A newsletter of the Accreditation Association for Ambulatory Health Care, Inc.

AAAHC

triangletimes

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2016-2017 Bernies winners announced

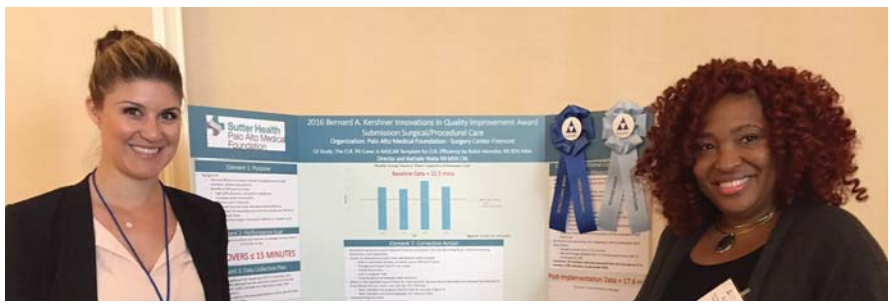
In November 2016, the AAAHC Institute for Quality Improvement announced the six finalists for the 2016-2017 Bernard A. Kershner Innovations in Quality Improvement Award (the Bernies).

Each of finalists submitted a fully developed, implemented, and successful quality improvement study. Each was recognized at *Achieving Accreditation*, March 17-18, in Tampa, Florida and the individual studies were presented as posters that are reproduced on pages 2-7 along with a brief profile of the organization and its approach to QI.

The submissions were divided into surgical/procedural and primary care categories. The AAAHC Institute's expert panel selected a winner in each category and attendees at *Achieving Accreditation* also had the opportunity to cast a vote based on their healthcare setting for a People's Choice award.

SURGICAL/PROCEDURAL AWARD TO PAMF SURGERY CENTER FREMONT

The Bernie for surgical/procedural care was awarded to Palo Alto Medical Foundation (PAMF) Surgery Center Fremont for "The O.R. Pit Crew: A NASCAR Template for O.R. Efficiency" (page 2). PAMF Surgery Center Fremont also won the People's Choice award in this category.



PRIMARY CARE AWARD TO UNIVERSITY OF UTAH

The Bernie for primary care was awarded to University of Utah for "Increasing Human Papillomavirus (HPV) Vaccination Rates" (page 5).

The People's Choice award for primary care went to Premise Health Center for Living Well Family Healthcare, Lake Buena Vista, FL for "A Multi-Disciplinary Approach to Condition Management in a Primary Care Setting" (page 7). ▲

Standard Bearer: 4.E.4 Medication Reconciliation

Medication reconciliation is the process of documenting all medications a patient takes, including OTCs, within the patient's medical record and as a component of discharge instructions. Documentation should include dosage and frequency. The goal is to prevent patients from committing self-inflicted medication errors and to avoid incidents of prescribing errors and adverse drug events (ADEs). Adverse drug events may run as high as 14% in ambulatory care. Estimates by the U.S. Dept. of Health and Human Services indicate that up to 50% of ADEs are preventable.

In the *AAAHC Quality Roadmap 2016*, Standard 4.E.4 is identified as one of the most common deficiencies seen in ASCs. In more than 10% of organizations, surveyors cited partial or non-compliance. In some cases, the PC or NC rating may have resulted from the lack of documentation in clinical records. Although 4.E.4 is a frequent deficiency in surgical settings, the Standard for medication reconciliation applies to all organizations.

THE STANDARD

4.E. *The organization facilitates the provision of high-quality health care by:*

4 *Performing medication reconciliation.*

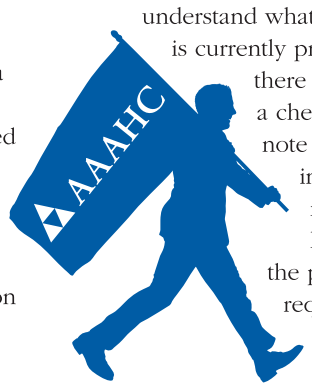
INTENT OF THE STANDARD

Medication reconciliation should be a component of all patient encounters. Documentation of currently prescribed and non-prescription medications within the patient record and in discharge instructions mitigates risk of self-inflicted medication errors and ADEs when the information is accurate and accessible to all providers, pharmacists, and the patient.

An organization may have a process for medication reconciliation but if the result is not documented, there is no evidence that it was followed. AAAHC Standard 4.E.4 is one of those Standards that depends on written documentation as the primary means used by a surveyor to verify compliance.

MEETING THE STANDARD

- Have a written process for patient encounters that includes questions regarding current medications. A checkbox for medication reconciliation on an intake form or within the EHR can serve as a prompt and confirmation that the process was completed.
- Include medication name, dosage, frequency, and manner of administration (pill, injection, liquid, etc.).
- Include documentation of allergies and sensitivities with reactions in the clinical record as well.
- If medications are changed (new orders, new dosage, or discontinuation), this should be highlighted in the medical record and in discharge instructions so that patients and other providers understand what medication is currently prescribed. If there are no changes, a checkbox and note to that effect in the medical record and a list provided to the patient are still required. ▲



Life Safety Code and ASC risk assessment

In May 2016, CMS adopted the 2012 editions of NFPA 101 and 99 as its standard for physical environment and fire safety. Shortly thereafter, AAAHC released an updated handbook for Medicare deemed status surveys which featured a revised Physical Environment Checklist section cross-referencing NFPA codes within the CMS Conditions for Coverage (CfC). Currently, CMS and AAAHC are surveying for compliance with the updated 2012 Life Safety Code.

Recently, some organizations have expressed concerns about citations received following Life Safety Code surveys. Organizations reported being cited for a variety of issues, including gas and vacuum systems, electrical equipment, and heating, ventilation, and air conditioning, which they were unaware would be required components of their survey. This points to some prevailing confusion as to the parameters of the updated CMS code.

Per the *Accreditation Handbook for Medicare Deemed Status Surveys* 11.2016 Update, "Facilities that qualify as **NEW** (built or permits approved after July 5, 2016) will be surveyed under requirements applicable to new facilities/systems under the 2012 editions of the NFPA 99 and NFPA 101. Facilities that fall under **EXISTING** requirements must be in compliance with the edition of the NFPA code set that was in use by CMS at the time the facility and/or its systems were installed or previously altered, renovated, or modernized. Life Safety surveyors will verify compliance with requirements applicable to the surveyed ASC."

The 2012 edition of NFPA 99, is a risk-based code. Health care facilities are divided into four categories, based on the services and levels of care provided, with distinct requirements for compliance based on associated risk. Per CMS, ASCs built after July 5, 2016 are considered **NEW** and a risk assessment is explicitly required. However, the category within which an individual ASC falls can only be determined through completion of a risk assessment, therefore, **EXISTING** ASCs (built prior to July 5, 2016), must also complete a risk assessment in order to determine category.

NFPA 99 provides two examples of procedures for facility risk assessments for determination of category:

1. ISO/IEC 31010, Risk Management – Risk Assessment Techniques
2. *NFPA 551, Guide for the Evaluation for Fire Risk Assessments*, *SEMI S100307E, Safety Guideline for Risk Assessment and Risk Evaluation Process.*

ASCs may use any other formal risk assessment system they have; it is not a requirement to choose one of these two options. ▲

Surgical/Procedural finalist

Palo Alto Medical Foundation (PAMF) Surgery Center Fremont

submitted by: Robin Menefee, RN, BSN, MBA, Director and Nathalie Waite, RN, MSN, CNL

THE ORGANIZATION: PAMF Surgery Center Fremont has four operating rooms, ten pre-op and 15 post-op bays, plus two endoscopy suites. The surgery center performs a variety of ophthalmologic, ENT, orthopedic, and general surgical and GI procedures. Surgery Center Fremont completed 8,000 cases in 2016.

THE STUDY: Aiming to improve OR turnover time to 15 minutes or less, this study looked outside health care for a model. The successful intervention mimics an auto racing pit crew. The performance goal is based on creating an OR turnover process that focuses on teamwork and efficiency. Each role for the turnover team is named and defined.

