AAAHC Quality Roadmap 2015

Accreditation Survey Results
FROM THE PRESIDENT AND CEO

This report is a chance to pause, take stock, and tell the story of AAAHC-accredited organizations at a point in time. We do this annually, and the process serves to inform refreshed educational offerings and revised Standards for the coming year.

Three years ago, AAAHC made the decision to share this analysis publicly. This year’s report consists of a thorough review of compiled data from 13 months (June 2014–June 2015) of completed surveys, and an analysis of findings with regard to compliance with 2014 Standards. In addition to a thematic overview, we’ve grouped datasets based on broad practice types: ASCs, office-based facilities, and primary care settings. This allows readers an informal opportunity to benchmark the compliance of their organization against that of their peers. We don’t want you to re-invent the wheel; if you’re challenged by a particular Standard or topic represented by a group of Standards, it’s likely that other, like-organizations are, too. So in addition to identifying those Standards with a high-incidence of partial-(PC) or non-compliant (NC) ratings by surveyors, we’re offering additional support to help you improve in those areas. Consider this a “quality roadmap” to guide your organization’s performance.

Since the first release of these data (previously presented as the AENEID Report), some topics have appeared annually across organizations of all types and sizes. Various Standards related to documentation and others focused on quality improvement consistently make the list of those with the highest frequency of deficiencies. We have placed an additional emphasis on these topics in our webinars, at Achieving Accreditation, in toolkits developed by the AAAHC Institute for Quality Improvement, and in our newsletters. We’ll continue to develop tools to allow you to build a robust library of resources addressing these topics. I invite you to take advantage of them.

This year, for the first time, issues of compliance with safe injection practices appeared as a recurring theme across all organizations. As a patient safety issue, we cannot stress enough how important it is for every healthcare organization to follow the guidelines of the Centers for Disease Control and Prevention’s One and Only Campaign®, an effort in which AAAHC is a founding partner.

This document will be most helpful when read in conjunction with the 2014 or 2015 edition of the Accreditation Handbook for Ambulatory Health Care and your most recent survey report.

Sincerely,

Stephen A. Martin, Jr., PhD, MPH
President and CEO The Accreditation Association
I. DESCRIPTION OF THE DATA
The information in this report comes from AAAHC surveyors’ ratings of compliance with our 2014 Standards and their comments detailing the nature of any deficiencies found. The data were collected during onsite surveys of organizations seeking initial or re-accreditation, including ambulatory surgery centers in the Medicare Deemed Status program.

This report includes data collected over 13 months (June 2014 - June 2015). It does not include focused surveys—those that did not include all core Standards (Chapters 1-8 of the Accreditation Handbook)—or those that were the result of a random selection to confirm continued compliance or some required inter-cycle activity. Results of surveys for organizations in our health plan program are not included.

The data points represent 1399 complete surveys. The illustration to the right shows the distribution of surveys for this period by the most commonly described organizational types: ambulatory surgery center (ASC), Medicare deemed status ASC, office-based surgery facility (OBS), and primary care setting (PC). PC includes military (U.S. Air Force and U.S. Coast Guard), community health, Indian health, occupational health, student health, and other primary care settings.

In III. ANALYSIS OF FINDINGS BY SETTING, you will find additional data on a subset of ASCs, specifically those participating in the AAAHC/Medicare Deemed Status program, and on student health organizations and Patient Centered Medical Homes (PCMH), each a subset of PC.

II. OVERALL FINDINGS

High compliance
Surveyors rate AAAHC Standards as substantially compliant (SC), partially compliant (PC), or non-compliant (NC). The highest compliance findings (100% rated SC across all organization types) indicate that AAAHC-accredited organizations treat patients with respect, consideration and dignity, and provide them with the opportunity to participate in decisions involving their health care. These organizations have no inconsistency in their use of identifiers within individual clinical records and, when another party is responsible for making healthcare decisions on behalf of a patient, this person is likewise, appropriately identified.

We also find that AAAHC-accredited organizations consistently address the coordination and/or transfer of care when a patient requires consultation with a specialist.

Most common deficiencies across all organizations
While this report looks in depth at those Standards with the highest incidence of PC and NC ratings by surveyors, most organizations that seek AAAHC accreditation successfully achieve a three-year term. This year we are focusing on the four topics that offer the greatest opportunity for improvement.

