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

AAAHC

triangletimes

Volume 6 | Issue 2 | Spring/Summer 2019

Kershner award winners announced

Each year at the March *Achieving Accreditation* conference, an expert panel of the AAAHC Institute recognizes examples of outstanding QI methodology and outcomes with the Bernard A. Kershner Award for Innovation in Quality Improvement Award (The Bernie's). Submissions are made in two categories, surgical/procedural and primary care settings. Additionally, attendees at *Achieving Accreditation* have the opportunity to cast a vote, based on their health care setting, for a People's Choice award.

And the winners are:

SURGICAL/PROCEDURAL

The Bernie was awarded to the CSA Surgical Center, LLC in Columbia, MO for the study, "Post-Operative Pain Reduction Quality Study: Pre-Operative Administration of Acetaminophen."

The Knoxville Ophthalmology ASC won the People's Choice award for "Single Dose Anesthesia Medications: Correction Administration and Narcotic Documentation."

PRIMARY CARE AWARD

The Bernie was awarded to American Dental Partners/ForwardDental, for the submission, "Caries Risk Assessment Quality Improvement Study."

The People's Choice went to Lac Courte Oreilles Community Health Center for the study, " Retinopathy Exams for Diabetic Patients."

Rori Comstock and Lisa Leathers from CSA Surgical Center

Kimberly Grensavitch, Julie Lynch, and Dr. Jesley Ruff from Forward Dental with AAAHC Board Chair Dr. Arnaldo Valedon

Please take this opportunity to learn from these exemplary QI studies. You may view the expert panel surgical care and primary care winners' submissions and facility profiles on pages 2 and 3 of this issue.

BACKGROUND ON THE BERNIE'S

The award is named for a past AAAHC Board member (1991-2001), AAAHC Board president (1995-1997), and founding Chair of the Board of the AAAHC Institute where he served from 1999-2010. Throughout his career, Bernard A. Kershner made it a priority to continually underscore the importance of quality improvement. He described establishing procedures in his own freestanding centers as "far above what could possibly be required of a health facility—I wanted not only to be beyond reproach but also to raise the bar for professional competency at every level of the organizations." In recognition of his advocacy for patient safety and quality, the AAAHC Institute named its award for him in 2004.

DO YOU HAVE A QI STUDY WORTHY OF SUBMISSION TO THE 2019-2020 INNOVATIONS AWARD PROGRAM?

Have you recently completed a QI study that you are proud of and includes all the 10 Elements as outlined in Standard 5.I.C? If "yes," consider submitting it for the 2019-20 Innovations Award program. Submissions are open. Please check the AAAHC website for further details.

To review all finalists' posters, please visit https://www.aaahc.org/quality/2018-2019-innovations-winners-finalists/. ▲

Message from the President & CEO

Issued in November 1999 by the Institute of Medicine (IOM), *To Err Is Human* asserts that the problem is not bad people in health care—it is that good people are working in bad systems that need to be made safer. The IOM Committee recognized that simply calling on individuals to improve safety would be as misguided as blaming individuals for specific errors. Health care professionals have customarily viewed errors as a sign of an individual's incompetence or recklessness. As a result, rather than learning from such events and using information to improve safety and prevent new events, health care professionals are reticent to admit adverse events or "near misses", often because they fear management repercussions. While more than a decade old, the objective of the IOM message is worth repeating—regularly.

Noel M. Adachi, president and CEO of AAAHC

And, while primarily focused on hospitals, the IOM message is just as relevant to the ambulatory care environment. It is our responsibility to ensure that we are employing continuous quality improvement to address procedural problems before errors result in harm to patients or facility employees and contractors. Continuous quality improvement (CQI) is a quality management philosophy that encourages all team members, including your governing board, employees and contractors, to continuously ask *what can be done better in my facility and through my services*. CQI builds on existing quality management approaches that have become very common in healthcare—TQM, Lean, and Six Sigma, but are often ineffectively implemented. Combined, these principles emphasize that internal and external customer satisfaction—and in this case, patients—is paramount, and that problems are caused by processes, not people. Effective implementation requires a systematic approach where internal and external data drives the search and identification of problems and improvement solutions.

Continuous quality improvement is at the core of the AAAHC Accreditation and Certification programs. It is the connecting thread that carries an organization throughout the 1,095 days of the accreditation or certification cycle—*quality every day*. As outlined in Chapter 5 of the AAAHC Accreditation program Standards, "in striving to improve the quality of care and to promote more effective and efficient use of facilities and services, an accreditable organization maintains a quality management and improvement program that links peer review, quality improvement activities, infection prevention and safety, and risk management in an organized, systematic way." The intent of this chapter and as evident throughout all our accreditation and certification Standards is the involvement of both administrative and clinical personnel in quality management and improvement activities of the organization. Through ensuring ongoing compliance with AAAHC Standards, an organization can better understand and improve underlying work processes and systems versus the traditional quality assurance emphasis on correcting after-the-fact errors of individuals.