Analysis of the initial data showed turnover times averaging 22.5 minutes. Problems were identified, including undefined steps in the process and lack of assigned roles. With implementation of the OR Pit Crew, communication and trust between crew members improved and confusion and waste decreased. Re-measurement data showed that turnover time had decreased to 17.6 minutes, an improvement of nearly 5 minutes per case.*

APPROACH TO QI: PAMF follows lean methodology. This approach engages the entire facility in QI planning and development. Any team member can start a process to correct or streamline to improve workplace safety and efficiency. Regular brainstorming sessions are held to encourage staff members to contribute ideas about an ongoing study or propose topics for a new one. During these sessions, feedback is solicited and the group reaches a collective decision about how to proceed. This give-and-take is fundamental to the organization's collaborative culture. The OR Pit Crew is the result of a lean approach and illustrates commitment to team-based solutions for clinical operations and QI.

*Continued measurement in 2017 has shown monthly averages of 14.8 minutes, exceeding the performance goal.

2016 Bernard A. Kershner Innovations in Quality Improvement Award Submission Surgical/Procedural Care

Organization: Palo Alto Medical Foundation - Surgery Center Fremont

QI Study: The O.R. Pit Crew: A NASCAR Template for O.R. Efficiency by Robin Menefee RN BSN MBA Director and Nathalie Waite RN MSN CNL

Element 1: Purpose

- Background:
  - Fast and efficient turnovers improve the experience for staff members, doctors and patients.
  - Benefits of efficient turnovers:
    - High staff, physician, and patient satisfaction
    - Increased center productivity
    - Effective use of resources.
- Problem: Extended turnover times decrease overall efficiency.
- Purpose: To improve the operating room turnover process and efficiency and shorten turnover times.
- For the purpose of this project, a turnover is defined as "wheels out to wheels in."

Element 2: Performance Goal

The performance goal is to achieve and maintain an average turnover time of 15 minutes or less.

TURNOVERS ≤ 15 MINUTES

Element 3: Data Collection Plan

- Baseline data was gathered from September 2015 to December 2015.
- Turnover times were obtained from the electronic record and manually logged by the Patient Traffic Controller on a daily basis using a data collection tool. (Figure 1)
- Delay reasons were added to the daily data collection tool to identify areas for discussion at team huddles.

Date 1/18/2017

FR OR 1		FR OR 2		FR OR 3		FR OR 4	
Start Time	7:30	Start Time	8:15	Start Time	7:30	Start Time	7:30
1 Rose In Room	7:52	1 Rose In Room	8:30	1 Gregori In Room	7:45	1 Epstein In Room	7:41
Pacu	8:37	Reg Blk Pacu	10:25	Pacu	10:36	Pacu	8:05
MD Late Turn Over	1:28	Turn Over	0:49	MD Late Turn Over	0:28	MD Late Turn Over	0:15
Start Time	9:15	Start Time	10:19	Start Time	10:00	Start Time	8:15
2 Rose In Room	10:05	2 Rose In Room	11:14	2 Burns In Room	11:04	2 Epstein In Room	8:20
Pacu	11:33	Pacu	13:05	Pacu	12:52	Pacu	9:39
Turn Over	1:17	Turn Over	0:53	MD Late Turn Over		Turn Over	0:17
Start Time	11:15	Start Time	12:15			Start Time	9:45
3 Rose In Room	12:50	3 Rose In Room	13:58			3 Epstein In Room	9:56
Pacu	14:12	Pacu	15:08			Pacu	12:03
Turn Over	0:34	Turn Over				break Turn Over	1:00
Start Time	13:15					Start Time	13:00
4 Rose In Room	14:46					4 Kimm In Room	13:04
Pacu	15:32					Pacu	14:15
Turn Over						Turn Over	0:13
Start Time	17:00					Start Time	14:30
7 Kimm In Room						5 Kimm In Room	14:28
Pacu						Pacu	14:51
Turn Over	0:05					Finished Early Turn Over	0:31
						Start Time	15:30
						6 Kimm In Room	15:22
						Pacu	
						Turn Over	

Figure 1 .Data Collection Tool.

Element 4: Evidence of Data Collection

Turnover times were tracked on a daily basis by the center's Patient Traffic Controller using the data collection tool. The tool was displayed daily for O.R. team member discussion to continuously manage improvements. (Figure 1)

Element 5: Data Analysis

- The average turnover time from September 2015 to December 2015 was 22.5 minutes.
- Primary reasons for delays from the data collection tool were:
  - MD Late
  - Regional Blocks
  - Instrument Turnover

Element 6: Comparison with Goals

- In comparison to the performance goal of 15 minutes, data analysis showed a baseline average turnover time of 22.5 minutes. (Figure 2)
- In order to reach the goal of 15 minutes, the current performance had to be improved by 33%.

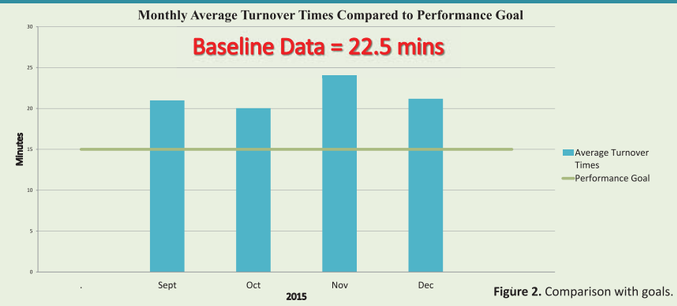


Figure 2. Comparison with goals.

Element 7: Corrective Action

- Brainstorming sessions were held with frontline employees from the Operating Room, Sterile Processing, Admissions, and Leadership.
- Causes for extended turnover times identified by staff included:
  - Delay in admission process, primarily due to difficult IV starts
  - Disorganized system due to new center
  - Undefined process
  - Lack of assigned roles
  - Undeveloped trust between team members
- Based on the identified opportunities for improvement, the work group developed and adopted the NASCAR Pit Crew Model that our center now calls the "O.R. Pit Crew."
  - Team members are assigned specific roles for turnover (Figure 3)
  - Team members are interchangeable, but roles are static
- Implementing this model
  - Improved communication and trust
  - Decreased confusion and questions regarding turnover
  - Maximized resources
  - Reduced waste and time
- The O.R. Pit Crew was rolled out in January 2016.
- The team strives to work smarter, not harder.

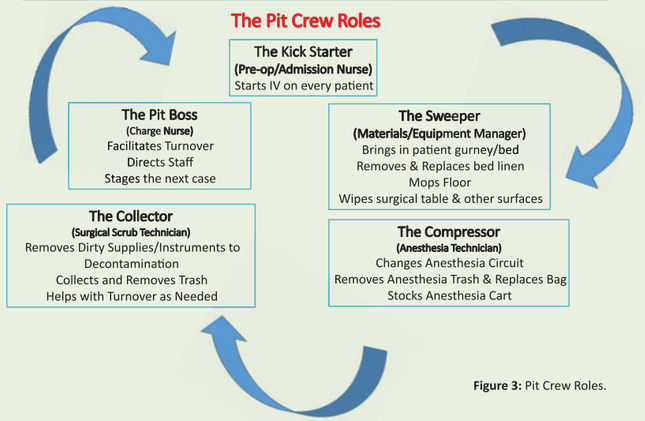


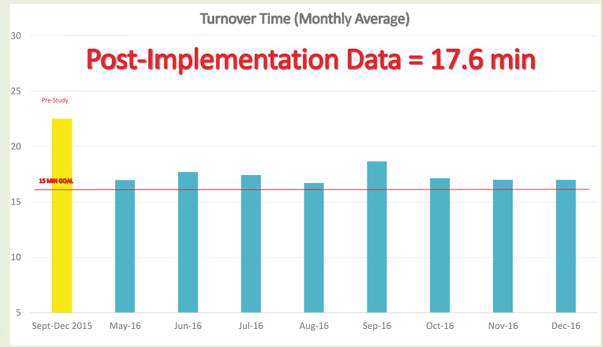
Figure 3: Pit Crew Roles.

