AAAHC AENEID Report 2013

Standards Compliance Analysis:
Where organizations excel and where they struggle
A NOTE FROM THE AAAHC PRESIDENT

For almost 35 years, AAAHC has been collecting data on ambulatory health care organizations. This past spring, we announced a new initiative to transform this warehouse of information into a useful tool. AENEID*, as we’ve nicknamed the initiative, was conceived as a way to sort the more than 700 individual data points that result from each accreditation survey to identify overall trends in ambulatory health care, to see patterns of compliance with AAAHC Standards and to sort and analyze the results in multiple other ways. Now this process is in place and we can present our analysis to AAAHC accredited organizations (and others) to acknowledge areas of high compliance and to promote improvement in areas of concern.

Our goals for this first report were to:

1. Confirm, with data, our anecdotal evidence that some topics addressed by the Standards are universally challenging and to identify these specifically.

2. Explore whether the type of organization has a bearing on compliance rates for specific Standards.

3. Offer a preliminary analysis for compliance issues with specific Standards.

It is with pleasure that I provide this initial set of findings. This report is based on analysis of AAAHC survey results for surveys conducted under 2012 Standards. Charts show both overall results and results for ambulatory surgery centers, office-based surgery, and primary care settings.

In addition to an overall analysis, the sorted data offer organizations a means of comparing their own compliance with AAAHC Standards against the performance of peer organizations. It also offers AAAHC a means of targeting future educational efforts.

Standard identifiers in section II reflect the 2012 editions of the Accreditation Handbooks. Section III consists of a table that includes the 2012 Standard identifier, the updated 2013 identifier (when there was a change), and the language of the 2012 Standard.

This report also provides a focused look at three of the top five most common Standard deficiencies across all types of organizations. This exploration of possible causes is intended to jump start your organization’s corrective actions if a self-assessment reveals that your organization is among those that were less than substantially compliant with any of these Standards.

AAAHC and the AAAHC Institute for Quality Improvement are developing additional guidance to support improvement on these Standards in 2014. We are creating new educational and other resources for organizations seeking AAAHC accreditation and those already accredited by us. Some of these are described in section V.

I hope you will find the information here useful to your organization and I welcome your feedback.

Sincerely,

John E. Burke, PhD
AAAHC President and CEO

*Accreditation Association Electronic National Evaluation and Information Dataset.
I. DATA SOURCE
The information in this report comes from AAAHC surveyors’ ratings of and comments on compliance with our Standards. The data are collected during onsite surveys of organizations seeking accreditation. This report includes data findings from surveys using Standards from the 2012 editions of the Accreditation Handbook (collected from June 2012 through June 2013).

In October 2013, the AAAHC Institute for Quality Improvement conducted an analysis of 1,519 complete surveys, that is, surveys including all core Standards (Chapters 1-8 of the Accreditation Handbook).

2012 Surveys by Organization Type

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC</td>
<td>74%</td>
</tr>
<tr>
<td>OBS</td>
<td>12%</td>
</tr>
<tr>
<td>PCO</td>
<td>10%</td>
</tr>
<tr>
<td>OTHER</td>
<td>4%</td>
</tr>
</tbody>
</table>

II. FINDINGS
Surveyors rate Standards as substantially compliant (SC), partially compliant (PC), or non-compliant (NC). The proportion of SC ratings is compared to the proportion of NC and PC ratings for each Standard to calculate the findings below.

High compliance
Overall, AAAHC accredited organizations were highly successful (99.9% or greater scored as SC) in meeting the Standards identified in this section. From Chapter 1, Rights of Patients, these high compliance Standards include 1.A, 1.E, 1.F.3’.

Organizations are operated in accordance with federal and state antidiscrimination laws (2.I.B.13).

Organizations effectively address administrative responsibilities related to the purchase, maintenance and distribution of equipment, materials and facilities. (3.A.8)

Individual health care professionals practice ethically and legally. (4.B)

Health care services provided are relevant to the needs of the patients served. (4.L.1)

And virtually all organizations are effectively establishing individual clinical records that include the name, date of birth and responsible party (6.B.1,3,5).

*See page 5 for complete descriptions of Standards.
Most Common Deficiencies

The 2012 Standards that were most commonly rated partially or non-compliant by surveyors are identified below. The first chart illustrates those that present challenges for all organization types. The next three charts show additional Standards that indicate a high incidence of partial or non-compliance for ambulatory surgery centers, office-based surgery settings and primary care practices.

