

Surgery Center Accreditation

Joe Niamtu III

The field of orthognathic surgery puts the “maxillofacial” in oral and maxillofacial surgery (OMS). Prior to this, oral surgeons were still among the best-trained head and neck surgeons, with an amazing scope, but when we began performing orthognathic surgery, the public and the competitors stood up and took notice. Orthognathic surgery is a unique service that our profession has dominated for decades.

The past decade has brought about many changes that have negatively affected the prevalence of orthognathic procedures. Unfortunately, these factors have nothing to do with the actual need for the procedure or the desire of our profession to perform it. These factors are largely insurance related, and it has gotten to the point where many experienced surgeons have abandoned orthognathic surgery because of the low pay, high liability, and intensity of work-up. This author feels that this will shift and that patients

will pay for what they view as necessary procedures. Very few patients balk at spending \$5,000 to \$7,000 (US) for orthodontics, breast implants, or wide-screen televisions. Our challenge is to make orthognathic surgery safe and affordable for patients and referring specialists. This author and his partners have pursued this mechanism by incorporating an Accreditation Association for Ambulatory Health Care (AAAHC) surgery center in our offices (Figures 4-1 and 4-2).

There are many advantages in having an accredited office and surgery center. These include improved patient care, safety, convenience, ability to bill for facility fees, and marketing advantage. Most oromaxillofacial surgeons are familiar with the accreditation process, but are intimidated and hesitant because of lack of understanding of the process. I, like others, once thought accreditation had to do with the physical facility.

I thought that I had to literally build a “small hospital” in my office and this misinformation kept me from proceeding. In reality, the accreditation process is much more about governance than physical plant. In effect, having an accredited facility is like practicing with Mother looking over your shoulder. It forces you to “do the right thing.” Accreditation requires the office and staff to address all common issues of patient care from sign in to sign out. It requires policies for most things that we all take for granted. It also requires the practice to perform such tasks as peer review, chart review, and efficiency studies. Although this seems distasteful to the average busy practitioner, it really does provide excellent and important feedback on safety, patient care, and efficiency. These studies may include patient care parameters such as the prevalence of postoperative nausea and vomiting, or more clerical topics such as average waiting times for new patients.

Practicing in an accredited facility is similar to having one’s own hospital, in terms of requiring specific policies, equipment, staff, medications, etc (Figures 4-3 and 4-4). It may require the surgeon to dictate operative reports, perform more sophisticated drug counts, have emergency power back-up, and perform other cross-checks. Although many private practitioners cringe at such “extra work,” I have unanimously found one thing to be true. All of the doctors that I know personally have expressed that the accreditation process was not an easy one, but it was the best thing they had ever done. It has made them better



FIGURE 4-1 The author’s office and surgery center.



FIGURE 4-2 The main operatory of the office.

2 Diagnosis and Treatment Planning



FIGURE 4-3 A back-up power supply was one piece of equipment required for accreditation.

doctors, made their offices safer and more efficient, provided a marketing advantage, and put OMS on the highest possible level.

Going solo through the accreditation process is a task of awesome proportion, as is fishing in

the ocean without a guide. With a guide, the fisherman can go directly to a productive area with known baits and techniques and save a lifetime of frustration. The same thing is to be said about an accreditation consultant. There are well-recognized companies that serve as coaches to greatly simplify the accreditation process. Using a consultant can save the surgeon and staff thousands of hours and thousands of dollars. The consultants assist the office in every step of the process and even perform a mock office accreditation survey. When our offices underwent professional accreditation consultation, the fee was approximately \$5,000 (US). In retrospect, it was some of the best money we had spent in the 22 years that we have been in business!

My worst fear was that we would have to purchase tens of thousands of dollars of “equipment.” In actuality, we did purchase an emergency back-up system for approximately \$3,000 (US), some lighted exit signs, a few fire extinguishers, and a label maker. The biggest changes were, as mentioned above, in terms of policies. We were required to draft or improve such things as patient confidentiality issues, hospital transfer policies, and needle stick and emergency policies. We had to develop credentialing policies similar to the

hospital, and each of my partners had to “apply for specific privileges.” We needed regular inspections by the local fire marshal and we needed to keep track of such mundane things as operating room (OR) schedules and practice marketing materials.