Element 8: Re-Measurement

- Team members maintained the initial O.R. Pit Crew flow for the first 30 days without changes.
- Team members were encouraged to submit suggestions within the first 30 days.
- Re-measurement period was from May 2016 to August 2016.
- A consistent method (Element 3) was used to collect data.
- Data Analysis:
  - Average turnover time = 17.8 minutes
  - Average turnover time improved by 4.7 minutes
  - Reduced the gap between the 17.8-minute performance and 15-minute goal to 16%

Element 9: Additional Corrective Action and Re-Measurement

- At re-measurement, the main causes for extended turnover times were 1) regional blocks in pre-op and 2) extended instrument turnover times.
- Regional Blocks:
  - After coordination with pre-op, anesthesia, and scheduling, patients requiring regional blocks were asked to arrive earlier.
  - Regional blocks were added to surgical schedule to allow for additional prep time.
- Instrument Turnover issues:
  - Short Term Solution: implement "Pink Card System"
    - Allows the intra-operative team to identify instruments that will be required for the next case
    - Indicates to team members that those instruments should be first out of OR for immediate processing
  - Long Term Goal: additional instruments will be purchased in next fiscal cycle
- Re-measurement period was from September 2016 to December 2016
- Data Analysis:
  - Average turnover time = 17.3 minutes
  - Reduced the gap between the 17.3-minute performance and 15-minute goal to 13%
- **Conclusion: The turnover time was improved from 22.5 minutes to 17.6 minutes, a 22% reduction, by December 2016.**



Element 10: Communication of Findings

- At daily engagement huddles, frontline staff and leadership update team members on turnover times.
- Positive feedback and opportunities are shared and discussed with the team.
- Findings and status of the project are presented at monthly Gemba Walks. See poster board presentation (Figure 4).
- Staff are empowered to work through issues regarding turnovers and are supported by leadership when changes are suggested.

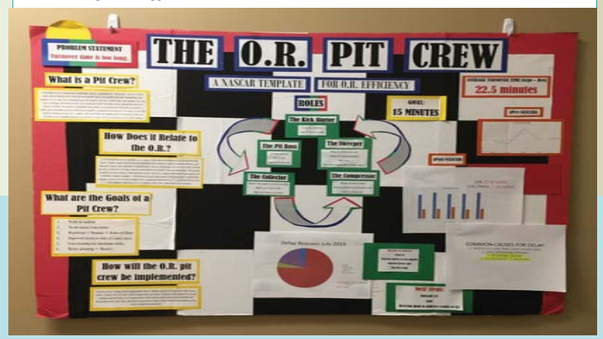


Figure 4. GEMBA Poster.

Surgical/Procedural finalist

Mankato Surgery Center

submitted by: D. Craig Rosfjord, BSN RN, PHN,
Quality Improvement and Safety Nurse

Timeliness of Obtaining Surgical Clearance Documentation

D. Craig Rosfjord, BSN, RN, PHN Mankato Surgery Center

THE ORGANIZATION: Mankato Surgery Center is a freestanding, multi-specialty ASC located at the Wickersham Health Campus in southern Minnesota. The 16,000 square-foot ASC includes four surgery suites for same-day surgery and two procedure rooms. Areas of specialty are gynecology, orthopedics, ENT, ophthalmology, urology, podiatry, and pain management. The center serves around 4,500 patients a year.

THE STUDY: The ASC sought to increase the efficiency of obtaining documents required prior to surgery. Initial data collected over 24 days and involving 425 cases identified that complete documentation was received more than 3 days prior to surgery 89.65% of the time. A goal was set at 95% for all surgical clearance documents (consent form, surgeon notes, history and physical, EKG, lab results, X-ray results, medication lists, etc.) to be in hand at least 3 days before the scheduled date of surgery.

As a corrective action, Mankato Surgery Center set new guidelines for how soon a surgery could be scheduled following the pre-op appointment, distributed a list of required surgical clearance documents to nursing staff and surgery schedulers, communicated the performance goal, and created a primary care contact directory to facilitate communication between the facility and the patient's other health care providers. Re-measurement following implementation of these corrective actions showed 97.8% of required clearance documentation received within the 3-day minimum parameter, a result exceeding the established goal.

APPROACH TO QI: The center has recently rolled out a collaborative approach to QI. The Quality Improvement and Safety Nurse takes the lead as Chair of the Quality and Safety Committee. The committee is comprised of all frontline staff and is charged with choosing topics and implementing studies. Currently, the committee is working on studies related to improving pain management scores and discharge instructions. Other individuals on the team have expressed interest in topics related to their specific roles and departments such as a pre-op nurse who is creating a study on triaging appointment times. Increased participation drives ongoing QI efforts by encouraging staff to take the initiative in identifying topics/areas for studies.

MANKATO SURGERY CENTER

Element 1: Purpose

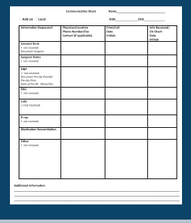
- The purpose of this quantitative quality improvement study was to establish a baseline of the timeliness of obtaining surgical documentation and to create action plans to mitigate delays.
- Anesthesiology created a policy that surgical clearance documentation will be available ≥3 days before routine scheduled surgeries in order to minimize the risk associated with anesthetic and the patient's surgery.
- It is known that surgical clearance documentation was arriving ≤3 days and the day of surgery.
- It is known that surgical clearance documentation was missing and/or incomplete.

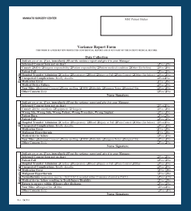
Element 2: Performance Goal

- Obtain ≥95% of surgical clearance documentation ≥3 days before the surgical procedure.
  - Performance goal based on Dean, A. (2012, August 15). Preoperative Patient Assessment in an Ambulatory Surgery Center. The ADA Group.

Element 3: Data Collection Plan

- Collect Pre-Op Nurses Communication Sheet on a daily basis.
- Collect Variance (incident report) Report forms.
- Calculate the date of surgery verses the date surgical clearance documentation is received.
- Identify what clinical documentation is missing or incomplete.
- Collection period: 3/8/2016 – 4/8/2016.





Element 4: Evidence of Data Collection

- From 3-8-2016 through 4-8-2016 all Nurses Communication Sheets were collected for analysis and data collection.
- From 3-8-2016 through 4-8-2016 all Variance Report forms were evaluated for inclusion.
- All data collected that met criteria were verified by an audit in Amkai Charts of the Consents and Attachments documentation: consent, surgeon notes, H&P, Anesthesia Record, Scheduling Worksheet, lab reports, EKG, medication reconciliation and other clinical documentation.
- Data that met criteria were entered in an Excel Spread Sheet.

Element 5: Data Analysis

- Number of days audited: 24.
- Total number of surgical procedures: 425.
- Surgical Clearance Documentation received ≥3 days: 89.65%.
- Most common variance or occurrence: Health History & Physical (H&P) 23 – 57.5%, Labs 7 – 17.5%, cardiac clearance tests 5 – 12.5%.
- Variance Forms that included an occurrence of late or missing surgical clearance documentation: 44 – 10.35%.
- Total number of days without an occurrence: 4
- Identified the clinic that generated the highest number of occurrences: 13 occurrences – 32.5% of the occurrences.
- Most common licensure: MD – 16 occurrences vs. 11 non-physician practitioners.
- Most common surgeon: 7 different surgeons from 2 different organizations.
- Average number of cases per day vs. timeless: average 17.7 cases per day.
- Most common day of the week: Tuesday 13 – 35% and Friday 10 – 25%.
- Most common primary care provider: 27 different providers from multiple medical clinics within 60 miles of Mankato.

Element 6: Comparison with Goal

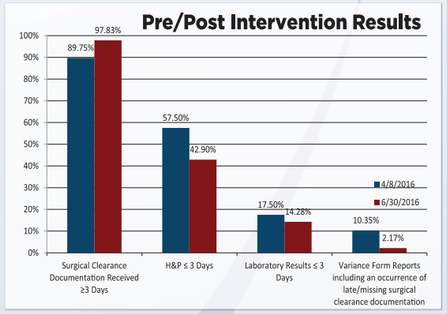
- The baseline for receiving ≥95% surgical clearance documentation ≥3 days is 89.65%.
  - Data analysis shows H&P is the most problematic to receive ≥3 days at 57.5%.
  - "Clinic" was identified with the highest number of occurrences.
  - Identified which providers had occurrences.

