OMA Application for Office Based Surgery Survey 1.2

Please Read All Instructions Carefully Before Entering Any Information in this *Office Based Surgery Application for Survey*

This *Application* was designed to provide the Oregon Medical Association Accreditation Committee with a profile of the organization that has requested an accreditation survey. The answers to the questions do not weigh toward achieving or not achieving accreditation. They provide descriptive information which is helpful to the surveyors, staff and Accreditation Committee in understanding the organization and its practices.

Surveyors will review the *Application* and supporting documents prior to conducting the on-site survey and may seek verification and clarification of certain items during the survey. **The *Application* cannot be processed unless each question is answered and all information is provided, including the list of documents requested on page 7. It is very important that this document be completed accurately.**

All information should be directed to:

D'Arcy Renhard
Oregon Medical Association
11740 SW Parkway #100
Portland, OR 97223-9038

Instructions

1. Print or type the information requested, or place an "X" in the appropriate box for questions requiring a "**Yes**" or "**No**" response. If an item or question is not applicable to the organization, enter "**NA**" in the appropriate place.

2. Please complete, copy and return the *Application* along with supporting documentation requested on page 7 to OMA. Please **do not** assemble documents in bound notebooks or utilize plastic page protectors and, remember to retain one copy of the completed documentation for your files.

3. Include a check made payable to "Oregon Medical Association" in the amount of $500. Please note that this application fee is non-refundable.

Legal Name of Organization_____
(Please note: The legal name listed above will be the official name of the organization used on all OMA documents, including the Certificate of Accreditation and the website.)

Additional name(s) used by organization including "dba:"
_____
_____
_____
Web Site Address_____
Street Address_____
_____
City/State/Zip _____
Telephone_____ Fax_____
Survey Contact Person (name/title)_____
Email _____
Telephone _____ Fax _____

For internal use: Customer #_____ Amount _____ Check # _____

If currently OMA -accredited, also provide the name of the organization as it appears on current Certificate of Accreditation:

_____

_____

Chief Administrative Officer_____

Chief Medical Officer_____

Name of individual to whom the accreditation decision letter should be addressed:

_____

Indicate date organization began or will begin to provide service (month/year):

_____

Please provide a brief description of the organization's ownership, history, community served and health care services provided:

_____

_____

_____

_____

Please indicate below the appropriate numbers for this facility:

_____ Providers (credentialed physicians)

_____ Operating rooms

_____ Procedure rooms

Please indicate your organization's area(s) of specialty (check all that apply):

	Cardiology		Ophthalmology
	Cosmetic Surgery		Oral and Maxillofacial Surgery
	Dentistry		Orthopedics
	Dermatology		Otolaryngology
	Dermatological Surgery		Pain Management
	Facial Plastic and Reconstructive Surgery		Plastic Surgery
	Family Practice		Podiatry
	Gastroenterology		Reproductive Medicine
	General Plastic Surgery		Urology
	General Surgery		Vascular Surgery
	OB/GYN		Other _____

INTRODUCTION
To assist OMA in making travel arrangements for the survey team, please provide the following information:

Nearest major airport –
Name _____ City/State _____

Is there convenient taxi service from this airport to the survey site and suggested hotels? [ ] Yes [ ] No

Please recommend two comfortable hotels/motels close to the survey site. If possible, list facilities:

Hotel # 1—Name_____

Street Address_____

City, State, Zip _____Telephone_____

Distance from airport (miles) _____ Distance from survey site_____

Hotel # 2—Name_____

Street Address_____

City, State, Zip _____ Telephone _____

Distance from airport (miles) _____ Distance from survey site _____

If this is your first OMA accreditation survey application, please answer the following questions. If you are applying for re-accreditation, please go to the next page.

Why are you seeking accreditation?
(Choose all that apply)

___ Requirement by third-party payor or liability insurance carrier
___ Directive from professional society or state legislature
___ Desire to improve performance
___ Recognition of commitment to high quality standards
___ Other
_____
_____

Why did you choose the OMA to be your accreditation organization?
(Choose all that apply)

___ OMA's reputation
___ Referred by an industry colleague or an organization/association
___ Dissatisfaction with your previous accreditation experience
___ Price
___ Experience with OMA in a previous organization
___ Other
_____
_____

Documents to be Submitted with this OMA *Office Based Surgery Application for Survey*

Copies of each of the following documents must be submitted with the completed *Application*. Use currently existing material whenever possible. Please do **NOT** assemble documents with staples, bound notebooks or utilize plastic page protectors since these materials will be disassembled by OMA for survey use. Simply clip the pages together using a paper clip or other similar method. *Please make sure that all pages are numbered.*

1. Brief statement of the mission, goals, and objectives of the organization.

2. Description of ownership, including the names and addresses of all owners or controlling parties.

3. A copy of the medical bylaws where applicable, or similar rules and regulations of the organization.Review of this document will include, but not be limited to, the following items:

    a. credentialing and privileging policies and procedures for practitioners and other health care professionals;

    b. committee structure; and

    c. governing body structure and procedures for appointment or selection.

