

# **Accreditation in the USA and National Patient Safety Goals**

**Walter G. Maurer, M.D.**

**Head, Section of Ambulatory Anesthesia  
Department of General Anesthesiology & Critical Care  
Cleveland Clinic Foundation, Cleveland, Ohio**



# Objectives of this Lecture

- **Discuss Regulation and Accreditation in the Health Care Industry**
- **JCAHO as a Form of Accreditation**
- **Quality Improvement & Sentinel Events**
- **NPSG – National Patient Safety Goals**
- **How does this all morph into P4P?**

**We're teaching doctors the importance of  
handwriting using elementary school techniques!**

# Why do health care facilities need accreditation?



- Health care consumes a major portion of national GNP for the United States.
- The American people will NOT permit the expenditure of that much money without some sort of oversight and regulation.
- Accreditation provides some minimal “standards” which all health care facilities should adhere to and it should encourage those accredited to constantly improve their care of patients.
- To be effective, that oversight should be “independent” of those who are to be accredited.



# American College of Surgeons - 1917

## The 5 Minimum Standards

- Staff membership restricted to physicians who are (a) graduates of medicine in good standing, legally licensed to practice in their states, (b) competent in their fields, and (c) worthy in character and in professional ethics; and that the practice of the division of fees, under any guise whatever, be prohibited.
- Staff initiate, with approval of the hospital governing board, adopt rules, regulations, and policies governing professional hospital work.  
Staff meetings at least monthly.  
Staff review and analyze at regular intervals clinical experience in the departments, such as medicine, surgery, obstetrics, and other specialties; clinical records as the basis of review and analyses.
- Accurate and complete patient records, filed in an accessible manner. A complete record being one which includes identification; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, X-ray and other examinations; provisional diagnosis; medical or surgical treatment; gross and microscopic pathological findings; progress notes; final diagnosis; discharge condition; follow-up and, in case of death, autopsy findings



# American College of Surgeons - 1917

## The 5 Minimum Standards

- **Diagnostic and therapeutic facilities under competent supervision available for study, diagnosis, & treatment of patients, to include, (a) clinical laboratory providing chemical, bacteriological, serological, and pathological services; (b) X-ray department providing radiographic and fluoroscopic services.**
- **Physicians privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question of the hospital as “open” or “closed,” nor need it affect the various existing types of staff organization. The word “staff” is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the “regular staff,” the “visiting staff,” and the “associate staff.”**

# The beginnings of Accreditation and Standardization



- 1917 – ACS develops the “Minimum Standards for Hospitals” (One Page!)
- 1918 – ACS begins on site inspections. Only 89 of 692 surveyed meet the minimum standards. Only 264 held staff meetings and 301 kept medical records
- 1926 – 1st standards manual, 26 pages
- 1950 – 3200 hospitals accredited
- 1951 – The ACP, AHA, AMA, and CMA join with the ACS to form the JCAH (Joint Commission on Accreditation of Hospitals) – 1959 CMA departs.
- 1965 – Social Security Act deems JCAH accreditation qualifies as compliance with the HCFA COPs.

# The beginnings of Accreditation and Standardization



- 1972 – DHHS must validate JCAH surveys
- 1978 – JCAH changed to JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
- 1988 – JCAHO changes from “nitpicking” looking a process and outcome.
- 1994 – Moving from QA to CQI
- 2002 – Shared Visions/New Pathways which concentrated on QI, safety, unannounced surveys, tracer methodology, self evaluation
- 2007 – Now called TJC (The Joint Commission) with new president – Dr. Mark Chassin

# So how did JCAHO get so much power?



- The federal law which formed Medicare, required these expenditures be monitored, ensuring that the government got real value for the money spent. Thus they set out the COP (Conditions of Participation).
- Hospitals (very wisely) realized the advantage of paying for (and thus designing) this monitoring and compliance with the COPs, rather than having the federal government do it for them.



# Medicare and JCAHO

- Thus in 1965 JCAHO applied for (and was granted) “deemed status”. Thus if you passed JCAHO accreditation standards, you were “deemed” to be in compliance with the COPs.
- The federal government still monitors JCAHO through random CMS surveys (usually on the heels of a JCAHO survey) AND through periodic broad reviews of JCAHO by the OIG.



# Why do I need JCAHO?

- To get paid by Medicare - CMS (i.e. “Deemed Status”).
- A requisite for other payers
- Useful for hospital marketing efforts
- Does provide an outside, unbiased, standardized, assessment of quality of care
- JCAHO standards focus on
  - Structure
  - Process
  - Outcome

**“No Prophet is Accepted in  
His Hometown”**

NT Luke 4:24



## Other Accreditation Options

- **HFAP (Healthcare Facilities Accreditation Program) - American Osteopathic Assoc.**
- **State/ CMS Inspection**
  - Not really “easier” (but is cheaper)
  - Certainly not standardized to national norms
  - Can be influenced by “local” politics
  - Lack of experience
  - Marketing this certification is problematic

# Accreditation “outside” of Hospitals - ASCs



- Initially the hospitals did not want to share the blessing of accreditation and grant “credibility” to free standing ASCs as a safe way to have surgery – **BIG MISTAKE!**
- Thus the formation of the AAAHC which now accredits the vast majority of ASCs.

# Accreditation of Office Based Surgery



- **The American Society of Plastic Surgeons mandated that to be a member of ASPS, you MUST only do surgery in an accredited facility (Hospital, ASC, Office).**
- **Thus they formed the AAAASF to provide their members with accreditation for the surgery done in their offices.**



## 2007 JCAHO Accreditations

- Hospitals = 4,252
- Long Term Care Facilities = 1,173
- Ambulatory Care Centers = 1,204
- Laboratory Services = 3,016
- Home Care = 3,416



# 2007 JCAHO Accreditations

- Behavioral Healthcare = 1,787
  - Office Based Surgery = 288
  - Critical Access Hospitals = 350
  - International Facilities = 10
- Outside USA



# JCAHO Competition (2002)

- **State/CMS Accreditation = 300**
- **HFAP Facilities Accreditation = 150**



# Current “Hot Topics”

- **National Patient Safety Goals**
- **Medication Management \***
- **Infection Control \***
- **Staffing Effectiveness**
- **Emergency Preparedness**
- **HIPPA**
- **ED overcrowding, Pain Management, Medical Staff Standards**

# Basic Format for JCAHO Standards and Measures



- **Structure Measures (the simplest)**
  - Presence of proper equipment
  - Logistical support
  - Availability of medications (pharmacy)
- **Process Measures (the most frequent)**
  - Preoperative evaluation
  - Patient informed consent
  - Adherence to sterile technique
  - Method for credentialing and privileging.
- **Outcomes Measures (the most difficult)**
  - Rate of postop infection
  - Rate of hospital admission of outpatient surgery
  - Rate of successful resuscitations.