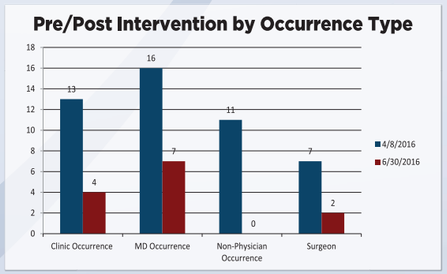
Element 7: Corrective Action

- The Clinic department managers will set new guidelines on how soon a surgery may be scheduled following the Pre-Op surgical clearance clinic appointment.
- The Clinic department managers will develop a comprehensive list of all documents needed for surgical clearance and distribute to Clinic nursing staff and surgery schedulers.
- The Clinic department managers will educate physicians and non-physicians practitioners on the goal of receiving ≥95% surgical clearance documentation ≥3 days.
- A Clinic manager will create a primary care manager telephone directory to communicate faster with any concerns.
- The Clinic managers, director of nursing and Mankato Surgery Center leaders will meet on a monthly basis to address concerns.

Element 8: Re-Measurement

	Pre-Measurement 3/8/2016		Post-Intervention Measurement 6/30/2016	
Total # of Surgical Procedures	425		322	
Total # of Days Audited	24		21	
Average # of Cases per Day	17.7		15.3	
	Number	% of Total	Number	%of Total
Surgical Clearance Documentation Received ≥ 3 Days	382	89.70%	315	97.8% GOAL OBTAINED
Total # of Days without an Occurrence	4	16.70%	9	42.90%
Most Common Occurrences Received ≤ 3 Days	# of Occurrences	% of Total Occurrences	# of Occurrences	% of Total Occurrences
Most Common Documentation Occurrences				
o H&P	23	57.50%	3	42.90%
o Lab Results	7	17.50%	1	14.30%
o Cardiac Clearance	5	12.50%	1	14.30%
Late or Missing Surgical Clearance Documentation Occurrence	44	10.40%	7	2.20%
Identified Clinic with Highest # of Occurrences	13	32.50%	4	57.10%
Most Common Licensure Occurrences				
o MD	16	37.20%	7	16.28%
o Non-physician	11	61.10%	0	0%
o Surgeon	7	19.44%	2	5.55%
Most Common Day of the Week for occurences.	Tuesday – 13; Friday - 10		Friday - 4	
Most Common Primary Care Providers who had occurrences.	27 providers from multiple clinics		No common providers from multiple clinics	





Element 9: Additional Corrective Action and Re-measurement

- To measure sustained improvements, additional re-measurement will be conducted at 3 and 6 months, annually or on an as needed basis.

Element 10: Communication of Findings

- Presented the study results to the Staff – Quality Improvement and Safety Committee.
- Posted the study results in the all-staff Education Book.
- Presented the study results to the Physician – Quality Improvement Committee
  - Reported the study results to the Mankato Surgery Center Board of Directors.
- Presented the study results to the Clinic.

Surgical/Procedural finalist

Maryland Endoscopy Center, LLC

submitted by: Phyllis Shriner, RN, BSN, CGRN
and Irma Haak, RN

THE ORGANIZATION: Maryland Endoscopy Center, a free-standing facility in Towson, Md., specializes in colorectal cancer screening and gastroenterology. Privileged physicians are affiliated with eight of Baltimore's medical institutions, including Mercy Medical Center, Good Samaritan Hospital, Union Memorial Hospital, Franklin Square Hospital, St. Joseph Medical Center, Sinai Hospital, Greater Baltimore Medical Center and Northwest Hospital Center. In the past year, the facility performed almost 7,000 procedures.

THE STUDY: The organization worked to ensure complete (100%) decontamination of "semi-disposable" biopsy valves. Use of these valves represented significant cost savings over single-use valves, but confirmation that the cleaning process resulted in full decontamination was a critical infection control concern.

To test the cleaning process, four valves were swabbed and sent to a lab for processing. The resulting data indicated a 75% negative culture due to one of the four valves testing positive for more than 100 colonies of bacteria. While the organisms found are generally considered "harmless," they can be opportunistic pathogens for immunocompromised patients. The organism is also one commonly found on the skin. Based on this information, the cause of the contaminated specimen was deemed "user error."

As a corrective action, the facility implemented a re-education activity for staff members. Following this intervention, retesting resulted in 100% negative cultures, meeting the established goal.

APPROACH TO QI: 'Who is in charge of QI?' is a favorite trick question at staff meetings. Maryland Endoscopy Center maintains that everyone is in charge of QI. The Center leader oversees all aspects of the QI process and consults regularly with the designated QI chairperson, but investigating issues and conducting QI studies involve all employees.

MARYLAND ENDOSCOPY CENTER

Verifying Cleaning Processes for Reusable Biopsy Valves

Phyllis Shriner, RN,BSN, CGRN Irma Haak, RN
Maryland Endoscopy Center, L.L.C.

Institute for Quality Improvement

Element 1: Purpose

- **To demonstrate that our cleaning process for reusable biopsy valves meets rigid standards ensuring complete decontamination.**
- **Disposable biopsy valves ensure that no cross contamination will occur since they are a single use accessory. But these valves incur additional cost to each procedure.**
- **Olympus makes a "semi-disposable" biopsy valve that is designed for multiple use.**
- **Cleaning of these valves involves an exact process of brushing in the grooves on the underside and top of each valve.**

Element 2: Performance Goals

We want 100% NEGATIVE CULTURES because otherwise this is an infection control issue and organisms can be transmitted from patient to patient if not completely decontaminated.

Element 3: Data Collection Plan

- **The underside and top of 4 "semi-disposable" biopsy valves were cultured using a swab technique and a separate swab for each valve. Each swab was then placed in a separate culture tube.**
- **The tube was labeled with the valve number assigned to that valve and each specimen tube was listed on the lab requisition.**
- **The specimen bag was then submitted with the requisition to the lab for processing.**

Element 4: Evidence of data collection:

The specimens were sent on May 1, 2015 and the report was received via fax on May 6, 2015. Four (4) reports were received: one for each culturette.

Element 5: Data Analysis

Date Culture Taken and Sent to Lab	Date Culture Report was Received back from the lab
May 1, 2015	May 6, 2015
Semi-Disposable Valve Number	Results
1	No growth after 2 days.
2	Micrococcus & related genera >100 colonies of bacteria present.
3	No growth after 2 days.
4	No growth after 2 days.

- **This organism is defined in Pathogen Safety Data Sheet as "generally regarded as harmless saprophytes that inhabit or contaminate the skin, mucosa, and perhaps also the oropharynx; however, they can be opportunistic pathogens for the immunocompromised."**
- **Since this is an organism found on the skin we attributed the bacteria report to contamination in the process of collecting the sample: *User Error*.**
- **The contaminated specimen was put through the cleaning process again.**

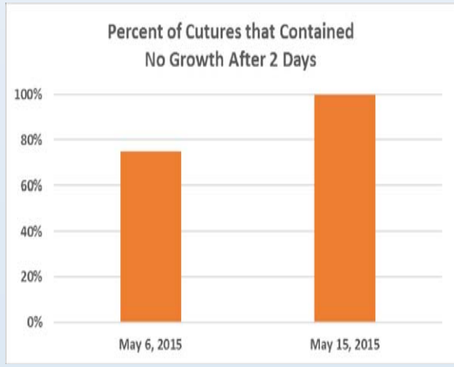
Element 6: Comparison with Goals:

We achieved 75% (3/4) negative cultures compared to the goal of 100% negative cultures. We did not reach our goal.