Since my partners and I had been steadily getting rejections for orthognathic surgery procedures, we wanted to make the process simple and affordable for surgical orthodontic patients without insurance coverage. This took a little thinking and reasoning. It all occurred about the time that I personally limited my OMS practice to only cosmetic facial surgery procedures. We saw that people (even those of average income) had no problem paying \$5,000 to \$12,000 (US) surgical fees for face-lifts and other cosmetic facial procedures. As most of us know, most people will pay cash for what they perceive as value to their life or health. The limiting factors with traditional orthognathic surgery was the hospital fees that could reach \$30,000 (US) and the surgeons fees that unfortunately are a thing of the past. It is well known that women readily pay \$5,000 to \$7,000 (US) for breast implants. Some merely write a check and some bring in “cookie jar” money, but thousands of women do it yearly. We wish that we could bill for orthognathic surgery like we did 20 years ago, but we also wish that gasoline was 75 cents (US) a gallon. We have attempted to provide a fair package for the patient requiring orthognathic surgery. We charge \$5,000 (US) per arch plus the anesthesiologist’s fee. There are some limitations when performing orthognathic surgery in the office. We find that single-arch surgeries are performed more commonly than those for double arch, although my partners have performed concomitant upper and lower osteotomies. We probably tend to be more conservative than with hospital patients, but it has not been a significant problem. On occasion, we will recover patients on a 23-hour basis with a staff registered nurse. Having the patient stay overnight with a nurse and on monitors has proven to be a safe and effective recovery strategy. Some patients choose to use a private duty nurse at their home, which is also a huge convenience and safety precaution. In Virginia, this costs the patient about \$300 (US).

We have used our surgery center and the ability to perform convenient, safe, and affordable orthognathic surgery as a marketing advantage with referring dentists and orthodontists as well as with the public.

In terms of accreditation agencies, multiple choices exist. The Accreditation Association for Ambulatory Health Care (AAAHC) is probably the most popular organization for outpatient office accreditation. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is the main accrediting body of



FIGURE 4-4 Dantrolene, a medication that most oromaxillofacial surgery offices do not have, is required for accreditation if general anesthesia is used in the office.

hospitals but also certifies outpatient centers. The American Association for Accreditation of Ambulatory Surgery Centers (AAAASC) is another accrediting body that, in this author's understanding, is comprised of plastic surgery offices for plastic surgeons. There are pros and cons of each individual accrediting body. The AAAHC is so popular that many patients recognize it. The JCAHO is the same body that accredits hospitals and there is something to be said about that statement in terms of understanding and marketing. Regardless of the accrediting body, it is the act of accreditation that makes one better.

In general, the time involved with getting accredited is beyond the available time commitment of most doctors. This means that one needs at least two extremely reliable, motivated, and willing staff members to head the team. Although every employee and doctor will be involved in some way, the team leaders are literally on the front line. I recommend that one of these persons be a registered nurse, as much of the accreditation process is similar to other health care facilities, and nurses simply understand it better and have been through similar situations. In all reality, the doctor merely needs to serve as a supervisor and be informed of major changes and be familiar with basic policy. As stated above, having a reputable consultant literally saves thousands of dollars and hundreds of hours.