4. Descriptive summary or table of the organization.

5. A copy of the organization's emergency plan, e.g., fire, earthquake, flood.

6. Statement of patient rights and responsibilities.

7. Examples of patient handouts.

8. Reports of any inspections conducted by state and local fire marshals, state or local health departments, or other code enforcement agencies.

1 RIGHTS OF PATIENTS

1. Does the organization make information available to patients and staff on:

a) patient rights?

Yes No

b) patient conduct and responsibilities?

Yes No

c) services available at the organization?

Yes No

d) provisions for after-hours and emergency care?

Yes No

e) fees for services?

Yes No

f) payment policies?

Yes No

g) provider credentialing?

Yes No

2 GOVERNANCE

1. Name(s) of governing body

_____
_____

2. How often does the physician meet with the staff, either formally or informally, for the purpose of discussing the operation and performance of the organization? _____

3. Are there minutes or other documentation of these meetings?

Yes No

4. Does the organization have a process for the identification, reporting analysis, and prevention of adverse incidents, as well as a system to evaluate consistent and effective implementation of that process?

Yes No

5. Does the practitioner(s) have privileges at a nearby hospital

Yes No

6. Provide the following information for all providers credentialed to practice within the organization, including physicians, nurses and other allied health care providers. A list of providers, if available, may be submitted.

NAME	SPECIALTY	Full-Time	Part-Time	Board-Certified	Board-Qualified
Total # Health Care Providers					

7. Does the organization conduct patient satisfaction surveys?

Yes No

8. Does the organization monitor the continued maintenance of licensure and/or certification for professional personnel?

Yes No

9. Does the organization have regular clinical staff meetings?

Yes No

3 QUALITY OF CARE PROVIDED

1. Does the organization have a process for adequate and timely transfer of information when patients are transferred to other health care providers?

Yes No

2. Are provisions are made to communicate with patients in the language or manner primarily used by them?

Yes No

4 RISK MANAGEMENT

1. Does the organization have a risk management program as part of the organization's overall quality management and improvement program?

Yes No

2. Which person or committee within the organization is responsible for the risk management program?

_____

3. As part of the risk management program is a review of clinical records and clinical record policies conducted?

Yes No

4. Is education in risk management provided to all staff within the organization?

Yes No

5 CLINICAL RECORDS AND HEALTH INFORMATION

1. Is there a designated person in charge of clinical records?

Yes No

2. Briefly describe the organization's clinical record filing system.

_____
_____
_____

3. Are data about hospital admissions and discharges routinely placed in the patient's clinical record?

Yes No

4. Does the organization have a method to identify, in the clinical records, the presence or absence of patient drug and material sensitivities?

Yes No

5. Does the organization have policies and procedures that address retention of active records?

Yes No

6. Does the organization have policies and procedures that address retirement of inactive records?

Yes No

6 FACILITIES AND ENVIRONMENT

If the organization has more than one service location it would like to be included in the accreditation site survey process, please note that the Office Based Surgery Accreditation Program is only available to organizations with a single location.

1. Name and address of facility. (Please provide a listing of facilities on a separate sheet of paper if more than two facilities.)

_____
_____
_____

2. Indicate how and where patients obtain medical care after-hours when an emergency arises and the organization is closed.

_____
_____

3. Describe the physician on-call system for after-hours and weekends.

_____
_____

4. Are personnel trained in CPR and in the use of cardiac emergency equipment available during all hours that patients are in the facility?

Yes No

5. Are appropriate emergency equipment and supplies readily accessible to all areas of the facility where patients may be located?

Yes No

6. Does the organization have a system in place for identifying, managing, handling, transporting, treating and disposing of hazardous wastes?