Element 7: Corrective Action

- **Re-education of staff members to include wearing clean gloves and performing appropriate hand hygiene while handling scopes.**
- **We repeated the study, this time using gloves and changing gloves between specimens.**
- **The same method was used with this second set of biopsy valves, again submitting 4 culturettes for processing at the lab.**

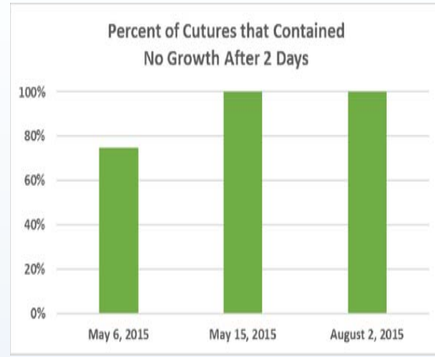
Element 8: Re-measurement



100% negative cultures achieved, GOAL MET.

Element 9: Additional Corrective Action and Re-measurement

We repeated the cultures one more time to demonstrate sustained performance.



GOAL MAINTAINED.

Random audits of scope room will include appropriate hand hygiene and wearing clean gloves while handling clean scopes.

Element 10: Communication of Findings

Report to PI Committee: Q2, PI meeting
Report to Governing Body: Q3, Board Meeting
Findings communicated to staff: Staff Meeting, August, 2015

Restudy: ☒ Yes ☒ No ☒ N/A

Original Study date: May, 2015

Target date for restudy: This will be an ongoing study and will be performed at random

Primary Care finalist

University of Utah

submitted by: Suzanne Martin, DNP, NP-C,
Nurse Practitioner, QI Director, Assistant Professor (Clinical)

THE ORGANIZATION: The University of Utah Student Medical Center, located in Salt Lake City, focuses on the needs of the university's student population of 32,000 and their dependents. The center provides primary care to approximately 10,000 students each year. Staff includes physicians and nurse practitioners who specialize in primary care, family medicine, and pediatrics.

FOCUS OF STUDY: Per the CDC, in 2014 only 8.2% of males aged 19-26 received the HPV vaccine. Male college students are often unaware of the value of the immunization, and health care providers may forget to offer the vaccine during routine visits. The University student health center sought to increase the HPV vaccine immunization rate among male college students, aiming for a goal that 20% of the defined population with a scheduled visit would receive the HPV vaccine. Initial data collected for an eight-month period showed that only 5.2% of eligible patients received the inoculation.

A staff group collaborated with an outside vendor to create a "Candidate for HPV vaccine" alert within the EMR. Staff training was conducted by the QI Coordinator. The post-alert re-measurement showed a marked increase with 25.1% of all males with a scheduled visit receiving the vaccine.

APPROACH TO QI: The health center completes two to three formal QI projects each year. All projects rely on a team effort, but this was particularly true for this study because it included a staff focus group at the outset. Information obtained from the focus group informed the corrective action/intervention for the project. This helped with staff buy in and to set the stage for the actual project. The EMR alert relied on teamwork between nursing and provider teams: The nursing team triggered the alert, then passed the ball to the provider team. Providers discussed/offered/ordered the vaccine, then passed the ball back to the nursing team, who administered the vaccine.

THE UNIVERSITY OF UTAH

Increasing Human Papillomavirus (HPV) Vaccination Rates

Suzanne Martin, DNP, NP-C
University of Utah Student Health Center (SHC)

Element 1: Purpose

- **PURPOSE: increase HPV vaccination rates among male college students through the use of an electronic medical record (EMR) alert.**
- 75% of sexually-active people acquire HPV, most often as teens or young adults (CDC, 2015)
- College students may qualify for catch-up HPV vaccination (CDC, 2016)
- Many male college students are surprised to learn that they qualify for the HPV vaccine (SHC Focus Group, 2015)
- Providers forget to offer the HPV vaccine at routine visits, leading to missed opportunities (SHC Focus Group, 2015)

Element 2: Benchmarks & Goals

- 8.2% of males, ages 19-26 received 1+ dose of the HPV vaccine in 2014 (CDC, 2015)
- 35% of male college students reported receiving the HPV vaccine in 2015 (ACHA, 2016)
- The average of these benchmarks provided a robust, yet achievable goal
- **PERFORMANCE GOAL: 20% of males with a scheduled visit will receive 1+ dose of the HPV vaccine**

Element 3: Data Collection Plan

SHC Focus Group: to determine (a) staff knowledge, (b) barriers to vaccination, and (c) logistical issues. Data recorded, transcribed, and summarized.

Baseline Chart Audit: to determine % of participants who received 1+ dose of the HPV vaccine at scheduled visit during baseline period of 12-1-14 to 7-31-15

# of vaccine-naive males, ages 18-26 w/ Student Health Insurance (SHIP) who received first dose of vaccine at scheduled visit*

# of males, ages 18-26 w/SHIP with a scheduled visit

*Required to avoid barrier of cost; > 70% of patient population has SHIP

Element 4: Evidence of Data Collection

SHC Focus Group:
See handout

Baseline Chart Audit:

20 participants received HPV vaccine, dose 1
386 participants were seen

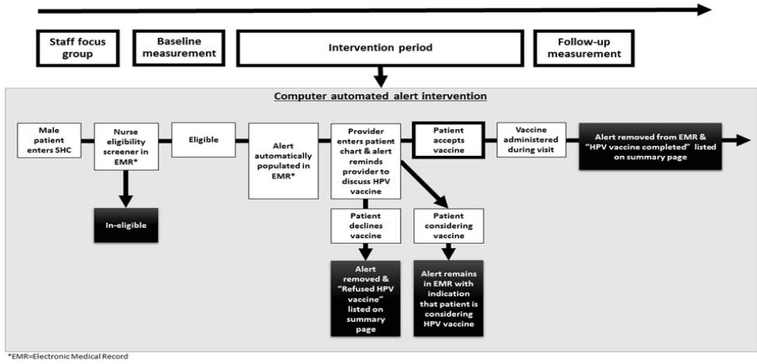
Element 5: Data Analysis

5.2% of males with a scheduled visit received 1+ dose of the HPV vaccine during the baseline period

Element 6: Comparison of Current Performance to Performance Goal

Baseline performance, 5.2% < Performance Goal, 20%

Element 7: Corrective Action



October-November, 2015
- IRB approval
- Staff focus group:
  - Conducted by an independent researcher
  - Assessed staff educational needs and barriers to HPV vaccination
- Collaboration with EMR vendor to create "Candidate for HPV vaccine" EMR alert

December, 2015
- Baseline chart audit
- Staff Training:
  - Conducted by QI Coordinator
  - Instructed nursing and provider staff on how to use and respond to the "Candidate for HPV vaccine" EMR alert
  - Fielded questions and concerns, i.e. updating or disabling the alert if patient had completed or declined the vaccine

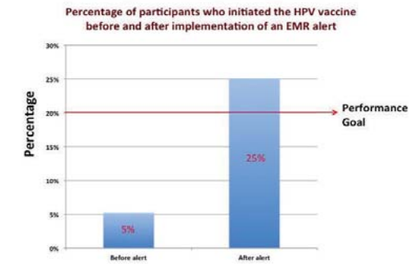
August, 2016
- Post-alert chart audit
- Communication of results to governing body and staff

Element 8: Re-measurement

Post-alert Chart Audit: to determine % of participants who received 1+ dose of the HPV vaccine at scheduled visit during post-alert period 12-1-15 to 7-31-16

87 participants received HPV vaccine, dose 1
346 participants were seen

25.1% of males with a scheduled visit received 1+ dose of the HPV vaccine during the post-alert period



Element 9: Additional Corrective Action

- No additional corrective action was indicated.
- EMR alert disabled 12-1-16 to determine whether offering the vaccine to males at routine visits became a learned behavior. Third round of measurement scheduled for 8-17.

Element 10: Communication of Findings

- Project presented to:
  - SHC governing body and staff 8-16
  - Intermountain West HPV Vaccination Coalition 11-16
  - Western Institute for Nursing 4-17 (pending)

Acknowledgements

Special thanks to the patients, staff, and EMR vendor at the University of Utah Student Health Center.

Primary Care finalist

Premise Health: Westlake Health & Wellness Center

submitted by: Danielle Smith, MSN, RN, FRE,
Health Center Manager

THE ORGANIZATION: Located in Houston, Tx., the Westlake Health & Wellness Center offers a Patient Centered Medical Home approach catered to BP employees and their families. The center provides a variety of health and wellness services including adult primary and pediatric care, laboratory testing, X-ray examination, full-service pharmacy, physical therapy, dental and vision care. On average, the facility conducts approximately 3,000 preventive exams annually.