# Sentinel Events

- **“An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof”**
- **1995 - JCAHO starts collecting reportable sentinel events.**
- **2002 - JCAHO began National Patient Safety Goals (NPSG) that were linked to these sentinel events.**

# Types of 4473 Sentinel Events Since 1995



- **Wrong site surgery = 13% (592)**
- **Suicide = 12% (555)**
- **OR/Post op complications = 12% (534)**
- **Medication error = 9% (416)**
- **Delay in treatment = 7% (336)**
- **Patient fall = 6% (257)**
- **Restraint injury = 4% (164)**

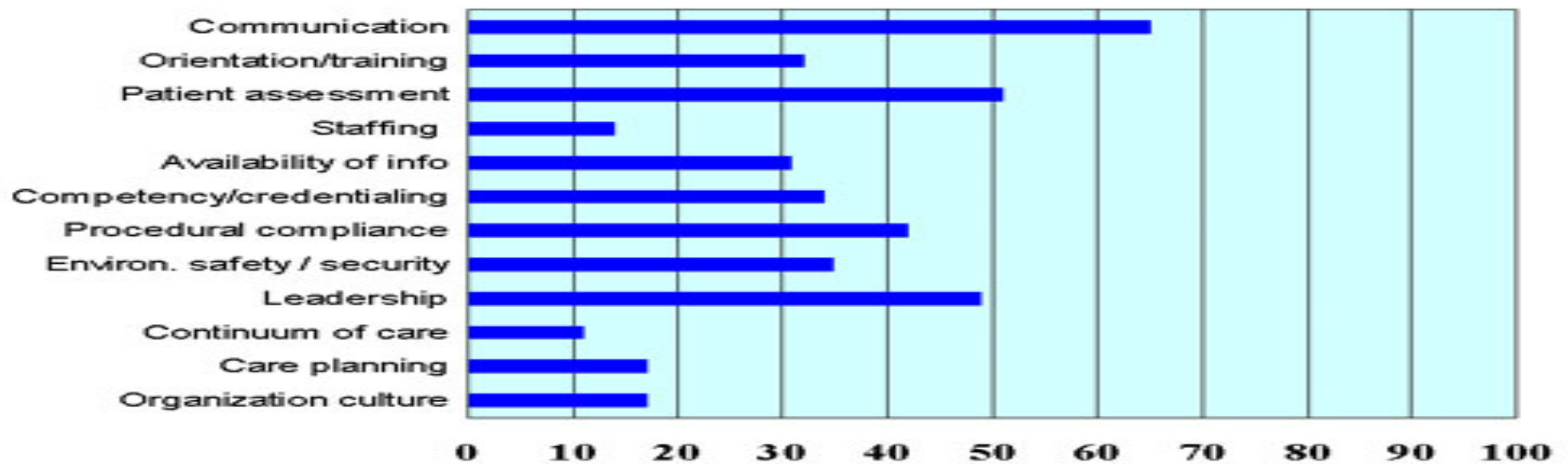
# Types of 4473 Sentinel Events Since 1995



- **Transfusion error = 2% (108)**
- **Anesthesia related = 1.8% (79)**
- **Fire = 1.5% (68)**
- **Ventilator injury = 1.1% (50)**
  
- **Resulting in death = 71% (3257)**

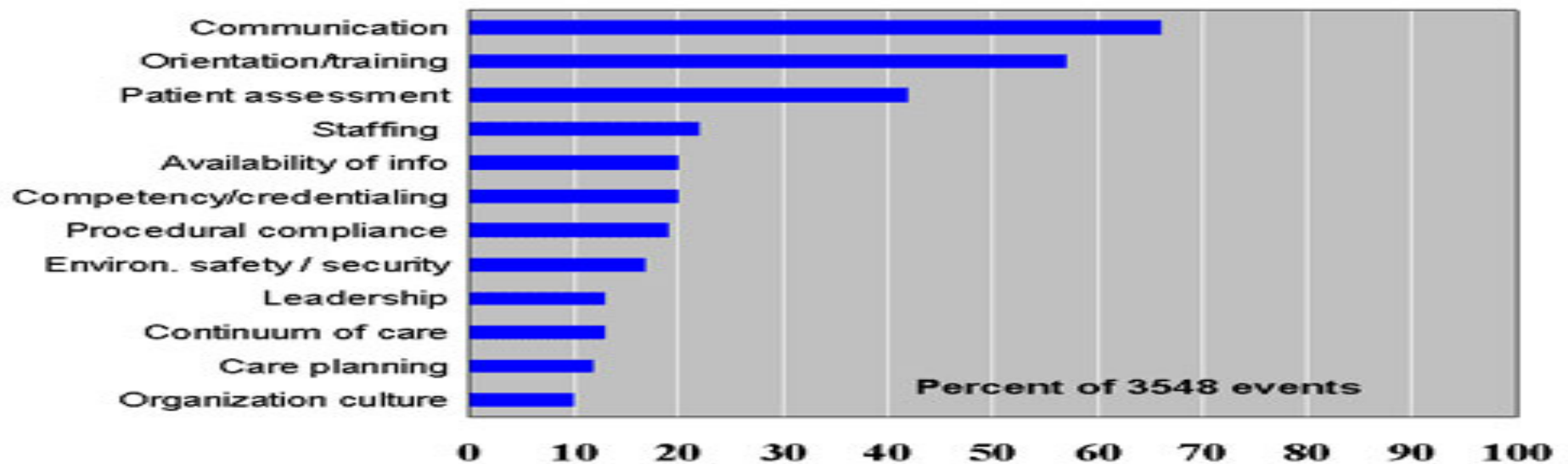
# Root Causes of Sentinel Events

(All categories; 2006)