1. Safe injection practices
Standard 7.I.C.2 requires that the organization select nationally-recognized guidelines for safe injection practices, use these guidelines to educate providers and as a benchmark for surveillance activities. This is the first year that deficiencies related to safe injection practices have appeared in this report. One possible reason is the launch in mid-2014 of reporting mandated by the Centers for Medicare and Medicaid Services (CMS) of infection control breaches. The reporting requirements specifically relate to instances of potential cross-contamination through re-use of needles or syringes, or inappropriate use of multi-dose vials.

Heightened awareness of this issue on the part of surveyors, may have led to an increase in the frequency with which
deficiencies were cited across all organization types. The end result is this: an important aspect of patient safety has been brought to the forefront of an accreditation survey.

AAAHC partners with the Centers for Disease Control and Prevention (CDC) in the One and Only Campaign© to promote safe injection practices.

Guidance from the One and Only Campaign©

SINGLE USE VIALS

Vials that are labeled as single-dose or single-use should be used for a single patient and single case/procedure/injection. There have been multiple outbreaks resulting from healthcare personnel using single-dose or single-use vials for multiple patients.

Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient, nor should it be stored for future use on the same patient.

To prevent unnecessary waste or the temptation to use contents from single-dose or single-use vials for more than one patient, clinicians and purchasing personnel should select the smallest vial necessary for their needs when making treatment and purchasing decisions.

MULTI-DOSE VIALS

Multi-dose vials should be dedicated to a single patient whenever possible. If multi-dose vials must be used for more than one patient, they should not be kept or accessed in the immediate patient treatment area. This is to prevent inadvertent contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment that could then lead to infections in subsequent patients. If a multi-dose vial enters the immediate patient treatment area, it should be dedicated to that patient only and discarded after use.

2. Credentialing, Privileging, and Peer Review

Standard 2.II.D is intended to ensure that all services offered by the organization are provided by health care professionals identified by the governing body as qualified to deliver them. It appears as a high-deficiency Standard for the third consecutive year. Issues consistently identified by surveyors in citing compliance problems with this Standard include:

- Failure to provide a comprehensive list of privileges for the activities of a provider, i.e., use of specific technologies or equipment, performance of procedures, or tasks (especially supervision of others). This may be a result of an organization adding services or equipment and failing to review and edit privileging forms and/or failing to obtain and document approval of these changes by the governing body.

- Failure to assign a time limit to initial privileging, or to meet the requirement of the Standard (or the organization’s own policy if it is more stringent) for renewal of privileges.

Less frequent, but a critical breach in compliance, is inappropriate credentialing and privileging. This occurs when an organization fails to independently verify credentials, when a provider signs off on his/her own privileges, or when privileges are granted based on those approved by another health care facility. Each organization is expected to perform its own credentialing (either by primary source verification, secondary source verification, or by using a CVO) and privileging.

Related Standard 2.III.H appears for the second year in a row. This Standard requires that the results of peer review are used as a part of the process for granting continuation of privileges. Surveyor comments reflect missing evidence that peer review was considered at the time of re-appointment.

Many organizations use provider dashboards to document peer review. These can be incorporated into the re-appointment application process. This is an easy means of internal benchmarking; Dashboards can visually identify high and low performers compared to an organization’s goals, and thereby provide a means of integrating peer review with quality improvement. See V. ROADMAP FOR IMPROVEMENT 2016 for additional resources.

Credentialing, privileging and peer review are three separate but related processes. Credentialing means validating a provider’s qualifications to offer healthcare services. Privileging is the process of governing body approval for a provider to deliver specific treatments, procedures, or to use specific equipment. Peer review is the process of confirming a provider’s competence by enlisting others of similar license to review clinical records, and other aspects of care, e.g., infection rates, compliance with medical staff rules and regulations, patient satisfaction surveys.
3. Quality Improvement

Standard 5.I.C addresses quality improvement studies and makes its third consecutive appearance on the list of high-frequency deficiencies across all organization types.