Yes No

7. Are the internal emergency drills held at least four times a year?

Yes No

8. Does the facility have illuminated signs at all exits from each floor or hall?

Yes No

9. Is there an alternate power source in case of power failure?

Yes No

10. Are provisions made to reasonably accommodate disabled individuals?

Yes No

11. Does the organization document periodic instruction of all personnel in the proper use of safety, emergency, and fire extinguishing equipment?

Yes No

7 ANESTHESIA SERVICES

1. Are there procedures performed in the organization that use:

(a) general anesthesia? [ ] Yes [ ] No

(b) deep sedation/anesthesia? [ ] Yes [ ] No

(c) regional anesthesia? [ ] Yes [ ] No

(d) moderate sedation/analgesia (conscious sedation)? [ ] Yes [ ] No

(e) minimal sedation? [ ] Yes [ ] No

(f) local/topical anesthesia? [ ] Yes [ ] No

(g) Is N_2O ever used as an anesthetic? [ ] Yes [ ] No

If yes, does the level of N_2O used ever exceed 50%? [ ] Yes [ ] No

If any part of question 1 is answered yes, answer questions 2-11. If all items are answered no, skip to question 1, Section 8.

2. Indicate the number of surgical procedures performed during the last three calendar or reporting years, as well as the type of anesthesia used.

Year	Total Number	General	Deep Sedation/ Analgesia	Regional Anesthesia	Moderate Sedation/ Analgesia (Conscious Sedation)	Minimal Sedation	Local/ Topical Anesthesia

3. What professional discipline (or specialty) of provider is credentialed and privileged to administer anesthesia?

_____Anesthesiologist

_____Certified Registered Nurse Anesthetist

_____Physician/Surgeon

_____Other, please list _____

4. If the organization administers moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia, does intra-operative physiological monitoring include continuous use of a pulse oximeter, EKG monitoring, and blood pressure determination at frequent intervals?

Yes No

5. Who is privileged to supervise anesthesia services?

_____Anesthesiologist

_____Certified Registered Nurse Anesthetist

_____Registered Nurse

_____Surgeon

_____Other, please list

6. Describe the procedures used to evaluate the patient immediately prior to surgery to assess the risks of anesthesia relative to the surgical procedure.

_____
_____

7. Describe the procedures used to evaluate the patient before medical discharge from the facility.

_____
_____

8. Are logs of the annual functional testing and calibration of anesthesia machines maintained?

Yes No

9. If the organization administers general anesthesia, is there end-tidal CO_2 determination and a means of measuring body temperature?

Yes No N/A

10. Does the organization provide anesthesia services to children?

Yes No

If yes, does the organization have appropriate equipment, medication and resuscitative capabilities for pediatric patients, including PALS and/or ACLS certified staff?

Yes No

11. Does the organization administer agents known to trigger malignant hyperthermia? *

Yes No

If yes,

(a) Does the organization have written protocols and emergency equipment and drugs for the treatment of malignant hyperthermia?

Yes No

(b) Does the organization perform periodic resuscitation technique drills for treatment of Malignant Hyperthermia?

Yes No

For a list of current agents and further information regarding malignant hyperthermia, contact the Malignant Hyperthermia Association of the United States, 39 East State Street, PO Box 1069, Sherburne, NY 13460-1069, (607) 674-7901, www.mhaus.org.

8 SURGICAL AND RELATED SERVICES

1. Are surgical or related procedures performed in the organization's facilities? Surgical services and related procedures that might be provided by the organization are defined as any invasive procedures performed for diagnostic purposes, including (but not limited to) pain management, endoscopy procedures, cardiac catheterization, lithotripsy and in-vitro fertilization.

Yes No

If yes, answer questions 2-12. If no, skip to question 1, Section 9.

2. Are surgical procedures performed in the facilities limited to procedures approved by the governing body?

Yes No

3. Describe procedures followed to ensure that preoperative diagnostic studies and a current history and physical examination are made part of the patient's clinical record before surgery.

_____
_____
_____

4. Describe procedures followed to ensure that the necessity or appropriateness of the proposed surgery, as well as any alternative treatment techniques, have been discussed with the patient prior to scheduling for surgery, and that the occurrence of such discussion is documented.

_____
_____
_____

5. Does the organization have a written transfer agreement and/or admitting privileges with a nearby hospital?

Yes No

If no, what is the organization's plan for handling medical emergencies?