Deficiencies Cited for All Types of Accredited Organizations

*Please note that the number of ASC surveys including this Standard was 764 (lower than the total for other Standards cited in this report).
III. STANDARDS REFERENCED

High Compliance

<table>
<thead>
<tr>
<th>2012 Standard ID</th>
<th>2013 Standard ID (if changed)</th>
<th>Standard Language</th>
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</thead>
<tbody>
<tr>
<td>1.A</td>
<td></td>
<td>Patients are treated with respect, consideration, and dignity.</td>
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<tr>
<td>1.E</td>
<td></td>
<td>Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.</td>
</tr>
<tr>
<td>1.F.3</td>
<td></td>
<td>Information is available to patients and staff concerning: Services available at the organization.</td>
</tr>
<tr>
<td>2.I.B.13</td>
<td></td>
<td>The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to: Operating the organization without violating federal or state antidiscrimination laws. (Edited for 2013.)</td>
</tr>
<tr>
<td>3.A.8</td>
<td>3.A.7</td>
<td>Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to: Controlling the purchase, maintenance, and distribution of the equipment, materials, and facilities of the organization.</td>
</tr>
<tr>
<td>4.B</td>
<td></td>
<td>Health care professionals practice their professions in an ethical and legal manner.</td>
</tr>
<tr>
<td>4.L.1</td>
<td>4.J</td>
<td>Concern for the costs of care is demonstrated by the following: The relevance of health care services to the needs of the patients. (Edited for 2013.)</td>
</tr>
<tr>
<td>6.B.1, 3, 5</td>
<td>6.C. 1,3,5</td>
<td>An individual clinical record is established for each person receiving care. Each record includes, but is not limited to: 1. Name 2. Date of birth 3. Responsible party, if applicable</td>
</tr>
</tbody>
</table>

Most Common Deficiencies

The following are Standards referenced throughout this report as compliance issues. The left hand column identifies the organization type(s) with a notable proportion of partial or non-compliant ratings for the Standard.

ASC = Compliance issue for ASCs  OBS = Compliance issue for OBS  PCO = Compliance issue for primary care

<table>
<thead>
<tr>
<th>2012 Standard ID</th>
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<tbody>
<tr>
<td>PCO 2.II.B.3.f</td>
<td></td>
<td>The governing body, either directly or by delegation, makes (in a manner consistent with state law) initial appointment, reappointment, and assignment or curtailment of clinical privileges of medical staff members based on professional peer evaluation. This process shall have the following characteristics: On an application for initial credentialing and privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested. At a minimum, the following credentialing and privileging information shall be provided for evaluation of the candidate: Information obtained from the National Practitioner Data Bank (NPDB).</td>
</tr>
<tr>
<td>ASC 2.I.B.11.g</td>
<td>2.I.B.11.f</td>
<td>Approving and ensuring compliance of all major contracts or arrangements affecting the medical and dental care provided under its auspices and ensuring that services are provided in a safe and effective manner, including, but not limited to, those concerning: The Centers for Medicare &amp; Medicaid Services (CMS) requirements, if the organization participates in the Medicare/Medicaid program.</td>
</tr>
<tr>
<td>ASC OBS PCO 2.II.D</td>
<td></td>
<td>Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specified period of time. The health care professional must be legally and professionally qualified for the privileges granted. These privileges are granted based on an applicant’s qualifications within the services provided by the organization and recommendations from qualified medical personnel.</td>
</tr>
<tr>
<td>ID</td>
<td>2012 Standard ID</td>
<td>2013 Standard ID (if changed)</td>
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</table>
| PCO | 2.II.B           | 3.f                          | At a minimum, the following credentialing and privileging information shall be provided for evaluation of the candidate: 
  f. Information obtained from the National Practitioner Data Bank (NPDB). |
| PCO | 4.E.4            |                               | 2012 wording: The organization facilitates the provision of high-quality health care as demonstrated by the following: Review and update of all individual patient medications at each visit, including over-the-counter products and dietary supplements when information is available. |
| PCO | 4.E.11           | 4.E.8                         | The organization facilitates the provision of high-quality health care as demonstrated by the following: Continuity of care and patient follow-up. |
| OBS | 5.I.G            | 2.III.G                       | The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in of Chapter 2.II. |
| OBS | 5.II.B           | 5.I.C                         | 2012 wording: The organization conducts specific quality improvement activities that support the goals of the written QI program. Written reports of QI activities must demonstrate that each activity includes at least the following elements: [10 elements are listed.] |
| ASC | 5.II.B.2         | 5.I.C.2                       | 2012 wording: The organization conducts specific quality improvement activities that support the goals of the written QI program. Written reports of QI activities must demonstrate that each activity includes at least the following elements: Identification of the performance goal against which the organization will compare its current performance in the area of study. |
| ASC | 5.II.B.6         | 5.I.C.6                       | The organization conducts specific quality improvement activities that support the goals of the written QI program. Written reports of QI activities must demonstrate that each activity includes at least the following elements: A comparison of the organization's current performance in the area of study against the previously identified performance goal. |
| OBS | 5.II.C           | 5.I.D                         | 2012 wording: The organization's written quality improvement program must include participation in external performance benchmarking activities that allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals. |
| ASC | 6.K              | 6.F                           | 2012 wording: The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistent location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified. |
| PCO | 6.O.1            | 6.N.1                         | The organization is responsible for ensuring a patient's continuity of care. If a patient's primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are: Obtained from the other (external) provider(s) or organization and incorporated into the patient's clinical record. |
| ASC | 8.A.2            |                               | The organization provides evidence of compliance with the following: Applicable state and local fire prevention regulations, such as the NFPA 101® Life Safety Code®, 2000 Edition, published by the National Fire Protection Association, Inc.* |
| ASC | 8.E              |                               | 2012 wording: The organization requires at least one (1) drill each calendar quarter of the internal emergency and disaster preparedness plan.* One (1) of the annual drills must be a documented cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization. The organization must complete a written evaluation of each drill, and promptly implement any needed corrections or modifications to the plan. |

