Outpatient Surgery and Sequelae

An Analysis of the AAAASF Internet-based Quality Assurance and Peer Review Database

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KEYWORDS

• Plastic and reconstructive surgery • Outpatient surgery • Sequelae

KEY POINTS

- The Internet-based quality assurance and Peer Review Program (IBQAP) has demonstrated the safety of procedures performed in the outpatient setting through the analysis of outcomes, the future of patient care will be directed by evidence-based medicine.
- Large inpatient surgical databases, such as the National Surgical Quality Improvement Program, the Nationwide Inpatient Sample, and the National Trauma Database, have long existed to provide quality assurance and improvement data for the inpatient cohort of patients.
- The acquisition of large data sets related to surgical care can best be achieved through the Internet.
- However, the structure of the data points must encompass the entire care process, from preoperative preparation to postoperative management.
- When outcomes are analyzed in conjunction with the indications for a procedure and the manner that care was delivered, evidence-based medicine is the end product.

INTRODUCTION

The number of surgical procedures performed in outpatient surgery facilities has increased dramatically over the past 20 years as a result of the development of safe standards for operation.[1,2] According to the National Center for Health Statistics, outpatient procedures performed in community hospitals in the United States increased from 16% in 1980 to 63% in 2005.[3] The growth of freestanding and office-based ambulatory surgery facilities has exceeded the number of hospital-based facilities. However, legislation requiring accreditation or licensure of these facilities has been slow to evolve. At this time, half of the states do not require any oversight of outpatient facilities.

The specialty of Plastic and Reconstructive surgery has been instrumental in supporting accreditation and licensure for outpatient surgery. Founded by Plastic Surgeons, the American Association for Accreditation of Ambulatory Surgery

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Clin Plastic Surg 40 (2013) 465–473
http://dx.doi.org/10.1016/j.cps.2013.04.010
0094-1298/13/$ – see front matter

Facilities (AAAASF), Inc was established in 1980 to develop an accreditation program to standardize and improve the quality of medical and surgical care in ambulatory surgery facilities while assuring the public of high standards for patient care and safety in an accredited facility. AAAASF now accredits single-specialty and multispecialty facilities accounting for most surgical specialties, including gastroenterology, podiatry, and oral and maxillofacial surgery. As the largest organization in the country that accredits office-based surgery centers, AAAASF has been engaged in the movement to mandate accreditation or licensure of outpatient surgery facilities nationally. AAAASF's main focus is safety and the improvement of patient care.[4,5]

In 1995 AAAASF championed AB 595 (Speier) in California that mandated accreditation or licensure for outpatient facilities in that state. In 2001 the American Society of Plastic Surgeons and the American Society for Aesthetic Plastic Surgery took a strong position in the effort to improve patient safety by mandating that their members operate only in accredited or licensed facilities.[4,5]

All surgical specialties now routinely perform some of their procedures on an outpatient basis. The outpatient surgery setting offers convenience, patient privacy and comfort, increased efficiency, and lower costs.

Those facilities that are accredited or licensed by the state, either free standing or office based, must comply with recognized standards of operation to safeguard patient care. Monitoring compliance with these standards is vital to ensure patient safety.

With this concept in mind, AAAASF, now the largest organization in the United States that accredits single-specialty or multispecialty office-based surgery centers, has taken the lead in evaluating compliance with standards through monitoring outcomes in their facilities. A major advance in this process was the development of the first Internet-based quality assurance database program (IBQAP).[6]

In recent years there have been numerous inpatient databases used to monitor surgical and medical outcomes, but there were no national databases providing an overview of outcomes in the outpatient arena. IBQAP was created in 1999 to fill that void.[6]

DATA COLLECTION

AAAASF standards require all accredited facilities to institute an ongoing quality improvement program that monitors and evaluates the quality of patient care, creates methods to improve patient care, and identifies and corrects deficiencies within their facilities. In adhering to this standard, all surgeons in accredited facilities must enter random case reports and all unanticipated sequelae into IBQAP. Peer review must be performed every 6 months. If peer review sources external to the facility are used to evaluate delivery of surgical care, the patient consent form is written to protect the confidentiality of the medical records, consistent with current HIPAA and other legal standards.

PEER REVIEW

Peer review is performed either by a recognized peer review organization or by a physician other than the operating surgeon. A minimum of 6 random cases per surgeon using the facility must be reviewed, and for group practices, 2% of all cases performed. These random case reviews must include assessment of the following 7 items:

1. Thoroughness and legibility of the history and physical examination
2. Adequacy and appropriateness of the surgical consent form
3. Presence of appropriate laboratory, electrocardiographic, and radiographic reports
4. Presence of a dictated operative report or its equivalent
5. Anesthesia record for operations performed with intravenous sedation or general anesthesia
6. Presence of instructions for postoperative and follow-up care
7. Documentation of unanticipated sequelae.

All unanticipated operative sequelae must be entered, including, but not limited to, the following 9 defined categories:

1. Unplanned hospital admission
2. Unscheduled return to the operating room for complication of a previous procedure
3. Untoward complications of a procedure, such as infection, bleeding, wound dehiscence, or inadvertent injury to another body structure
4. Cardiac or respiratory problems during stay at the facility or within 48 hours of discharge
5. Allergic reaction to medication
6. Incorrect needle or sponge count
7. Patient or family complaint
8. Equipment malfunction leading to injury or potential injury to patient
9. Death

Each unanticipated operative sequela chart review includes the following 5 informational items, in addition to the operative procedure performed:

1. Identification of the problem
2. Immediate treatment or disposition of the case