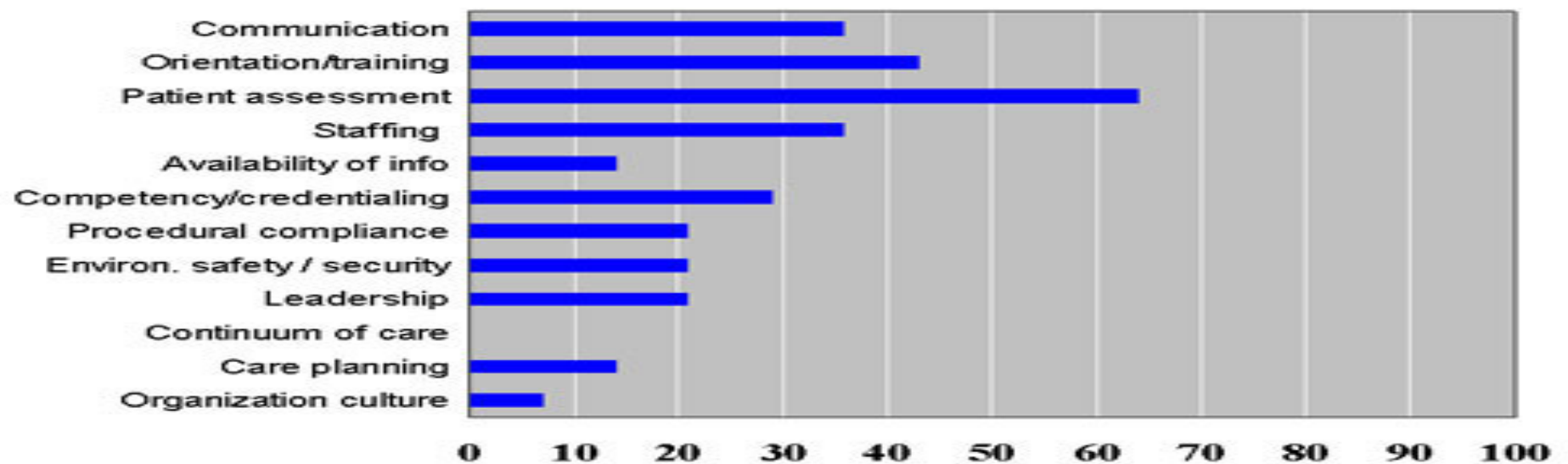


## Root Causes of Sentinel Events

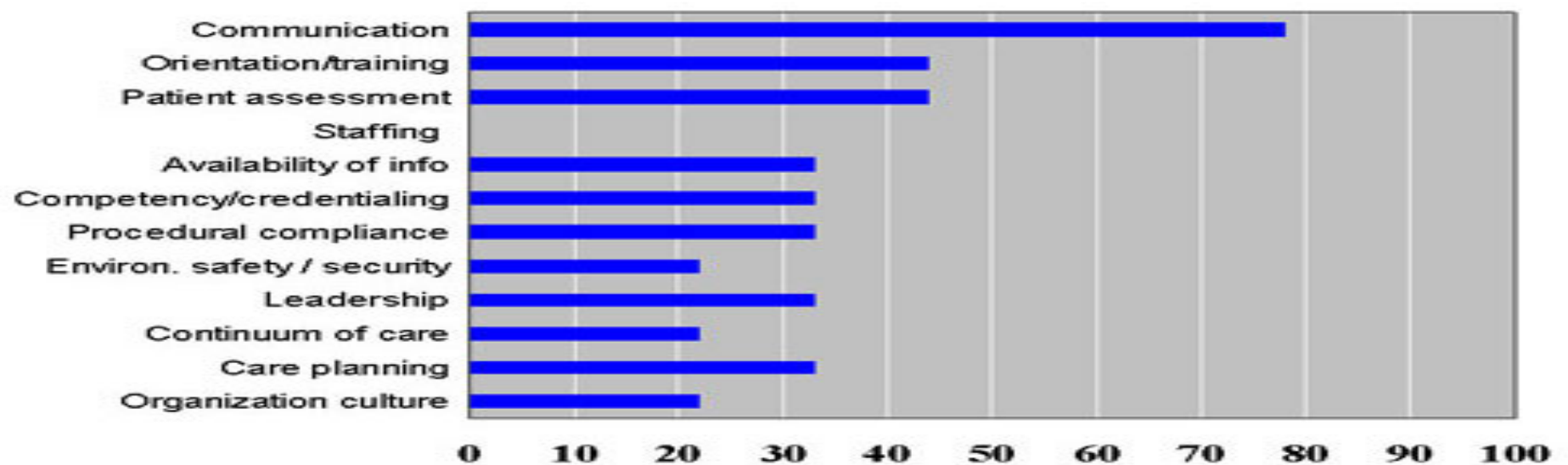
(All categories; 1995-2005)



## Root Causes of Anesthesia-related Events (1995-2004)



## Root Causes of Anesthesia-related Events (2005)

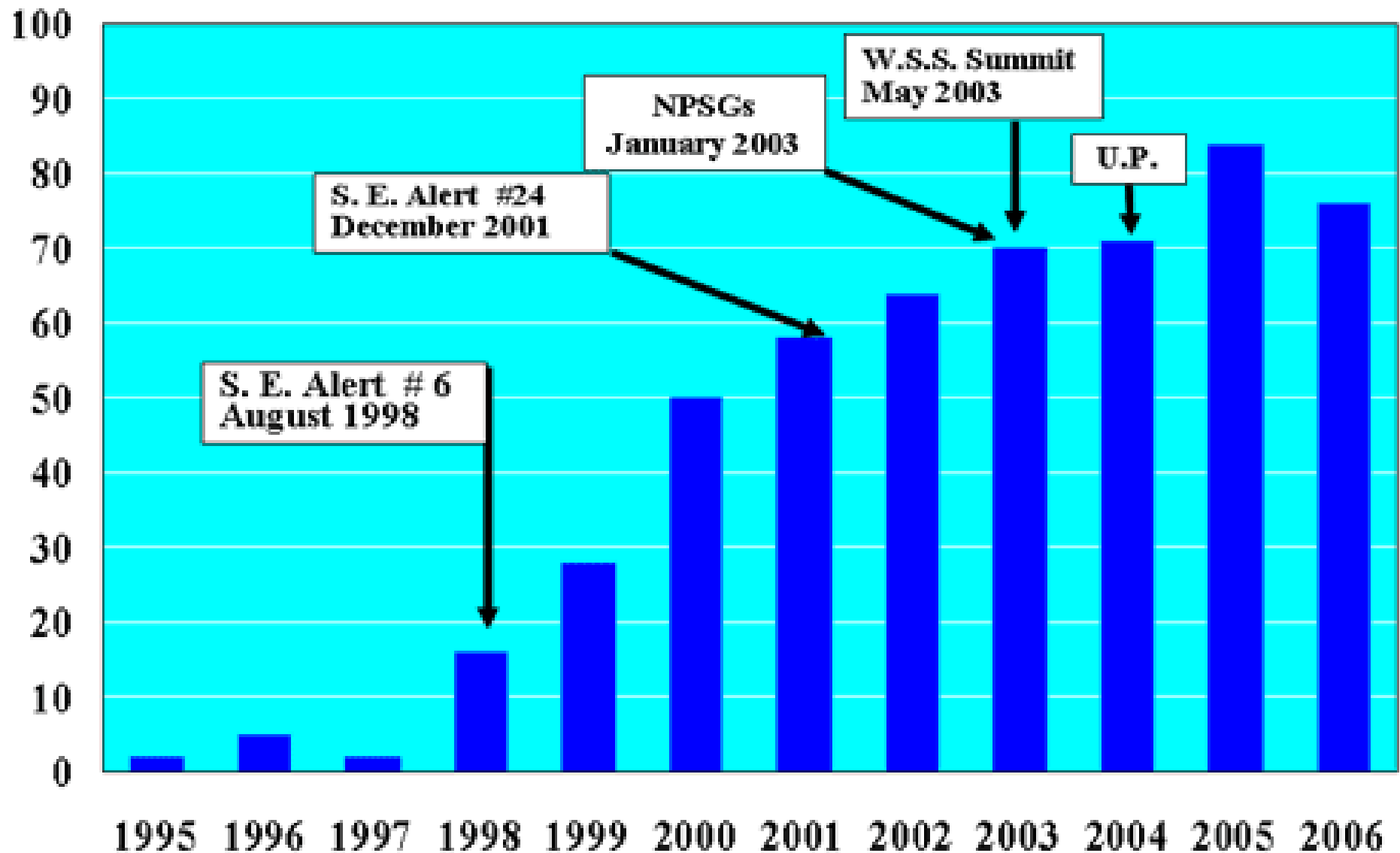




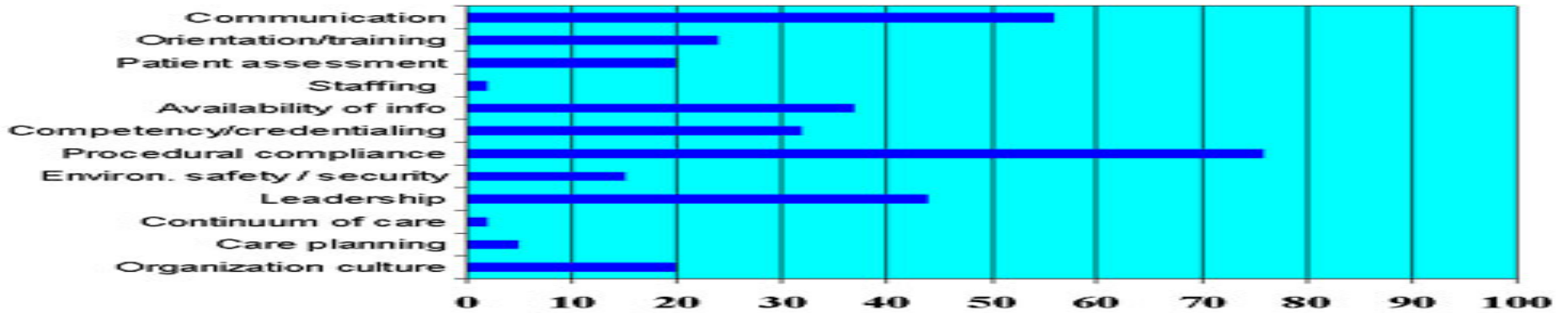
## Where does this data lead?