*Life Safety Code and NFPA 101 are registered trademarks of the National Fire Protection Association, Inc., Quincy, Massachusetts. For those organizations desiring assistance in reviewing applicable NFPA 101 code, a suitable reference is the Physical Environment Checklist for Ambulatory Surgical Centers, available from AAAHC.  
*Appropriate to the facility's activities and environment. Examples include medical emergencies, building fires, surgical fires, tornados, hurricanes, earthquakes, bomb threats, violence, and chemical, biological, or nuclear threats.
<table>
<thead>
<tr>
<th>Standard ID</th>
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</tr>
</thead>
<tbody>
<tr>
<td>PCO 8.N</td>
<td>8.L</td>
<td>2012 wording: The space allocated for a particular function or service is adequate for the activities performed therein, including space allocated for pathology and medical laboratory services, radiology/imagery services, pharmaceutical services, examination and treatment rooms, offices, operating/procedure rooms, recovery areas, storage rooms, reception areas, clinical records, and other special-function areas.</td>
</tr>
<tr>
<td>ASC 9.R*</td>
<td></td>
<td>Education and training in the recognition and treatment of malignant hyperthermia must occur before triggering agents are made available within the organization. Education and malignant hyperthermia drills are conducted at least annually thereafter when triggering agents are present within the organization. Organizations that have anesthetic and resuscitative agents available that are known to trigger malignant hyperthermia must have written protocols to promote patient safety, such as the Malignant Hyperthermia Association of the United States (MHAUS) protocol. These treatment protocols must: 1. Be posted and immediately available in each location where triggering agents might be used. 2. Include the use of dantrolene and other medications and methods of cooling and monitoring of the patient.</td>
</tr>
<tr>
<td>ASC, OBS 10.I.D</td>
<td></td>
<td>An appropriate and current health history must be completed, with a list of current prescription and non-prescription medications and dosages, when available; physical examination; and pertinent pre-operative diagnostic studies incorporated into the patient’s clinical record within 30 days, or according to local or state requirement, prior to the scheduled surgery/procedure.</td>
</tr>
<tr>
<td>ASC 11.L</td>
<td></td>
<td>If look-alike or sound-alike medications are present, the organization identifies and maintains a current list of these medications, and actions to prevent errors are evident.</td>
</tr>
<tr>
<td>ASC 12.I.D</td>
<td></td>
<td>The organization has a policy that ensures that test results are reviewed appropriately and that documents that test results are reviewed by the ordering physician or another privileged provider.</td>
</tr>
<tr>
<td>OBS 13.C.2</td>
<td></td>
<td>Health care professionals providing imaging services and/or interpreting results: 2. Have been granted privileges to provide these services.</td>
</tr>
</tbody>
</table>

**Quality is never an accident; it is always the result of intelligent effort.**

—John Ruskin
IV. ANALYSIS OF THE MOST COMMON DEFICIENCIES

Of the five specific Standards that were associated with high ratings of partially compliant (PC) or non-compliant (NC) across all organization types, three have been chosen for special attention for 2014. These are: 2.II.D, 6.K, and 8.E. Standards 5.II.B.2 and 5.II.B.6 are not a part of this group because they relate to specific requirements for QI studies and are addressed in other AAAHC publications and educational events (see section V).