_____
_____
_____

6. Are there provisions for obtaining blood or blood products, especially in an emergency?

Yes No N/A

7. What environmental controls are implemented to assure a safe and sanitary surgical environment?

_____
_____
_____

8. What kind of emergency power is available in the operating rooms and recovery rooms?

_____
_____
_____

9. Briefly describe the organization's protocol for instructing patients on self-care after surgery.

_____
_____
_____

10. Does the organization utilize laser technology?

Yes No

If yes, list the types of lasers that are used in the facility.

_____
_____
_____

11. Does the organization provide surgical services to children?

Yes No

12. Does the organization provide diagnostic and/or therapeutic services to children?

Yes No

9 PHARMACEUTICAL SERVICES

1. Is there a pharmacy on the premises?

Yes No

2. Does the organization own or operate a pharmacy?

Yes No

3. Describe procedures to ensure that records and security are maintained for the control and safe dispensing of drugs.

_____
_____
_____

4. Describe the organization's system that is in place to ensure expiration dates of all medications, including vaccines and samples, are checked on a regular basis and expired items are disposed of in a manner that prevents unauthorized access and protects safety.

_____
_____
_____

5. If applicable, does the organization have a system to prevent unauthorized access to prescription pads?

Yes No

6. If applicable, provide the following information about all pharmacy personnel employed by the organization.

	Number of Full-Time Individuals	**Number of Part – Time Individuals**	**Total Number Of Individuals**
Registered Pharmacists			
Pharmacy Technicians			
Other (list titles used by the organization)			
Total Pharmacy Personnel			

7. If there is no pharmacy on-site, are the drugs and other pharmaceutical supplies provided or made available in accordance with applicable federal and state laws?

Yes No NA

8. If there is no pharmacy on-site, does the organization have a pharmacist consultant available?

Yes No NA

10 PATHOLOGY AND MEDICAL LABORATORY SERVICES

1. What, if any, laboratory tests are performed in house?

_____
_____
_____

2. Are laboratory tests restricted to those that have a CLIA waiver? If no, answer question 3.

Yes No

For a complete list of CLIA-waivered tests, go to *http://cms.hhs.gov/clia*.

3. Does the organization perform clinical laboratory tests that are not CLIA waived? If yes, please describe.

_____
_____
_____

11 GENERAL INFORMATION

Name of Organization Seeking Accreditation

_____
_____
_____

The following questions are applicable to the organization seeking accreditation, and any of its physicians, other health care professionals, owners, officers and directors.

1. Is the organization aware of any review initiated or continuing within the last four years by a state medical board or other federal, state or non-governmental oversight entity of any physician or other health care professional with privileges at the organization?

Yes No

If yes, provide on a separate sheet of paper for each party or incident: Name of physician/health care professional; name and location of board/entity; date and reason for review; current status of review.

2. Is there any physician or other health care professional with privileges in your organization, whose license has been suspended, revoked or voluntarily surrendered or placed on probationary status within the past four years?

Yes No

If yes, provide on a separate sheet of paper for each party or incident: Name of physician/health care professional; name of action (suspension, revocation, voluntary surrender, probation); name and location of agency; date and reason of action; current status of review or reinstatement.

3. Is there any physician or other health care professional with privileges in your organization whose DEA license has been suspended, revoked or voluntarily surrendered within the past four years?

Yes No

If yes, provide on a separate sheet of paper for each party or incident: Name of physician/health care professional; name of action (suspension, revocation, voluntary surrender); date and reason of action; current status of review or reinstatement.

4. Has the organization or governing body placed any limitations or conditions on any physician or other health care professional's privileges within the past four years?

Yes No

If yes, provide on a separate sheet of paper for each party or incident: Name of physician/health care professional; limitation or condition; date and reason for action; current status of review or reinstatement.

5. During the past four years, has the organization or any of its physicians, other health care professionals, owners, directors, officers or administrators been named in or the subject of any malpractice suits?

Yes No

If yes, provide on a separate sheet of paper for each malpractice suit: Name(s) of the plaintiff(s) and defendant(s); docket or case number; court where filed; summary of allegations; any decision or settlement; if pending, the current disposition.

6. During the past four years, has any other civil or criminal investigation, complaint, action or indictment (other than traffic violations) been initiated or filed in state or federal court that directly or indirectly involves the organization or any of its physicians, other health care professionals, owners, directors, officers, or administrators?

Yes No

If yes, provide on a separate sheet of paper for each party or incident: Name(s) of plaintiff(s) and defendant(s); docket or case number; court where filed; summary of allegations; any decision or settlement; if pending, the current disposition.