- **Communication, training, and patient assessment are prime root causes.**
- **Thus these causes have spurred things like the “time out”, standardized patient handoffs, labeling of syringes, etc.**
- **Unfortunately the incidence of wrong site surgery, while initially improving, has now leveled off. Still at the top of the heap in SEs.**

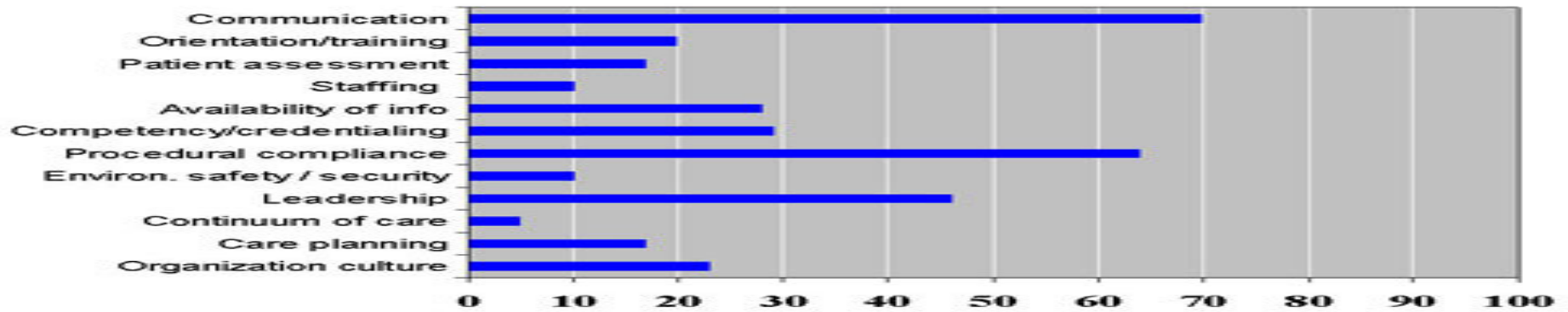
# Sentinel Event Trends: Wrong-site Surgeries Reported by Year



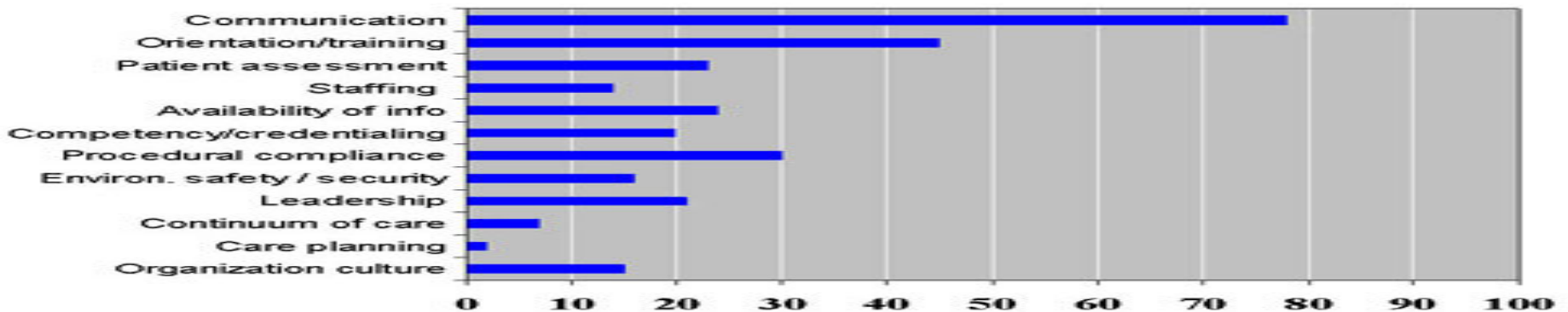
## Root Causes of Wrong Site Surgery (2006)



## Root Causes of Wrong Site Surgery (2005)



## Root Causes of Wrong Site Surgery (1995-2004)



# Why are we not complying with the “time out” procedure



- Are we committed to it?
- It has never happened to me?
- Are ALL the team members present?  
Surgeon, Anesthesiologist, Nurse
- We are rushed and say “I agree”?
- Many other items “added” to T/O?  
Implants, positioning, antibiotics,  
equipment, etc.



# National Patient Safety Goals

- Published yearly since 2002.
- Derived from the sentinel event data.
- Some are “retired” because they are solved (not very likely).
- Some are transferred into the JCAHO standards themselves (more likely).
- Many have distinct “subheadings” added as the years pass.



## 2008 NPSG #1

- *Improve the accuracy of patient identification with at least two patient identifiers.*
- Do you always ask the patient to spell their name AND give you their birth date?
- Do you check those responses against hard copy?
- Do you think the patient thinks less of you when you meet them and appear to “not know their name”?
- Do you identify by room number or surgery?
- Do you look on the “time out” as useful?



## 2008 NPSG #2A

- *Effective communication – read back of verbal orders/results*
- Are you now **ONLY** using verbal orders out of necessity or still out of convenience?
- Do you appear aggravated when a nurse wants to “read back” to you?
- Are non-MDs writing “verbal” orders that are really “routine” orders?



## 2008 NPSG #2B

- *“Do Not Use” abbreviations.*
- With zeros – “Lead, Don’t Follow”
- Daily instead of Q.D.
- 2gm. MgSO<sub>4</sub> vs 2gm. MSO<sub>4</sub> or MS
- ug vs mg



## 2008 NPSG #2E

- *“Hand off” protocols – ability to ask and respond to questions.*
- Different hand-off protocols?
- Lunch breaks vs taking over a case completely
- Signing out to nurses in PACU
- Resident vs Staff
- Does Staff perform their hand-off in the OR and include the resident?



## 2008 NPSG #3D

- *Labeling of medications*
- Syringes, IV bags (going to PACU)
- Review of syringes done in “hand off”
- Content of the label
  - Drug
  - Dose
  - Date (if not destroyed at end of case/day)
- “Syringe Swap” still a major cause of adverse anesthesia events!!



## 2008 NPSG #3E (NEW)

- *Safe use of anticoagulants*
- Products involved in harmful errors
  - #3 = Heparin
  - #6 = Coumadin
  - #9 = Lovenox
- 4/17 deaths = enoxaparin (LMWH)
- Unit dose, premixed infusions, smart pumps with drug libraries, standard protocols, frequent INRs, dietary interactions.



## 2008 NPSG #7

- *Hand Washing Compliance*
- So simple to do, low cost, why has it taken us this long to recognize?
- ID field has known this for years.
- We really have to make it a habit.
- How often is your anesthesia machine or computer interface wiped with a disinfectant?
- Especially important for Staff to model this behavior as we go from “OR to OR”.