An analysis of surveyor comments associated with PC or NC ratings found that for Standards 2.II.D, 6.K, and 8.E, there are multiple components that may have driven the relatively high proportion of these ratings. The possible issues are outlined for each below.

2.II.D Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specified period of time. The health care professional must be legally and professionally qualified for the privileges granted. These privileges are granted based on an applicant’s qualifications within the services provided by the organization and recommendations from qualified medical personnel.

Issues may arise from:

- A privileging process that:
  - Does not adhere to governing body bylaws
  - Does not include governing board approval of privileges
  - Is incomplete for initial, reappointment, suspension and termination of privileges

- A privilege list or Delineation of Privilege (DOP) form that fails to include key elements such as:
  - Privileges approved for a specific period of time
  - Privilege list specific to the provider’s qualifications
  - Privilege list specific to the organization’s scope of practice
  - Signature of reviewer

- A failure to list privileges on the DOP form, including but not limited to special consideration for:
  - Anesthesia
  - Fluoroscopy
  - Laser
  - Overnight care
  - Supervision of anesthesia provision by professionals other than physicians

6.K The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistent location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.

Issues complying with this Standard may have been associated with:

- Allergies not verified on each visit.
- Allergies inconsistently documented throughout the clinical record.
- Failure to document material allergies, such as latex, in the allergy list.
- Inconsistent documentation of untoward reactions to identified allergies.

8.E The organization requires at least one drill each calendar quarter of the internal emergency and disaster preparedness plan. One of the annual drills must be a documented cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization. The organization must complete a written evaluation of each drill, and promptly implement any needed corrections or modifications to the plan.

Possible problems leading to compliance issues included:

- Failure to complete 4 quarterly internal emergency and disaster plan drills.
- Failure to complete one CPR drill annually.
- Using in-services in place of drills for emergency management.
- Missing evaluation for each drill performed.
- Failure to document correction plan when needed.
- Failure to adhere to the organization’s drill policy.
V. FOCUS for IMPROVEMENT 2014

Organizations should initiate a self-assessment using the data in this report. Refer to your most recent survey report for your rating on the relevant Standards and the comments your survey team provided to explain PC or NC ratings. AAAHC will implement targeted interventions throughout 2014 to help organizations improve their understanding of and compliance with the requirements of these three commonly cited Standards (2.II.D, 6.K, and 8.E).

Look for:

- Renewed emphasis on education related to these requirements during the 2014 Achieving Accreditation programs.
- Increased emphasis on these topics in newsletters, webinars, and conference presentations.
- New toolkits to assist organizations in assessing their compliance prior to an accreditation survey, and providing a roadmap of steps for improvement if applicable.
- Additional consultative support from surveyors while on-site.

AAAHC annually reviews the language of each of the Standards, to determine if additional clarity would help organizations achieve a higher rate of compliance. Note: The Standards and Survey Process Committee welcomes public comment on current Standards at any time by e-mail to info@aaahc.org. A preview of proposed annual updates to the Standards and a 30-day comment period takes place each fall. The document including proposed changes and precise public comment period are posted on our website: www.aaahc.org.

AAAHC Resources

2014 Achieving Accreditation seminars:
March 14-15  Tampa, FL
June 20-21  Chicago, IL
September 12-13  Boston, MA
December 5-6  Las Vegas, NV

AAAHC Newsletters:
Triangle Times, a quarterly print publication
Connection, a bi-monthly electronic publication

To subscribe, provide your contact information to info@aaahc.org.

AAAHC Institute Resources

QI Toolkit:
Quality Improvement and Benchmarking: A Workbook of Strategies and Tools for Success, a step-by-step guide to building an effective and actionable QI study for your organization

Innovations in Quality Improvement Compendium, an annually updated review of award-winning QI studies

Quality Improvement Insights, a collection of white papers focused on specific topics within QI