When changing gears from an office operatory to an accredited outpatient surgery center, there are things that are significantly different and must be addressed. Do not get me wrong; being accredited does not somehow transform your office into another place. In fact, there will hopefully be minimal changes of your physical plant—you will merely be doing things better, more efficiently, and safer. Since most oromaxillofacial surgeons perform short procedures on young healthy patients, the entire process must be rethought when considering orthognathic or cosmetic surgery. With orthognathic surgery, the main challenge is the anesthesia. These patients cannot require intubated general anesthesia and the procedure can sometimes result in significant blood loss. Fluid management and postanesthesia recovery are other factors that require close care. In the hospital environment, the surgeon can pass through the recovery room and see the patient, and then go back to work or home. In the surgery center environment, you are in the recovery room, and you and your staff are responsible for the patient. This will require one staff member to be dedicated to that patient until they are stable for recovery. Sometimes, that may mean staying with the patient at the facility (for a fee) or accompanying the patient home in a private duty nursing role. With cosmetic procedures, the



FIGURE 4-5 A refurbished anesthesia machine purchased by the author, to have the ability to perform orthognathic and cosmetic surgery procedures in the office surgery center.

general patient population is older and many of the patients are medically compromised. This adds an entirely different spin on the anesthesia delivery. In addition, these cases can last 5 to 6 hours. Extracting four wisdom teeth from a healthy 16 year old with intravenous sedation is much more simple than performing a 4-hour osteotomy or face-lift on an older patient with medical problems.

In this author's experience, the biggest problem is obtaining repeatable anesthesia support. Anesthesiologists and nurse anesthetists are nationally in short supply, due in part to the recent popularity of remote surgery centers. Our experience has been that a nurse anesthetist will charge \$100 (US) per hour, and physician anesthesiologists charge at least twice that amount. It has been difficult to find anesthesia support 2 to 3 days per week and this remains our biggest challenge. This author and his staff will perform intravenous sedation with ketamine, Versed, and propofol on healthy, American Society of Anesthesiologists (ASA) Class I patients with straightforward procedures, but relegate to professional anesthesia assistance for compromised patients or extremely long cases. Our office maintains the same standards as the local

5



FIGURE 4-6 A used operating room table purchased for the surgical center. Great savings are appreciated when using durable and reliably refurbished equipment, and prolonged surgical procedures are best performed on a fully adjustable table.

3

4

4 Diagnosis and Treatment Planning

6 hospitals in terms of preoperative laboratories. Determined by their age, patients must present with preoperative physician history and physical, electrocardiogram, coagulogram, and possibly other tests. This is also a time-consuming process to coordinate the laboratory work and make sure it is back to the oromaxillofacial surgeon in time for surgery. This will take up a lot of time, for which ever staff member is in charge.

When dealing with surgery center patients, no insurance is accepted and no payment plans are generally used. Patients are required to pay the full fee for surgery and anesthesia up front. If you do not like paperwork, then you will not like accreditation. I would say that our routine daily paperwork doubled after accreditation. Whereas we had a single form for surgery, anesthesia,

recovery, and follow-up, we now have dedicated forms for all of these, and more. Despite this increased paperwork, it truly does make a more comprehensive and safer patient record. In the event of a lawsuit, our records are much more complete and comprehensive than they were prior to accreditation. Furthermore, the surgeon must dictate operative reports for all patients done at the surgery center. This may seem distasteful to many, but it is truly the right thing to do and makes for superior medical record-keeping.

As stated above, we did have to purchase some specialized equipment, but it was minimal. The back-up power supply was required. We purchased an anesthesia machine because we wanted to be able to perform comprehensive

procedures (Figure 4-5). We also purchased an OR surgical table because we knew we would be performing longer procedures (Figure 4-6). The anesthesia machine, OR table, and just about any other hospital-grade equipment are available for significant savings in used condition from many sources.

In conclusion to this portion of this chapter, initial accreditation was a task of awesome proportions. It was hard work for many of the team, but relatively little work for the doctor. There is no doubt that it has made me a better surgeon and made my office a better and safer place to have surgery and anesthesia. I would wholeheartedly recommend it to any oromaxillofacial surgeon who wants his/her practice to be all that it can be and better than the rest.

Chapter 4: Author Query Form

Author: Joe Niamtu III

Chapter: Surgery Center Accreditation

- 1 AU: as meant?
- 2 AU: input okay?
- 3 AU: as meant?
- 4 AU: as meant?
- 5 AU: as meant?
- 6 AU: as meant?