## 2008 NPSG #8

- *Reconcile patient medications*
- Has been extremely difficult to do?
- Who does this?
  - Nurses ? or Physicians ?
- Do you use generic or trade names?
- Encourage patients to carry a legible listing of medications, dose, frequency.



## 2008 NPSG #9

- *Implement a fall reduction program*
- Remember this was still 6% of all sentinel events.



## 2008 NPSG #13

- *Encourage patients **AND** families to be actively involved in their care.*
- The days of “the doctor should not be questioned” are definitely over.
- Probably one of the most important and least cost patient safety strategies.
- Need an easy “reporting strategy” for patients and their families.



## 2008 NPSG #15

- *Identify risks of patient suicide.*
- # 2 on the list of SEs
- Second only to wrong site surgery!



## 2008 NPSG #16 (New)

- *Recognition and Response to Changes in Patient's Condition*
- RRT (Rapid Response Teams)
- Different from a “Code Team”
- Warning signs occur 6 – 8 hours before
- Critical events in 4 - 17% of inpatients
- Probably staffed by ICU team members so that timely transfer to ICU can be accomplished if needed.

# NPSGs that Did Not “Make the List”



- **Obstructive Sleep Apnea screening.**  
This was considered immediately after the ASA published their guideline
- **Remember that these NPSGs will probably very quickly move into the area of “Pay for Performance”.**
- **ASA must consider all the above when they embark on developing any new guidelines.**



## Other NPSGs?

- **Influenza and Pneumococcal vaccine was moved from 2007 NPSG #10 into the standards manual.**
- **Reducing Pressure Ulcers was moved from 2007 NPSG #14 into the standards manual.**
- **Surgical Fires #11 in AHC only?**



## Future NPSGs

- **“Anesthesia Awareness” or more accurately “Unanticipated Intraoperative Awareness” (SEA 32).**  
**How has your facility responded?**
- **Use of IT in assisting accurate patient identification.**
- **Effect of Health Care Worker (HCW) fatigue on safe patient care. (look to airline and trucking industries)**

# How can you have input into the JCAHO standards?



- **PTAC (Professional Technical and Advisory Committee)**
- **ASA**
  - Two representatives on the Hospital PTAC  
Bob Lagasse, Don Arnold
  - Two representative on the Ambulatory PTAC  
Walter Maurer, Mark Singleton
- **SAMBA**
  - Two representative on the Ambulatory PTAC  
Tom Cutter, Peter Glass

# Tips to Understand JCAHO Accreditation and Surveys



- Accreditation is like salvation, everyone wants it. But no one wants to recognize that they are basically sinners.
- Art is in the eye of the beholder, and compliance with a standard is in the eye of the surveyor. Standards are indeed broad policy statements and EPs (elements of performance) have some greater detail.
- JCAHO is like a realtor, they don't represent the buyer. They represent the seller (CMS).

# Using Reporting of Quality Measures in P4P



- **Anthem demands annual reporting of measures and an option to renegotiate if compliance falls below 70%.**

Quality processes, behavioral medicine, obstetrical care, cardiac care, hospital credentialing, ED/asthma/pneumonia care, joint replacement, cancer care, CHF, AMI, patient safety

- **Other purchasers and payers:**

Requiring submission of data with rates made available to employees

Pay-for-performance schemes being devised such as forgoing co-pay if employee uses hospital or doctors with good “scores”



# The Leapfrog Group

- Launched in January 2000.
- By “The Business Roundtable” CEO group.
- To encourage large employers to recognize and reward health plans and hospitals that make breakthrough improvements in patient safety and quality.
- Using preferential referrals and “other” market reinforcements (like \$\$\$).



**THE LEAPFROG GROUP**  
for **Patient Safety**  
Rewarding **Higher Standards**

- **More than 150 public and private organizations that provide health care benefits**
- **More than 34 million Americans**
- **More than \$62 billion in health care expenditures**



# Initial Leapfrog “Leaps”

- **Computerized Physician Order Entry (CPOE)**  
Elimination of 80% of preventable drug errors
- **Intensive Care Physician Staffing (IPS)**  
CCM trained M.D. on site or tele-monitoring,  
or risk adjusted outcomes comparison  
29% mortality reduction (JAMA, 11/02)
- **Evidence Based Hospital Referral (EHR)**  
Volume, process measures, outcomes  
>30% mortality reduction - 7 complex treatments

# 27 NQF “Safe Practices” Adopted by Leapfrog



- Adequate staffing ♦
- Prevention of:
  - Surgical site infection (SSI) ♦
  - Pressure ulcers
  - DVT (Deep venous thrombosis) ♦
  - Tourniquet – ischemia/thrombosis ♦♦
  - Malnutrition ♦
  - Wrong Site, Wrong Surgery ♦
  - Central line sepsis ♦♦
  - Contrast induced renal failure
  - Aspiration

# 27 NQF “Safe Practices” Adopted by Leapfrog



- Anticoagulation services
- Document DNR orders ♦♦
- Hand washing ♦♦
- Flu vaccination of healthcare workers
- Identify high alert medications
- Medication unit dosing
- Perioperative beta blockers ♦♦
- Verbal order readback
- Pharmacists active in medication use
- Standardized abbreviations
- Prevent mislabeled radiographs

# IHI “Save 100,000 Lives” What Is It?



- **IHI Campaign to save 100K lives across the U.S.**

**1600 volunteer hospitals (free to participate)**

**Using six evidence-based interventions**

**Participating hospitals commit to at least one intervention and send mortality data as the main measure of the campaign’s ‘success’**



# The Six Changes that Save Lives

- **Rapid Response Teams**
- **Acute MI (e.g., aspirin, beta blockers, timely treatment)**
- **Ventilator Associated Pneumonia bundles (plus other complications) ♦♦**
- **Central Venous Line care to reduce infections (bundle of 5 practices) ♦♦**
- **Surgical Site Infection Prophylaxis ♦**
- **Prevention of Adverse Drug Events with patient medication reconciliation**

**So what about Anesthesiologists?**

**“Nothing is so exhilarating as  
to be shot at without result.”  
- Winston Churchill**

**Right now it looks like the surgeons  
will get shot at first, then us!!**



# SCIP Measures

## Surgical Care Improvement Project

- Mortality within 30 days of surgery
- 30 day re-admission rates
- Within 30 days of discharge

Post-op wound infection

AMI

Cardiac Arrest

PE

DVT

Pneumonia



# SCIP Measures (continued)

## ■ Surgical Site Infections

% On-Time prophylactic antibiotics \*\*

% Appropriate antibiotics \*

% With 24 post-op antibiotics

% BS <200 for 24<sup>0</sup> pre-op and 48<sup>0</sup> post-op\*\*

## ■ Cardiovascular Events

% at risk patients receiving beta blockers\*\*

## ■ Venous Thromboembolism

% receiving prophylaxis for VTE\*\*

## ■ Respiratory Complications

% ventilators with HOB greater than 30 degrees\*\*

# APR-DRGs – A new method of accounting for co-existing disease



- “Attempt to enhance the accurate coding of comorbid conditions so as to more accurately compare outcomes as displayed on public report cards.”
- System was developed by 3M.
- Is applied to “All Payers”, not just Medicare.
- 4 levels of “Severity of Illness” for each DRG.
- These are used to develop a “Risk of Mortality” score.



