laparoscopy?
- Liposuction??
- Aesthetics, veins, hair removal?
- Etc.??



Covered vs Non-covered

- Most of these procedures are covered by insurance (hence, the insurer's interest in pushing them to the office)
- The aesthetics are less likely to be covered

Why do these in the Office?

Economics as a Driver

- Both the PATIENT and the PRACTICE have “skin in the game” and can benefit

Economics as a Driver

- PATIENT:
  - **Saves money (lower co-pays for office procedures compared to ASCs in many plans)**
  - **Many other benefits of familiar surroundings**

In-Office Procedures: Pros

- Patient issues:
  - **convenience**
  - **decreased costs (co-pays)**
  - **familiarity with staff and site (less intimidating)**
  - **more control over encounter**
  - **assumes safety is not an issue of course**

Economics as a Driver

- PRACTICE:
  - **“Site of Service Differential” can be up to tenfold**
  - **More efficient in that the physician stays in the office and sees more (other) patients perioperatively**

In-Office Procedures: Pros

- Physician and Practice issues:
  - **convenience (not running to and from a facility)**
  - **significantly higher fee schedules**
  - **practice builder**

In-Office Procedures: BIG QUESTION

- Is it SAFE???
  - **Anesthesia?**
  - **Vagal reactions, syncope, etc?**
  - **Bleeding?**
  - **Perforation?**

In-Office Procedures: OTHER COSTS

- Closely followed by LIABILITY concerns
  - **One more thing that can go wrong?**
  - **One more way to get sued?**
- Obvious costs (supplies, equipment)

In-Office Procedures: MORE COSTS

- “Not-so-obvious” costs:
  - **Staff time**
  - **Inventory of supplies (ties up capital)**
  - **Space allocated**
  - **Lost opportunity**

PWH Experience

- First 3 years of in-office activities

In-Office Procedures: Our Experience

- More than 2000 procedures in first 3 years
  - **2 patients admitted for pain control**
  - **1 patient admitted for observation after perforation – did well**
  - **No other complications**

In-Office Procedures: Our Experience

- Best Practice - Analgesia:
  - **NSAIDS at hs night before**
  - **Pre-procedure p.o. narcotics / relaxants**
  - **To Block or Not to Block (doesn’t seem to matter)**
  - **We are not “snowing” people and they are doing well**
  - **Headphones and iPods help!**

In-Office Procedures: Our Experience

- Recovery Time:
  - **Average 30 minutes from end of procedure to “discharge” home**
- Most patients managed with NSAIDs only at home
- Called later that day and/or next morning to check on patient’s status

Is this right for you?

Safety Considerations: Things You'll Need

- Protocols and guidelines
- Safety / emergency kits
  - Include at least O_2, smelling salts, atropine, etc.
- Emergency drills
- Double check w/your Risk Manager or Insurer

Safety Considerations: Patient Selection

- Only ASA Class I patients (some Class II also)
- "Nervous Nellies" vs
- "Unsinkable Molly Browns"
  - Often pre-op workup can help differentiate
  - Unable to tolerate sonohyst, unlikely to tolerate GEA or hysteroscopy.

Safety Considerations: Equipment

- Must be up to date and in good repair
- Should be calibrated and checked out by engineer on regular basis
- Should keep log of maintenance and calibration

Safety Considerations: Supplies

- Check all drugs and supplies for "stale dates" (and document your checking)
- Have emergency equipment handy and know how to use it (in-service log)
  - Oxygen
  - Drugs
  - Emergency airway

Safety Considerations: Staff

- Team Training
- Credential your surgeons
  - Maintain file on your doctors
  - License, DEA, certificates of training prn
  - Board certification evidence
- Mock Drills
  - Syncope
  - CPR, etc.

Mock Drills

- Run one each Quarter
- Based on possible complications
- All staff who participate in office surgery should be present
- Roles for each aspect of patient care and safety should be clearly defined.

Mock Drills

- Ensure that all members of a patient care team are coordinated in the care of that patient.
- Have a team member role play a patient
- Act out the drills to help the entire team accomplish the goal of handling a potential complication in a standard, stepwise fashion.

Mock Drills

Focus on roles/responsibilities specific to each person:

- Communication
  - **Call for help (within the office)**
  - **Notify front desk about incident**
  - **Front desk should prepare to dial 911 if necessary and wait for ambulance at entrance of building if 911 is called**
  - **Verbally confirm roles with others ("I will call 911" or "I will go wait outside")**
  - **Communicate with other patients or family members**

Mock Drills

- Interventions (dependent on the situation)
  - **Place patient in supine position and elevate legs**
  - **Open/support airway**
  - **Check for pulse and blood pressure (if bradycardic, see ACLS algorithm)**
  - **Give fluids as tolerated**
  - **Debrief with all office staff after patient recovers**

Tracking Outcomes

- Important to dos:
  - **Develop "best practices"**
  - **Watch for errors and risks**
  - **Prove you're offering value to your patients**

Tracking Outcomes

- Forms should include:
  - **Patient ID**
  - **Procedure performed**
  - **Indication**
  - **Pre-op Prep / Analgesia**
  - **Intra-op "flow sheet"** **(BPs, meds, pain scale)**
  - **Post-op**
    - Complications?
    - Efficacy?

QA in the office

- Track outcomes, adverse events, etc.
  - **Prepare regular reports**
  - **Watch for trends or problems**
- Review the data on regular basis
- Report findings to governing body and staff
  - **Up and down the chain of command**

In Summary:

- Migration of procedures to the office
- Can be very good for the practice
- Can also be good for patients
- Proper planning is critical to success

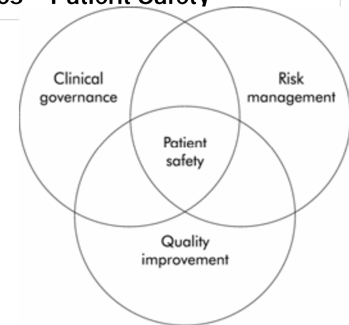
In Summary:

- Patient Safety is paramount
  - **ACOG has produced a monograph (see ACOG website: click on "Publications" tab, then "Task Force and Work Group Reports" and find "Report of the Task Force on Patient Safety in the Office Setting"**
  - **WHO also has a great resource:**

    WHO Guidelines for Safe Surgery 2009

    www.who.org and search for "Safe Surgery"

Office Procedures – Patient Safety



Thank you very much!