The health center is staffed by three full-time physicians, a physician assistant, three registered nurses and three medical assistants, in addition to two onsite pharmacists and a physical therapist. They also offer comprehensive dentistry services provided by two full-time dentists and three dental hygienists.

The facility is operated by Premise Health network which manages more than 500 worksite-based health and wellness centers in 45 states, including Guam and Puerto Rico.

FOCUS OF STUDY: In line with national screening guidelines, the facility worked to reduce the routine screening of TSH, HbA1c, and vitamin D for patients undergoing preventive health examinations through provider education. The performance goal aimed to reduce testing by 50% from the baselines established for each of the three screenings. Collating data from 948 health examinations performed in October-December 2014, the facility was successful in achieving a >50% decrease for all three metrics. In 2015 and 2016, re-measurement showed the reduction was sustained in all three areas. Targeting of tests for "at-risk" individuals has increased the rate of abnormal results indicating greater effectiveness.

APPROACH TO QI: During a quarterly business review, a client of the facility notified the Medical Director that there were too many TSH, HbA1c, and vitamin D tests being performed during preventive exams. All primary care providers were made aware of the amount of testing and evidenced-based guidelines and agreed to the interventions. Other members of the Primary Care Team (RN Supervisor, Health Center Manager) kept the providers abreast of the results of the interventions. The staff has monthly QI meetings where each line of service reports what they are doing for continuous quality improvement in their area. Additionally, there are weekly CQI meetings during which staff review the AAAHC Handbook and go over each Standard and how it is actualized at the site. QI really is ubiquitous at Westlake Health & Wellness Center and throughout Premise Health.

An Intervention to Reduce Unnecessary TSH, HbA1c and Vitamin D Testing in Accordance With Evidence-Based Guidelines Within a PCMH

Danielle Smith, MSN, RN, FRE
Premise Health, Westlake Health & Wellness Center

Premise Health

Premise Health is a leading worksite health and patient engagement company dedicated to improving the cost and quality of employee health care. With more than 40 years of experience, Premise Health manages more than 500 worksite-based health and wellness centers across the country.

Westlake health&wellness center

The Westlake Health & Wellness Center is a Patient-Centered Medical Home (PCMH) operated by Premise Health. Located on BP's Westlake campus in Houston, Texas, it serves as an innovative medical facility for BP ("Client") employees and their families.

Patient Population & Demographics

- Approximately 4,460 employees, dependents and retirees; average patient population is 40 to 45 years of age; male to female ratio is 54:46

Key Findings

One quarter post-intervention, the rates of testing for all three metrics dropped >50%.

- **TSH: 96% to 22%**
- **Vitamin D: 99% to 28%**
- **HbA1c: 97% to 31%**

This change was sustained six months later. In addition, the rate of abnormal results increased significantly for both Vitamin D (53% to 81%) and HbA1c (40% to 53%), suggesting more appropriate targeting of individuals for testing.

STUDY ELEMENTS

Element 1: Purpose

- The purpose of the study was to examine current practices and reduce the frequency of Vitamin D, TSH and HbA1c testing.
- U.S. Preventive Services Task Force (USPSTF) guidelines do not support routine screening for Vitamin D deficiency, thyroid dysfunction using TSH and diabetes using HbA1c.
- Data gathered for each quarterly business review revealed what appeared to be excessive rates of testing for these three measures.
- Westlake Health & Wellness Center performed 3,010 preventive health examination in 2014 and 3,195 in 2015. Therefore, unnecessary testing effects a large patient population and results in higher costs.
- This included reviewing current practice patterns and best practice testing guidelines with the Care Team, as well as modifying the EMR so that only CBC, CMP and lipid panels were pre-populated for easier selection.

Element 2: Benchmarks & Goals

- Current best practice screening guidelines do not support routine screening of Vitamin D, TSH and HbA1c in asymptomatic adults who are not at risk (USPSTF, 2015).
- Since a benchmark does not exist and routine screening is not supported, the Quality Team established a realistic and appropriate goal to decrease testing for Vitamin D, TSH and HbA1c during preventive exams by 50% from baseline.

STUDY ELEMENTS

Element 3: Data Collection

The data needed was already collected for all preventive health screens as part of Premise Health Quarterly Business Review data. It was not risk-adjusted to only include those who had no criteria for screening. Each quarter a report is run from the EMR that details the percent of physicals/preventive health screens associated with the following labs and what percentage of the labs are abnormal (out of reference range):

- CBC
- CMP
- Lipid Panel
- TSH
- HbA1c
- Vitamin D

During the Q1 2014 (January to March) Business Review meeting, concerns were raised by the Client and the Client's benefits consulting firm regarding the frequency of testing of the last three metrics based on the data presented for all physicals that quarter.

Element 4: Evidence of Data Collection

- The time frame for data collection occurred January to March 2014 (Q1) and April to June 2014 (Q2) for the initial measurement.
- Information collected at each interval was the percentage of TSH, CBC, CMP, Vitamin D, HbA1c and lipid panels performed with preventive exams and the percent of those labs that returned abnormal.
- The normal reference for TSH is 0.40 to 4.50; Vitamin D is 30 to 100 ng/mL; and HbA1c is <5.7% of total hemoglobin.

Of the 348 preventive health examinations performed from **January to March of 2014**:

TABLE 1

Q1 2014	TSH	CBC	CMP	Vit D	HbA1c	Lipids
% Exams With Lab	70.4%	68.82%	54.33%	78.5%	70.42%	62.21%
% Abnormal	13%	35%	47%	53%	40%	25%

Of the 878 preventive health examinations performed from **April to June of 2014**:

TABLE 2

Q2 2014	TSH	CBC	CMP	Vit D	HbA1c	Lipids
% Exams With Lab	95.82%	94.04%	85.67%	98.72%	96.71%	96.75%
% Abnormal	7%	41%	40%	53%	36%	21%

Element 5: Data Analysis

In the pre-intervention period:

- 70% to 96% of the preventive exams included TSH testing.
- 78% to 99% of the preventive exams included Vitamin D testing.
- 70% to 97% of the preventive exams included HbA1c.
- These results mirrored or exceeded rates of testing for CBC, CMP and lipid panels which suggested a pattern of routine screening for TSH, Vitamin D and HbA1c.
- The percentage of abnormal values for Vitamin D were >50% suggestive of appropriate testing. However, due to lack of consensus on what defines Vitamin D deficiency and the inconsistencies surrounding testing methods and lab values, widespread screening is of questionable benefit for asymptomatic adults (USPSTF, 2015).

Element 6: Comparisons with Goals

- The goal was to reduce testing by 50% from baseline.
- Inversely, this could be interpreted as not more than 20% to 49% of the preventive exams would involve these tests.
- 70% to 90% of the preventive screens were associated with TSH, Vitamin D and HbA1c.
- **A definitive practice gap was identified.**

Element 7: Corrective Action

In Q3 2014 (July to September), a meeting was held between Westlake Health & Wellness Center's Medical Director, Premise Health's Regional/National Medical Director, the Client's U.S. Medical Director and the Client's Senior Health Consultant. Current USPSTF recommendations for routine screening were discussed, along with desirable practice at the Westlake Health & Wellness Center regarding routine testing associated with preventive exams.

The following was decided:

1. **CBC, CMP and lipid panels would be the only routine labs for adult preventive exams.**
2. **TSH for women >50, individuals with signs or symptoms or on thyroid replacement therapy.**
3. **Vitamin D testing for individuals considered "at risk" according to UpToDate®. Characteristics include:**
   - **Dark skinned**
   - **Obese**
   - **Taking medications that accelerate the metabolism of Vitamin D**
   - **Limited effective sun exposure**
   - **Osteoporosis/osteopenia**
   - **Malabsorption**
4. **HbA1c testing for known pre-diabetics, diabetics, fasting plasma glucose >100 and for individuals considered at risk according to USPSTF. Characteristics include:**
   - **Individuals age 40 to 70 years who are overweight or obese**
   - **Family history of diabetes**
   - **History of gestational diabetes or polycystic ovarian syndrome**
   - **Certain racial/ethnic groups**

The Medical Director discussed these recommendations with the Care Teams at the Westlake Health & Wellness Center as well as the USPSTF Guidelines supporting the decisions.