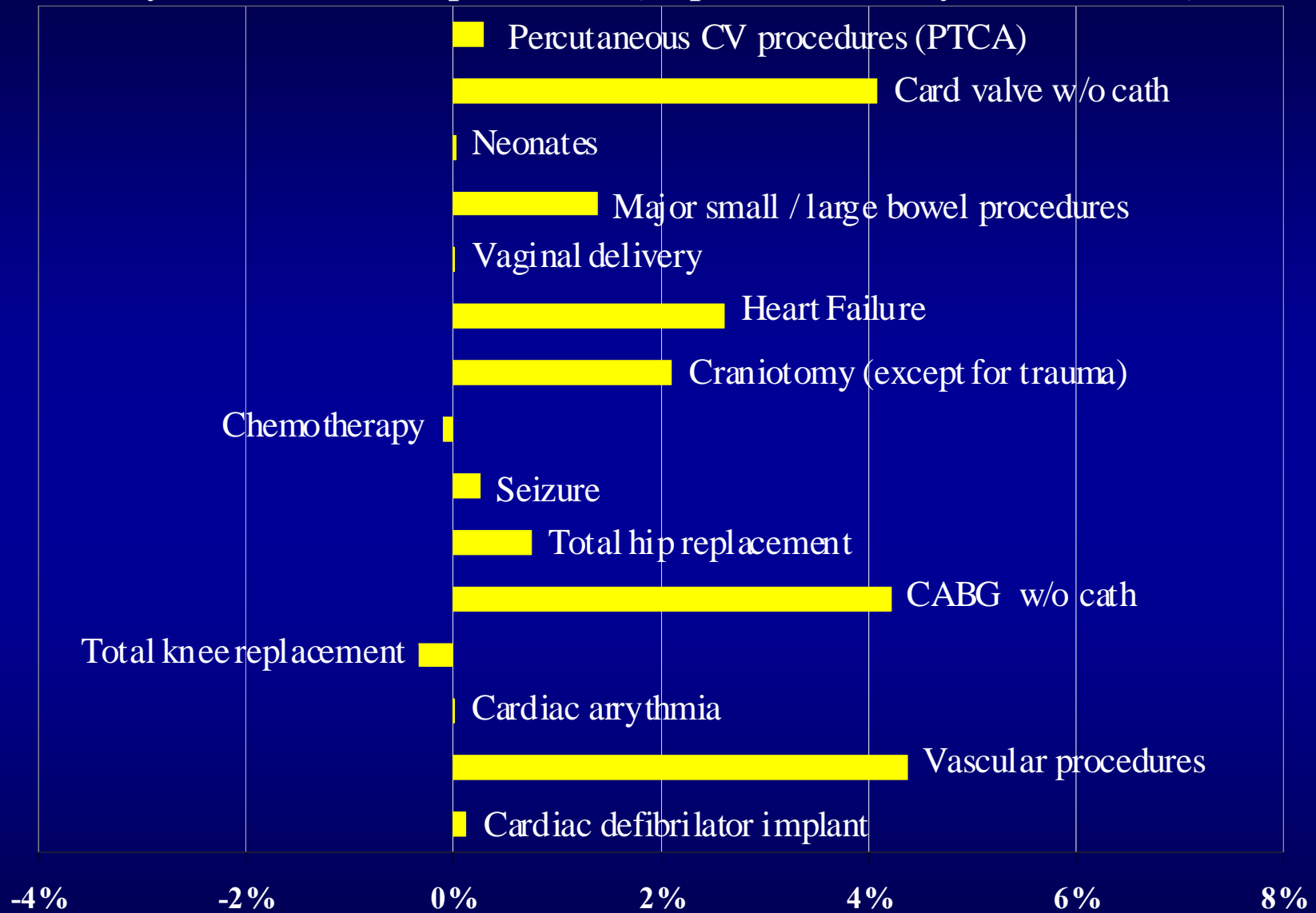
# Who is using APR DRGs

- **AHRQ (The Agency for Healthcare Research and Quality)**
- **HealthGrades**
- **US News and World Report**
- **Used in state-based performance reporting**
  - 33 state agencies use APR-DRGs**