7. Has the organization or any of its physicians, other health care professionals, owners, officers, directors, administrators, or staff been sanctioned, indicted, found guilty of criminal charges (other than traffic violations) or had disciplinary actions brought against them within the past four years by federal or state authorities, any professional medical society, accreditation agency or other governmental or nongovernmental oversight entity?

Yes No

If yes, provide on a separate sheet of paper for each party and incident: name and title of the party sanctioned/indicted/disciplined; name and location of the sanctioning/indicting/disciplinary agency or entity; nature of the sanction/indictment/discipline/ or verdict; date and reason for the action; current status.

8. Has the organization or any of its physicians, other health care professionals, owners, officers, directors, administrators or staff been found guilty of any unfair labor practices or employment discrimination?

Yes No

If yes, provide on a separate sheet of paper for each action or case: Name of the party/plaintiff filing the action; name of the defendant(s); agency or court where filed; docket or case number; summary of allegations; any decision or settlement; if currently pending, the current disposition.

9. Have federal, state, or municipal authorities initiated legal action or otherwise cited or sanctioned the organization for matters concerning workplace safety or environmental regulations?

Yes No

If yes, provide on a separate sheet of paper for each action or case: Name of party/plaintiff filing the action; name of the defendant(s); agency or court where filed; docket or case number; summary of allegations; any decision or settlement; if currently pending, the current disposition.

Name of Chief Executive Officer_____

(Print Name)

Signature of Chief Executive Officer_____**Date**_____

OMA will maintain as confidential all information provided to it with respect to any organization that is seeking or has obtained accreditation, will use such information solely for purposes of reaching an accreditation decision, and will not disclose such information to any third party except (1) on prior written authorization from the organization; or (2) as otherwise required by law.

All written or verbal information provided to the OMA regarding the survey and/or accreditation process must be accurate and true. Providing falsified documentation or information for use in evaluating compliance with the OMA standards may be grounds for denial or revocation of an organization's accreditation status or may result in termination of the application.

The applicant is subject to the current accreditation policies and procedures of OMA. By signing this *Office Based Surgery Application for Survey*, the applicant agrees to the accreditation policies and procedures of the OMA as amended from time to time. As an accredited organization, the applicant will receive notice regarding changes in the OMA's policies and procedures. In addition, all changes to the OMA's policies and procedures will be published.

The undersigned makes application to the OMA for an accreditation survey of the organization named below encompassing all components of the legal entity. The undersigned certifies that the organization meets the survey eligibility criteria, and grants permission to the state licensing agency or any other relevant examining or reviewing group to release official records of the organization to the OMA if necessary for its consideration concerning accreditation.

The applicant recognizes and agrees that it shall not be entitled to monetary damages, whether compensatory, consequential, collateral, punitive or otherwise, from the OMA, its officers, directors, employees, agents, surveyors, or members of its committees as a result of any controversy or claim with the OMA arising out of any procedures, actions or decisions with respect to accreditation.

In the unlikely event that the applicant has an controversy or claim with the OMA arising out of any procedures or decision with respect to accreditation, the applicant hereby agrees that applicant shall have the right to reconsideration or appeal of such decision in accordance with the OMA's appeal procedures in effect at the time of such appeal and, upon final decision by the Board of Directors of the OMA, to submit such decision for settlement by arbitration administered by the XXX _____ in accordance with its Commercial Arbitration Rules. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. Applicant hereby waives all other rights to sue or to resolution of any such claims against the OMA, its officers, directors, employees, agents, surveyors, and members of its committees in a court of law.

Chief Medical Officer or
Chief Administrative
Officer_____
(Please Print) Name Title

Signature of Chief
Medical Officer or
Chief Administrative Officer_____
Date

Name of
Organization_____
(Please Print)

12 MATERIALS FOR REVIEW BY SURVEY TEAM

If they exist, the following materials should be available on-site for review by the survey team. Do **not** submit these documents with this completed *Office Based Surgery Application for Survey*, unless an exception is noted below.

1. Personnel/credential records for physicians, dentists and other health care practitioners.

2. Reports from companies providing maintenance and calibration of equipment used in providing patient care.

In addition, if any of the following have been changed or updated since submitting your application, the most recent copies should be available on-site for review by the survey team:

1. Policies governing credentialing.

2. Policies and procedures for fire, bomb threat, and other emergency situations.