Quality Management and Improvement Standards (Chapter 5) are intended to continuously improve patient care and to promote effective, efficient use of resources. AAAHC expects that this is accomplished through an active, integrated, organized, data-driven program that links peer review, QI activities, and risk management. The Standards drive this intent by focusing on:

1. The overall QI program (Standard 5.I.A)
2. On-going data collection processes (Standard 5.I.B)
3. Benchmarking (Standard 5.I.D)
4. Documentation of improvement (Standard 5.I.C)

Surveyor comments provided when Standard 5.I.C is rated PC or NC usually cite:
- No clearly stated, quantitative goal
- No statement of comparison between current performance and goal
- Incomplete study
- No reporting to governing body

Hints for meeting QI Standards
The essence of QI is quantifiable improvement. Without identifying the current state, the goal, the transitional activity, and the new state, it is difficult to demonstrate improvement.

IMPROVING GOAL SETTING
1. Use an identified benchmark against which to measure your current performance.
2. Use the SMART acronym to write your goal.

| S | Specific | The goal is clear and easy to understand. It translates into action by using words like increase or decrease. |
| M | Measureable | The goal is objective and can be assessed by gathering quantitative data, e.g., 25%, 20 minutes, all, none. |
| A | Achievable | Those responsible for the goal have the knowledge, skills and resources to deliver the result. |
| R | Relevant | The goal “matches” the purpose, e.g., improves compliance, increases patient satisfaction, saves money. |
| T | Time-bound | The goal has a completion date, e.g., by 12/31, third quarter. |

IMPROVING DOCUMENTATION
Close the loop. When a successful QI effort is completed, write it up as a study and share it throughout your organization.

4. Documentation

AAAHC surveyors have three means of assessing compliance: personal observation while on-site, responses to interviews they conduct with organization staff, and documented evidence. For many Standards that are applicable to all organizations, written documentation is the primary way to confirm that the requirement is being met. Requirements for documentation appear throughout the Standards.

Surveyor findings
Comments provided when these Standards are rated PC or NC cover the full range of required documentation. For example:
- No privilege lists; lists did not include all procedures performed; no documented privileges for supervision; no documented approval of privileges
- Allergies/reactions not consistently documented
- Non-drug allergies, e.g., OTC, herbals, materials/untoward reaction not assessed
- H&Ps incomplete
- No evaluation of emergency drills
- No evidence that peer review is considered at re-appointment

Standard 6.F is a very specific example of a documentation issue that is frequently cited in survey reports. The Standard requires that allergies and untoward reactions are recorded clearly and consistently in patient clinical records. While EMRs have largely solved the problem of a consistent location for this information, verification at each encounter is frequently missed.

To address this Standard more fully, record whatever information the patient is able to provide, entering "unknown" as a response if he/she is unable to describe the reaction. Avoid NKDA (no known drug allergies) in favor of NKA (no known allergies) when a patient does not indicate any sensitivities.

**The value of documentation**
Requirements for written documentation can be perceived as burdensome. Consider that:
1. Documentation promotes consistency. Everyone engaged in a documented process will follow the same steps.
2. With a documented policy or process, a variation in result can be identified quickly to pinpoint a problem or embrace an improvement opportunity.
3. Your organization becomes accreditable because you memorialize your approach to quality. This can pay dividends when negotiating with payors or liability insurers, and it is essential should you become the target of litigation.

### III. ANALYSIS OF FINDINGS BY SETTING

**Most common deficiencies, Ambulatory Surgery Centers (ASCs)**

Three Standards related to credentialing, privileging, and peer review are among the highest-frequency deficiencies for ASCs. Standards 2.II.B.5, 2.II.D, and 2.III.H are most often rated PC or NC because the organization has failed to meet requirements for re-credentialing/re-privileging per its own policies or at least every three years. Verification of all items is required at the time of initial credentialing and anything with the potential to expire (license, DEA registration) or change (liability claims history, Medicare/Medicaid sanctions, privileging limitations, for example) must be verified again at each re-credentialing/re-privileging interval.

Often an accurate delineation of privileges (DOP) is missing. Some organizations failed to include privileges for supervision of others—especially for the administration of anesthesia—or to update privilege lists to include all procedures performed. Most of these issues are correctable by reviewing and updating the process of credentialing and privileging to make it more robust. The patient safety toolkit on *Credentialing and Privileging* released in 2015.
includes a calendar template that may be useful.