# The Cleveland Clinic Foundation

## Mortality Rate: Peer Group vs CCF (Top APR DRGs by CCF Volume)

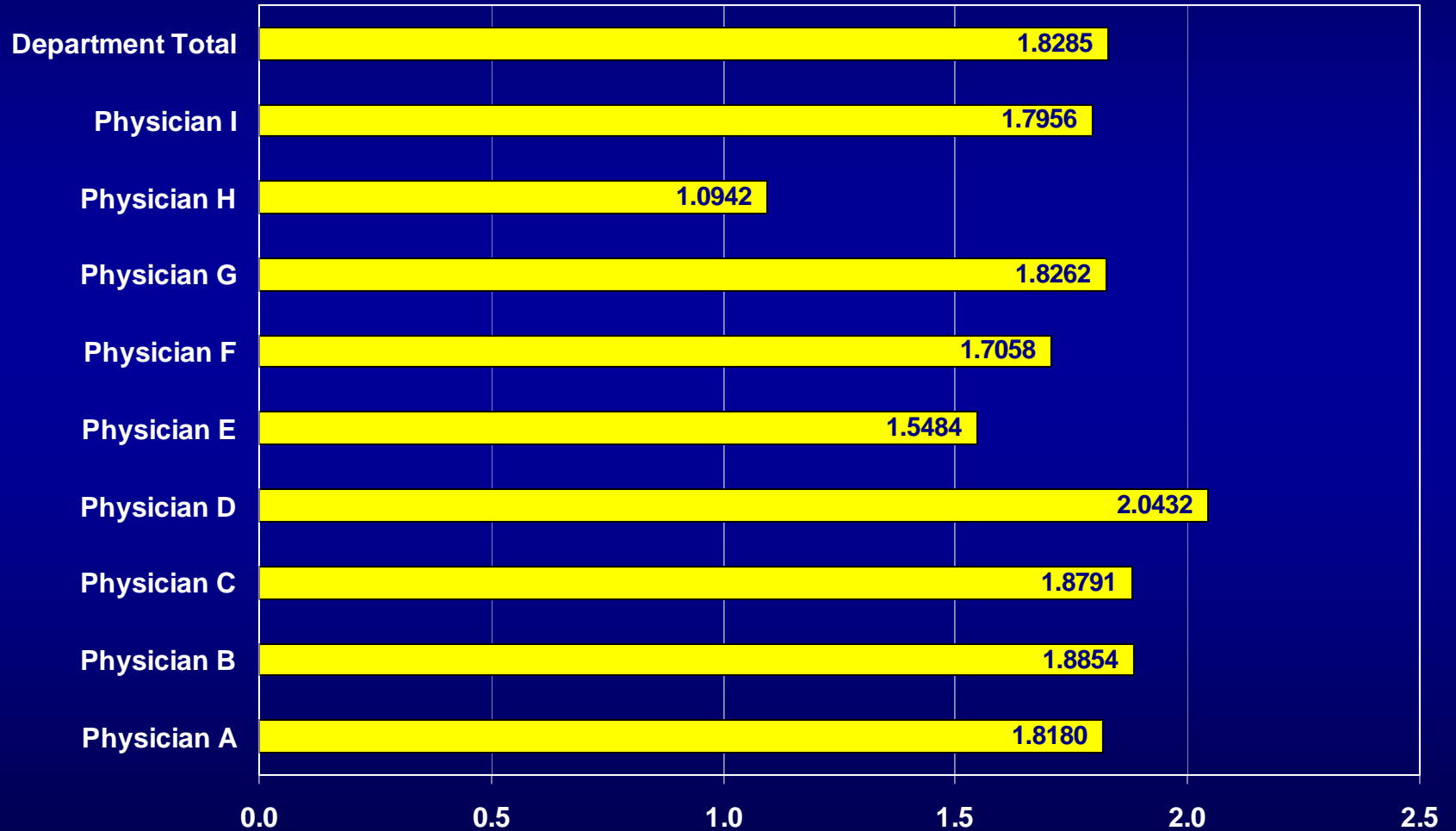


← GT Expected Mortality | LT Expected Mortality →

Source: TSI.  
Time Frame: Jan - May, 2004



## Average Severity of Illness Index by Physician





The Cleveland Clinic Foundation

## Severity Adjusted Length of Stay by Physician by APR-DRG APR-DRG XXX

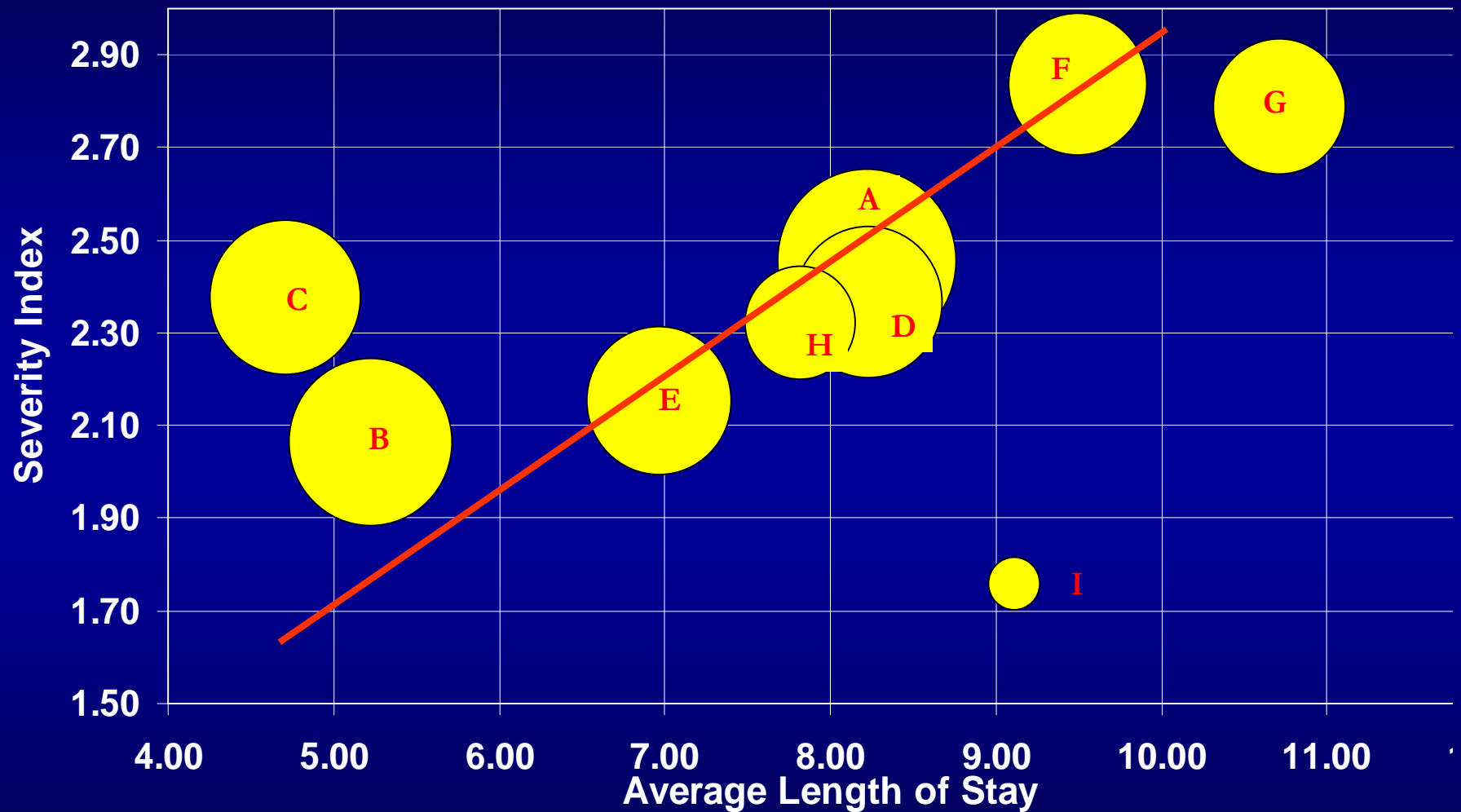
Physician Name	Severity Category								Total		
	1-Minor		2-Moderate		3-Major		4-Extreme		# cases	ALOS	Avg severity of Illness
	# cases	ALOS	# cases	ALOS	# cases	ALOS	# cases	ALOS	# cases	ALOS	Avg severity of Illness
Physican A	13	5.31	64	6.66	18	12.06	6	19.83	101	8.23	2.4544
Physican B	35	2.49	35	4.71	12	12.58	2	18.00	84	5.23	2.0622
Physican C	24	2.25	29	4.21	16	6.88	4	14.50	73	4.71	2.3741
Physican D	16	4.88	35	5.43	15	13.87	3	30.67	69	8.23	2.3666
Physican E	13	5.15	44	6.68	6	9.50	2	17.50	65	6.97	2.1511
Physican F	2	4.00	36	6.47	16	10.75	6	26.17	60	9.50	2.8366
Physican G	11	6.45	21	8.90	19	12.74	5	20.00	56	10.71	2.7874
Physican H	7	5.14	22	6.32	9	12.11	1	21.00	39	7.82	2.3207
Physican I	6	7.33	2	4.50	1	29.00			9	9.11	1.7572
APR-DRG TTL	138	4.20	310	6.32	134	11.49	41	22.63	623	8.03	2.4855