Preventive templates in the EMR were changed to reflect the new practice recommendations.

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STUDY ELEMENTS

Element 8: Re-Measurement

Of the 948 preventive health examinations performed from **October to December of 2014**:

TABLE 3

Q4 2014	TSH	CBC	CMP	Vit D	HbA1c	Lipids
% Exams With Lab	22%	88%	89%	28%	31%	89%
% Abnormal	11%	15%	28%	81%	53%	53%

Of the 741 preventive health examinations performed from **July to September of 2015**:

TABLE 4

Q3 2015	TSH	CBC	CMP	Vit D	HbA1c	Lipids
% Exams With Lab	18%	80%	94%	14%	24%	94%
% Abnormal	16%	17%	41%	71%	72%	41%

GOAL ACHIEVED!

One quarter post-intervention the rates of testing for all three metrics dropped > 50%.

- **TSH 96% to 22%**
- **Vitamin D 99% to 28%**
- **HbA1c 97% to 31%**

The rate of abnormal results increased significantly for Vitamin D and HbA1c suggesting more appropriate testing.

- **Vitamin D from 53% to 81% abnormal**
- **HbA1c from 40% to 53% abnormal**

Element 9: Additional Corrective Action and Re-Measurement

There was no additional corrective action required. The re-measurement in Q1 2016 (January to March) shows the reduction of all three measures is sustained.

Of the 483 preventive health examinations performed from **January to March of 2016**:

Q1 2016	TSH	CBC	CMP	Vit D	HbA1c	Lipids
% Exams With Lab	23%	63%	78%	21%	26%	77%
% Abnormal	12%	11%	25%	53%	57%	38%

Element 10: Conclusion

- Initial results were shared with the Westlake Health & Wellness Center clinical staff and the Client.
- Results were also shared with regions targeted for peer review of TSH and Vitamin D testing including Premise Health's Medical Operations Leadership, Quality Focus Team, Senior Medical Management Team and Quality Council Team.
- In April of 2016, findings were shared with the entire organization during the Quality Improvement Workshop for awareness and replication.

Primary Care finalist

Premise Health: Center for Living Well Family Healthcare

submitted by: Kathleen McKim, RN, BSH, LHRM, CPHQ, Clinical Services Manager

THE ORGANIZATION: The Center for Living Well, a 15,000 square foot facility in Lake Buena Vista, Florida, is a Patient Centered Medical Home. Serving approximately 40,000 employees and families enrolled in a Disney healthcare plan, the center offers a variety of services including comprehensive adult and pediatric primary care, acute urgent care, full-service pharmacy, laboratory testing, X-ray examination, as well as a wellness, chronic care and educational coaching programs.

The center is operated and staffed by Premise Health, a leading worksite health and patient engagement company, which manages more than 500 worksite-based health and wellness centers in 45 states, including Guam and Puerto Rico. With over 40 years of experience, the company serves more than 200 of the nation's leading employers.

FOCUS OF STUDY: The study sought to support patients with chronic conditions (i.e., diabetes, hypertension, and hyperlipidemia) to keep their diseases under control using interventions such as patient education, provider training, and blood pressure-only nurse visits. The organization used HEDIS measures as the benchmarks for performance goals in management of the three conditions. Data was collected from EMRs and results were compared to performance goals.

Based on the 2013-2014 results, the Center met the performance goal for hyperlipidemia but not for diabetes or hypertension. To address the results, the facility developed a Care Coordination Workflow which included a Pharmacist/Diabetic Educator, a registered dietician, and a multidisciplinary care team and a care coordinator to manage services for the three target populations. After implementation of the corrective action, two re-measurements in 2014-2015 and 2015-2016 showed results which exceeded performance goals for all three conditions.

APPROACH TO QI: The Center for Living Well takes a team approach to quality improvement. A five-year plan outlines overall goals and objectives established collaboratively by the leadership team and the client organization. The Clinical Services Manager cascades the quality plan from these goals and, as a team, the Center staff identifies tasks, studies, processes, and resources that are needed to successfully accomplish those goals. A Quality Committee oversees the implementation of the QI plan.

A Multi-Disciplinary Approach to Condition Management In a Primary Care Setting

Kathleen McKim, RN BSN LHRM CPHQ
Center for Living Well Family Healthcare

Organization

The Center for Living Well is a Patient Centered Medical Home operated by Premise Health located in Lake Buena Vista, Florida.

Premise Health is a leading worksite health and patient engagement company dedicated to improving the cost and quality of employee health care. With more than 40 years of experience, Premise Health manages more than 500 worksite-based health and wellness centers across the country.

Patient Population and Demographics:

- Approximately 20,000 employees, and their dependents with an average of 880 visits per week.

Key Findings

A multidisciplinary approach, integrated services, and coordination of care with better tracking and follow up resulted in improvements in three performance goals.

	Diabetes	Hypertension	Hyperlipidemia
Results: Pre and Post	73% ⬆ from 65%	75% ⬆ from 67%	71% ⬆ from 66%
Goal	67%	68%	65%
Sustained Goal Over Time	Yes	Yes	Yes

Element 1: Purpose

- The purpose of this study was to assess the effectiveness of a multi-disciplinary approach to monitoring and treating patients with diabetes, hypertension, and hyperlipidemia.
- There is an ever increasing need for primary care providers to manage chronic conditions within their practice.
- Good chronic disease management helps prevent complications, decreases morbidity and mortality, and improves quality of life.
- The reduction of chronic disease complications is directly related to the reduction of healthcare costs.
- Large patient panels make it impossible for providers to adequately monitor trends in key outcomes and patient adherence.

Element 2: Benchmarks and Goals

Benchmarks

- Using HEDIS measures as a basis for developing performance outcomes, leadership established the following organizational goals for the 2013-2014 fiscal year:
  - 67.37% of patients with a diagnosis of diabetes will have a HbA1c <8
  - 68.13% of patients with a diagnosis of hypertension will have a blood pressure <140/90
  - 65% of patients with a diagnosis of hyperlipidemia will have an LDL <130 mg/dl

Goals

- To meet or exceed the organization's 2013-2014 goals.

Element 3: Data Collection Plan

- Reports were generated from the organization's outcome measures database. The database collects and stores biometric results and visit information from the electronic medical record.
- The analysis is based on the total number of Center for Living Well patients with a diagnosis of diabetes, hypertension, or hyperlipidemia for the fiscal year October 1, 2013 through September 30, 2014.
- Results were calculated and the organization's benchmarks were used for comparison.

Element 4: Evidence of Data Collected

- Patients were identified as having diabetes: 811
- Patients were identified as having hypertension: 1,838
- Patients were identified as having hyperlipidemia: 1,720

Element 5: Data Analysis

Diabetes	Goal	2013-2014 Results
Percent Meeting Goals	67.37	65.19
Hypertension		
Percent Meeting Goals	68.13	66.5
Hyperlipidemia		
Percent Meeting Goals	65.0	65.52

Element 6: Comparison with Goals

- The Center did **not** meet the organization's 2013-2014 goals for diabetes or hypertension.
- The Center did **not** meet the established performance goals for diabetes, hypertension and hyperlipidemia from 2010 to 2014.

Element 7: Corrective Action

- The Center for Living Well leadership recognized the necessity for a reliable treatment protocol and a viable method for the routine tracking of outcomes, monitoring patient activities and compliance.
- A plan was developed that included a Pharmacist/Diabetic Educator, a registered dietician, a care coordinator, a multidisciplinary care team, and the development of an onsite outcomes database using Microsoft Access.
- The Care Coordinator and the Care Team are responsible for the coordination of services for the target population.