Similarly, peer review deficiencies reflected a process error. Surveyor comments include:

- Peer review was not considered at the time of reappointment.
- Peer review was not linked to quality improvement.
- Peer review was not performed by a similarly licensed peer.

Standards cited from Chapter 5 relate to QI studies. The specific element (5.I.C.6) that is a high-frequency deficiency for ASCs is the comparison of current performance to the identified performance goal. Partial- or non-compliance arises when one or both of these components is not written as a quantitative statement (see SMART goals, page 5).

### Medicare Deemed Status ASCs

![Bar chart showing highest deficiencies for Medicare Deemed Status ASCs]

The Chapter 8 (Facilities and Environment) Standards most often cited reflect issues with fire drills (not conducted frequently enough or insufficiently documented) and with required inspection and testing of fire suppression systems.

Also significant for Medicare deemed ASCs are lapses in documentation. Does your organization complete all the steps outlined in your policies? Do you have a system to ensure that clinical records are complete?

### Most common deficiencies, Primary Care Organizations

![Bar chart showing highest deficiencies for Primary Care Organizations]

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Medical Home (PCMH)

For organizations seeking accreditation including review of medical home (PCMH) Standards, the chart below illustrates patterns of compliance issues with the Standards in Chapter 25.

Standard 25.A relates to the patient/provider relationship. Surveyor findings indicate that the most frequently deficient element in this group was, ironically, the explanation of the Medical Home approach to care. Standard 25.B.2 addresses access to the Medical Home.

Standard 25.C covers comprehensiveness of care and the high deficiency element is a scope of services that includes end-of-life care. Accredited Medical Home organizations appear to be more comfortable executing QI studies on clinical topics.

Student Health

The issues unique to student health settings are seen in the chart below. Most PC or NC ratings for a specific Standard occur in fewer than 10% of surveys. The most frequently noted deficiency is 8.L, the requirement that space allocated for a particular function or service is adequate. While this may not be easily correctable, these organizations should be aware of the potential domino effect for privacy, either during patient encounters or with regard to security of clinical records.

The only outlier is 8.O which tells us that primary care organizations are not performing and/or documenting tests of their fire suppression systems. This is the equivalent of a missed Life Safety Code requirement for a Medicare-deemed ASC.

Also edging over 10% is 7.I.C.2, the selection of a national protocol for safe injection practices.

For primary care organizations, the highest frequency PC or NC rating is for Standard is 6.F: the prominent, consistent documentation in individual clinical records of allergies or untoward reactions to drugs or materials. Other deficiencies are consistent with OVERALL FINDINGS (pages 3-6).

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Standard 25.E is Medical Home quality improvement and the elements that are frequently missing are studies that address the issues of relationship, accessibility, comprehensiveness, and/or continuity of care. Accredited Medical Home organizations appear to be more comfortable executing QI studies on clinical topics.
“OBS” is an organization type designated by AAAHC to indicate a smaller surgical setting, specifically one with four or fewer physicians and two or fewer procedure rooms. We typically see a greater number of Standards rated PC or NC in these organizations. Accreditation is an “open book test” and smaller organizations should seek out additional resources to assist them in meeting Standards about which they are uncertain. (See V. ROADMAP FOR IMPROVEMENT 2016.)

The Standards cited above from Chapter 2 relate to credentialing and privileging at a basic level. Even a single provider organization is required to demonstrate a process that includes review of credentials and privileges on at least a triennial basis; an outside physician or dentist must provide this service to a solo provider.

Elements of Standard 5.I.C refer to documented quality improvement studies and have been discussed in an earlier section of this report. Standard 5.I.D focuses on external benchmarking. It is important for organizations, regardless of size, to identify best practices resulting in key performance measures. Medical specialty associations may be a resource for this kind of information. Participation in AAAHC Institute benchmarking studies is another option to help achieve compliance with the elements of this Standard.

The documentation theme is represented by Standards 4.E.4 (medication reconciliation), 6.E (the requirement that a patient’s clinical record includes a summary of past and current diagnoses and procedures in order to facilitate continuity of care), and 6.F (covered in II. OVERALL FINDINGS).