Source: TSI. Time Frame: Jan - May, 2004



The Cleveland Clinic Foundation

## Physician Severity Index vs. Length of Stay - APR DRG XXX



Bubble Size represents total May YTD Discharges

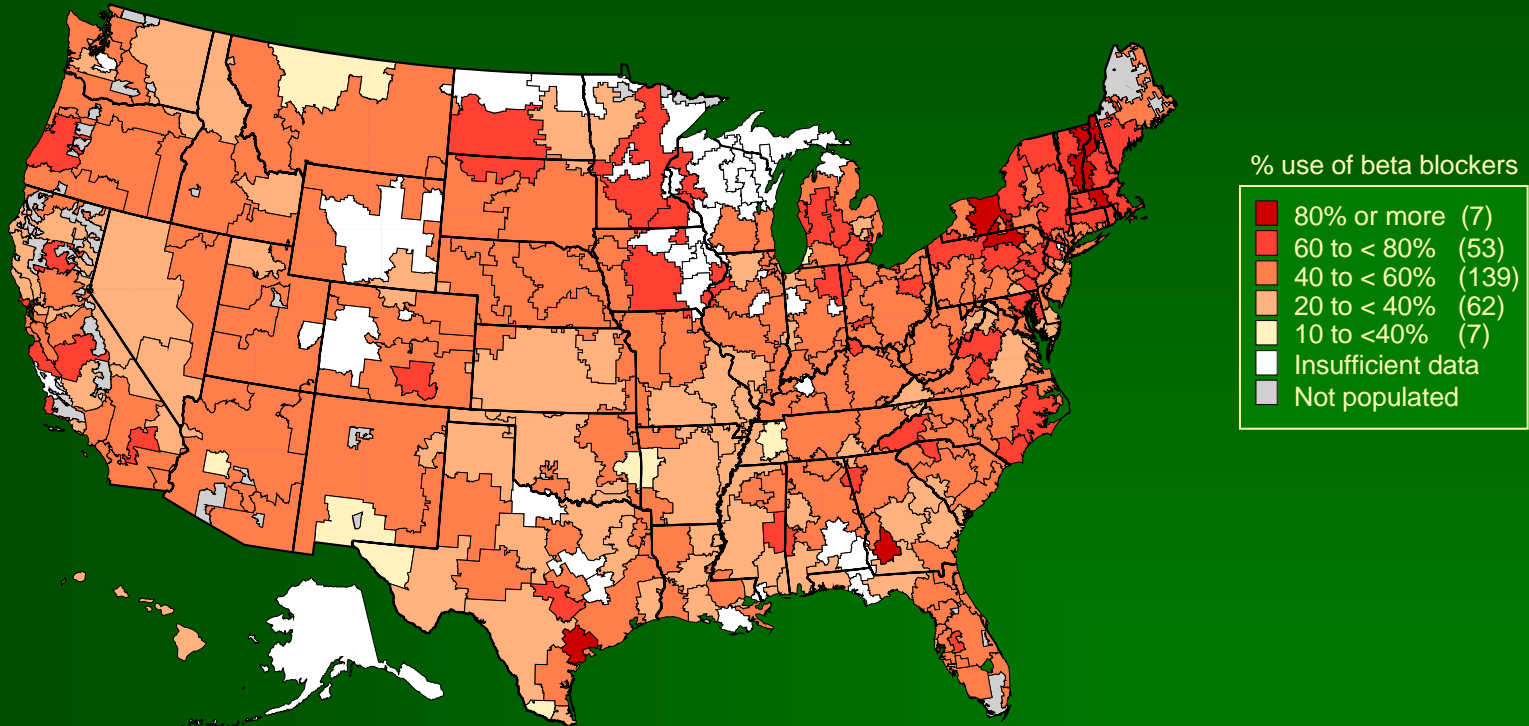
**Dealing with the federal  
government;**

**If you do not have a seat at the  
table,**

**you are probably on the menu!**

# The Quality Challenge

- Great variation exists in the quality of health care people receive
- Variation in care quality contributes to health care cost increase



**Example:** Usage of beta blockers following a heart attack

NOTE: According to the American College of Cardiology the use of beta blockers following a heart attack should be 100% for all eligible patients without contraindications.



# “Pay for Performance” Terms

- Value = quality/cost
- Efficiency = cost
- Provider: individual or group
- Pay for Performance (P4P): provider gets bonus for high scores on quality indicators
- Pay for Value (P4V): provider gets bonus for high scores on quality and efficiency indicators
- Not true P4P, but relevant:
  - Financial incentives for higher productivity, lower resource utilization, etc.
  - Gainsharing: Providers share in cost savings that they help to achieve. Alignment of incentives.

# Results of a few major P4P initiatives (over 100 now running)

## Bridges to Excellence

Several large employers, health plans, provider groups

Grant from RWJ Foundation

Boston, NY, Cincinnati, Louisville

Physician Office Link, Diabetes Care and Cardiac Care Link

500 physicians split \$1 million in 2004

Implementation of processes related to patient safety and quality of care.

## CMS/Premiere

270 hospitals, high performers on core measures split \$7 million per yr, worst are penalized

1<sup>st</sup> year: Median improvement in single composite quality score of 7.5%; composite quality score for heart failure improved 12%



# More Results

## **Integrated Healthcare Association of CA**

**Coalition of 6 health plans, 7 million enrollees, 5 years  
24,000 PCPs split \$50 million in 2003**

**Evidenced based performance goals:**

**Clinical measures**

**Patient Experience (placed on public internet)**

**Investment in IT**

**35K more mammograms, 10K more immunizations  
for children .....**



# CMS 2007 PQRI

## Physician Quality Reporting Initiative

- Partnership with AMA. ASA was there
- 74 Quality Measures
- Bonus paid (1.5%) of ALL claims, IF you report at least 3 measures for 80% of relevant cases
- This is a “risk free” opportunity to develop and test systems before P4P
- New CPT II codes for reporting



# Implications for Anesthesia

- **COPD**

- #51 Spirometry evaluation

- #52 Bronchodilator therapy

- **Bacterial Pneumonia**

- #57 Assessment of O<sub>2</sub> saturation

- **CAD**

- #06 Oral antiplatelet therapy

- #07 Beta blockade if prior MI



# Implications for Anesthesia

## ■ Diabetes

#01 Hgb A1c

#03 Control BP

## ■ Geriatric Care

#46 Medication reconciliation

## ■ Heart Failure

#05 ACE inhibitor or ARB for LVSD

#08 Beta blockade for LVSD



# Implications for Anesthesia

## ■ Perioperative Care

**#20 Timing of antibiotics – Ordering MD**

**#30 Timing of antibiotics – Administering MD**

**#21 Selection of antibiotic – Cephalosporin**

**#23 Venous thromboembolism prophylaxis  
when indicated**

# **Additional AMA PCPI Finalized Measures**



- **Head elevation for prevention of ventilator associated pneumonia**
- **Central catheter insertion protocol to prevent bloodstream infections**
- **Prophylaxis for stress ulcers in ventilated patients**
- **Management of temperature for surgery under general anesthesia**

# AMA PCPI measures under current development



- **Peri-operative Cardiac Risk Assessment**
- **Avoidance of EKG overuse for patients having low-risk surgery**
- **Peri-operative continuation of beta-blockers**

# Approved Performance Measures sent by ASA to AMA PCPI



- **AMA Physician Consortium on Performance Improvement (PCPI)**
- **Use of pencil-point spinal needles to reduce dural puncture headaches.**
- **Management of postop hypothermia.**
- **Patient education – postop analgesia.**
- **Appropriate use of clear liquids for NPO guidelines.**
- **Postop shivering Tx with meperidine.**

**Change is Inevitable.....**

**.....Participation is Optional**

**Sedation  
Advising Your Facility in  
Developing Guidelines  
Walter Maurer, M.D. [maurerw@ccf.org](mailto:maurerw@ccf.org)**

**Links to Documents on ASA Website (as of 10/13/2007)**

**Privileging for Moderate Sedation (Non-Anesthesia Providers)**

<http://www.asahq.org/publicationsAndServices/standards/40.pdf>

**Privileging for Deep Sedation (Non-Anesthesia Providers)**

<http://www.asahq.org/publicationsAndServices/standards/39.pdf>

**Statement on the Safe Use of Propofol**

<http://www.asahq.org/publicationsAndServices/standards/37.pdf>

**ASA Position on MAC**

<http://www.asahq.org/publicationsAndServices/standards/23.pdf>

**Distinguishing MAC from Conscious Sedation**

<http://www.asahq.org/publicationsAndServices/standards/35.pdf>

**Continuum of Depth of Sedation**

<http://www.asahq.org/publicationsAndServices/standards/20.pdf>

**Sedation/ Analgesia for Non-Anesthesiologists**

[www.asahq.org/publicationsAndServices/sedation1017.pdf](http://www.asahq.org/publicationsAndServices/sedation1017.pdf)