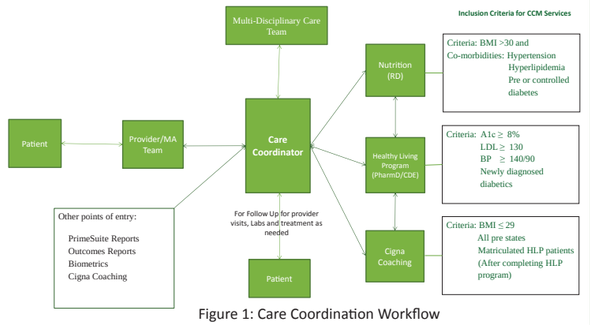

Figure 1: Care Coordination Workflow

Element 8: Re-Measurement

- Reports were generated for the fiscal year October 1, 2014 through September 30, 2015 using the same criteria from the previous year.
- Results were calculated and the organization's benchmarks were used for comparison.

Diabetes	Goal	2013-2014	2014-2015*
Percent Meeting Goals	67.37	65.19	72.73
Hypertension			
Percent Meeting Goals	68.13	66.5	74.67
Hyperlipidemia			
Percent Meeting Goals	65.0	65.52	70.71

* Chronic Disease Management program initiated in January of 2015

Element 9: Corrective Action

- The Center for Living Well Quality Team recommended a re-study of outcome measures at the end of the 2015-2016 fiscal year.

	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Diabetes	59.35	59.06	65.19	72.73	73.56
Hypertension	59.99	58.38	66.5	74.67	82.28
Hyperlipidemia	64.51	63.92	65.52	70.71	70.29

Element 10: Communication

This study was shared with the following entities:

- Quality Team
- Governing Body
- Premise Health Leadership
- Center for Living Well Leadership

References

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Surveyor Spotlight

ENDEL SORRA, DO

In 2008, Lt. Colonel Endel Sorra, DO retired from the Air Force after 21 years serving as an aerospace, occupational, and family medicine physician in a variety of clinical and leadership assignments. Shortly thereafter, Dr. Sorra began surveying for AAAHC. "My last job in the Air Force was on the Inspector General team where I began working side-by-side with surveyors from AAAHC. I found them to be a wonderful group to work with which is why I wanted to train to become a surveyor myself."

UNIQUE CHALLENGES

Dr. Sorra is privileged to survey ASCs, office-based surgical settings, and student health organizations. He hopes to add Indian health and Coast Guard, and he is joining a cohort of surveyors who will fulfill AAAHC on-site responsibilities for Bureau of Prisons healthcare facilities (see box, right).

"I especially enjoy surveying student health organizations because so many of the issues the staff and patient population face are similar to those of the military.

"In both cases these are young people away from home—most of them for the first time—who are facing the unique challenges of their new surroundings. Acquaintances are new and sometimes 'forced' and these young adults are expected to succeed in their endeavors as adults with a highly variable background in adult skills.

"This causes stresses," said Dr. Sorra, "which can show up as illnesses or symptoms suggestive of illnesses although a large percentage have a psychological overlay."

A CONSULTATIVE APPROACH

Dr. Sorra considers the consultative approach used by AAAHC to be particularly effective. "It is an unbiased look which critically assesses the operations of the facility we visit with an emphasis on education and improvement. All too often, honest feedback may not be provided by those who are part of the process at a given clinic or center, so an outside set of eyes is very valuable, particularly with an educational intent."

A PROUD MOMENT

When he is not surveying or working in cardiac/pulmonary rehabilitation and urgent care, Dr. Sorra enjoys spending time with his two adult children and Christine, his wife of 32 years. He also spends time exercising and at one time was a competitive powerlifter. One of his proudest moments, combining these passions, was a competition in which he and his son competed together. Each of them achieved a state lifting record. The most important lesson learned that day, he observes, was not the lifting or the records, but the time spent with his family. "Reflecting on that reminds me of how important that time is, no matter what we are doing."

"Over the last several years I have scaled back the lifting and have started doing some short triathlons. I try to exercise most days, dividing my time between lifting, running, swimming, and cycling. I commute to work on my bicycle as often as I can."

MULTIPLE PERSPECTIVES

Currently, Dr. Sorra is an occupational medicine specialist in Albuquerque, New Mexico. He received his medical degree from New York College of Osteopathic Medicine and has been in practice for more than 20 years. He feels a synergy between his background and experience in occupational medicine and his role as a surveyor for AAAHC.

"In my professional life I take on multiple perspectives, from clinician to patient to surveyor, but in all of them I see a link to AAAHC Standards. All are concerned with promotion of health and safety in the workplace." ▲

U.S. Bureau of Prisons awards AAAHC contract

The federal Bureau of Prisons (BOP) has awarded AAAHC a contract to review ambulatory health care in correctional facilities throughout the United States and Puerto Rico. The Health Services Division of the Bureau operates more than 70 correctional health care facilities providing essential medical, dental, and mental health services to the incarcerated population.

The BOP organizes its services by medical care levels tailored to the needs of the inmates and to the capabilities of the correctional institution. Many of the services offered by the BOP are outpatient, similar to those provided by a community clinic. They have treatment tiers that include basic preventive care, advanced care for chronic or acute conditions, and daily nursing care.

AAAHC has identified a cohort of highly-qualified surveyors who have experience and/or training in correctional health care. The process of credentialing and privileging these surveyors has begun and the first surveys are being scheduled. A recent webinar to introduce AAAHC was attended by 312 Bureau of Prisons healthcare staff and providers.

Meet the AAAHC Staff

TARIN ENGLISH
MANAGER,
ACCREDITATION SERVICES

Tarin English is not one to back down from a challenge. When a friend asked if she was interested in taking improvisation classes, Tarin said, "Sign me up!"

"I like improv because there is no time to overanalyze. You have to put yourself out there, be in the moment and ready for anything. That can be scary but also immensely empowering."

UP FOR A CHALLENGE

Rising to a challenge seems to be a theme of Tarin English's life. She started out in college as an education major then switched to liberal arts and English. After graduation she found a job training students in a court reporting program. But first she had to teach herself the theory and the keyboarding skills (which use syllables and sounds rather than actual lettering).

Then came the financial collapse of 2008, and she found herself casting around for a new opportunity. That's when she happened to come across a job opening at AAAHC primarily responsible for releasing decisions and managing the Standard 2.I.D change process. She had never worked in health care but again, she was up for the challenge of learning something new. She applied and got the job. At AAAHC she quickly moved up through several roles to her current position as manager of report coordinators.

Her team reviews the reports that surveyors submit after the on-site visit. Report Coordinators check to ensure the message conveyed is clear and consistent. "There is a great deal of collaboration that goes on between my team and surveyors and my team and me. There's a joke that I should get one of those 'take-a-number' dispensers you see at a deli counter because there's always a line in front of my office door."

COMMUNICATING ACROSS CHANNELS

She sees her team as one of the crucial pieces in the accreditation process. "Report coordinators have a unique position in the process; they are the link between surveyor and Accreditation Committee and surveyor and organization. The connection is all about what is communicated and how."

Tarin sees the survey report itself as a tool for education and QI not just for the organization seeking accreditation but also for AAAHC. For example, feedback about surveys is important to Education since there may be evidence that a specific Standard needs clarification. Similarly, surveyors benefit from the team's feedback regarding individual performance. As a liaison to the Accreditation Committee, Tarin also shares her knowledge with the body charged with final accreditation decisions.

"Our work provides opportunities for communication across various channels and for necessary change and improvement which benefits the larger mission of AAAHC.

"In Accreditation Services every day is different. When things are constantly changing, there is always an opportunity for learning. In a peer-based process like ours, the surveyors actually have experience in meeting the Standards. They have worked in the field so they understand the issues organizations face and can help them meet the Standards through a consultative approach that contains some flexibility and allows for customization.

GOING FOR IT

In addition to improv, Tarin recently did stand up at a venue in Chicago. "A member of the class asked if I'd be interested, and I am always up for a challenge. I didn't commit right away but could not stop thinking about it. Someone once told me, 'if you can't stop thinking about it then you should go for it.' I did and it was a great experience!"

Let's make it plain: Tarin English has guts. Whatever her next challenge is, Tarin will meet it head on—an approach which seems to be a guiding principle of her life inside and outside of AAAHC. ▲