Standard 7.I.C.2 is discussed in detail in the overall findings on safe injection practices (page 4).

Standard 8.E covers quarterly emergency drills. Problems with this Standard range from failure to perform drills to failure to evaluate, identify, and implement needed corrections or modifications.
V. ROADMAP FOR IMPROVEMENT 2016

Use the data in this report for on-going self-assessment. Your AAAHC survey report includes comments to explain any PC or NC ratings received by your organization. These should help you to individualize the results of this overview report and to benchmark your survey results.

Here are some of the plans to address high-deficiency themes in 2016:

Safe Injection Practices
AAAHC will continue to partner with the Safe Injection Practices Coalition and to share these resources with our accredited organizations. The One and Only Campaign® website (http://www.cdc.gov/injectionsafety/1anOnly.html) includes infographics, toolkits and videos among other resources.

Look for our 2016 webinar offerings and Patient Safety Toolkits to include this and other infection prevention and control topics.

Credentialing, Privileging and Peer Review
We have released two patient safety toolkits addressing these issues in 2015. Credentialing and Privileging, and Peer Review and Benchmarking are relevant to all ambulatory health care settings. Each is available on our website at www.aaahc.org/institute/Patient-Safety-Toolkits.

A webinar presented in 2015 on Peer Review and Benchmarking is still available for a limited time at www.aaahc.org/education/webinars/Past-Webinars.

Quality Improvement
Illuminating Quality Improvement, a facilitator-led tool for moving from data collection activities to meaningful QI studies was launched at Achieving Accreditation in December 2014. It has been exceptionally well received and we will continue to use it in this context. As we look forward to 2016, we are planning to make it more widely available to our organizations.

Documentation
Most organizations would benefit from conducting a comprehensive annual inspection of documentation. Specific items to address include:

- Routine chart review should ensure that the records contain complete information. Do you have an EHR system that can warn you when a record is incomplete?
- Who’s reviewing governing body (GB) minutes to make sure that they are complete and contain evidence of the GB determinations?
- Who in the organization receives a copy of the AAAHC Handbook and checks the policies to make sure your organization remains compliant from year to year?
- Who ensures that the maintenance logs are reviewed and action is taken (and documented) when necessary?
- When you evaluate your emergency drills, are you documenting your process corrections?

Seminars
Achieving Accreditation is a comprehensive face-to-face program covering Standards and special topics related to accreditation. In 2016, programs will be held in:

March 18-19, Tampa, Florida
June 10-11, San Diego, California
September, TBD
December 2-3, Encore at Wynn Las Vegas, Nevada
AAAHC Newsletters

Triangle Times is a quarterly print publication sent to all accredited organizations and by subscription request. Most issues include Standard Bearer, a column focused on the interpretation and meaning of an individual Standard. Past issues can be reviewed on the AAAHC website: www.aaahc.org/news/newsletters/TTimes/.

Connection is a bi-monthly e-newsletter sent on request to subscribers. Each issue focuses on a single topic related to improving the quality of your ambulatory health care organization. Past issues can be reviewed here: www.aaahc.org/news/newsletters/Connection.

AAAHC Institute Resources

Each December, the Bernard A. Kershner Innovations in Quality Improvement Award is presented to AAAHC-accredited organizations for exemplary QI studies. One award is given for the best study by a surgical/procedural organization; another is given for the outstanding work by a primary care organization. The awards are made at the Achieving Accreditation with winners presenting their work.

Previous winning studies are published in the annually updated Innovations in Quality Improvement Compendium, available for purchase at www.aaahc.org/institute > Publications.

Quality Improvement Insights is a collection of white papers on specific topics in the area of QI including benchmarking.

Using Benchmarking Measurement to Improve Performance over Time is a whitepaper illustrating the use of benchmarking within a QI study. This resource is available free of charge on our website.

Patient Safety Toolkits address a variety of topics in surgical and non-procedural settings and are released regularly. Often they are inspired by high-deficiency Standards.

Each includes an overview of the importance of the topic to ambulatory health care settings, a review of published articles, and one or more tools that you can put into practice to improve performance in your organization.

The complete list of toolkits can be found at www.aaahc.org/institute/Patient-Safety-Toolkits1.