And the effort is worth it not only for patients, but also for day-to-day operations. CQI offers lots of benefits to organizations including:

- Team member accountability
- Creativity and solution creation including identifying opportunities for additional programs and services
- Heightened team member morale
- Improved processes, information management, and documentation
- Greater adaptability to changes
- Tools and methods to monitor program effectiveness

continued on page 4

Surgical/Procedural

CSA Surgical Center, LLC

by Lisa Leathers, RN, BSN, DON

THE ORGANIZATION: CSA Surgical Center opened in 2014 and is a licensed and AAAHC-accredited ambulatory surgery center in Columbia, Missouri. The facility has two operating rooms with four pre-operative and four PACU bays. We are a majority physician-owned NueHealth facility and currently specialize in general and vascular surgery, performing 1,800 cases/year.

THE STUDY: This study focused on an intervention to improve the immediate post-operative pain management of laparoscopic cholecystectomy patients. Narcotic administration in the recovery room seems to increase the likelihood of persistent nausea, has a less than desired effect on managing existing post-operative pain, and may increase patient length of stay in this population.

CSA studied the effects of administering cost-effective PO Tylenol to patients pre-operatively by monitoring post-operative pain management interventions and length of stay in the recovery room compared to a cohort population.

For the group receiving PO Tylenol pre-operatively, the study found the following:

- Extended length of stay (> 2 hours) due to pain was reduced by 19% and eliminated during the re-measurement period.
- The need to administer a narcotic in the recovery room was reduced by 14% and was noted at 12% during the re-measurement period.
- The number of patients requiring 3 or more narcotic interventions in the recovery room was eliminated in the initial study and during the re-measurement period.

Based upon the results of the study, medical staff elected to adopt this protocol for a myriad of procedures. Pre-operative Tylenol administration has become a standard at the facility.

APPROACH TO QI: CSA strategically promotes a culture of continual QI by adhering to the AAAHC QAPI platform. The medical staff and facility employees are directly involved in quality improvement initiatives. There are typically 8-10 ongoing studies at any time ranging from matters of internal value to highly impactful opportunities to improve the patient experience. Every idea is reviewed, and subsequent resolutions are recognized at all levels in the organization. Quality initiative results are often shared with the community through social media and a website blog. As a result, the facility's culture of continual quality improvement is nurtured and continues to grow.

Post-Operative Pain Reduction Quality Improvement Study

Pre-Operative Administration of Acetaminophen in Patients Undergoing Laparoscopic Cholecystectomy

Lisa Leathers, RN, BSN, DON on behalf of CSA Surgical Center

PURPOSE

Can pre-operative pain medication administration improve post-op pain management for patients undergoing Laparoscopic Cholecystectomy?

- Post-operative management of Laparoscopic Cholecystectomy was often challenging due to efforts commonly required to simultaneously manage **pain** and nausea.
- Literature had suggested the administration of pain medication pre-operatively could reduce post-operative pain and in doing so, potentially reduce post-operative narcotic administration.

The purpose of this study was to evaluate that claim and implement interventions to reduce post-operative pain thereby improving post-operative results for Laparoscopic Cholecystectomy patients.

GOALS

Patient self-report* of post-operative pain reduction through administration of 1000mg PO acetaminophen pre-operatively for patients who underwent laparoscopic cholecystectomy as evidenced by ...

- **10% reduction in overall narcotic administration**
- **10% reduction in length of stay due to pain in the post anesthesia care unit (PACU) greater than two hours**

Our overall goal was better pain control resulting in the use of fewer narcotics, lower incidence of narcotic-induced nausea and vomiting, shorter lengths of stay, and more satisfied patients.

** Numerical rating pain scale (0 = no pain, 10 = severe pain)*

DATA COLLECTION

Data Collectors: Peri-operative nurses

Source of the Data: Patient charts ; patient self-report of pain

Length of Data Collection: A time frame of one year was chosen to ensure appropriate sample size to support data. The project encompassed data from January-December 2016.

DATA

The data obtained included the total number of patients undergoing Laparoscopic Cholecystectomy during 2016 with six months of data prior to implementation of the project and six months of data after implementation of the project.

- Data was collected on 69 cases during the 6 months prior to the study and 65 cases during the 6 month period during the study. In all, data was collected on 134 cases.
- Data was collected with respect to patient pain level upon arrival to PACU and at discharge, duration of stay in PACU, and whether or not pain was a contributing factor to duration of stay, and narcotic usage both intra-operatively and post-operatively.

DATA ANALYSIS

Length of Stay

During the 6-month period *prior to implementation ...*

- 46% (32 patients) had a length of stay in PACU greater than 2 hours
- 26% (18 patients) of extended stays in PACU were related to pain

During the 6-month period after *implementation ...*

- 42% (30 patients) had a length of stay lasting more than two hours
- 7% (5 patients) of lengths of stays greater than 2 hours were related to pain

Note: While the extended length of stay related to pain was reduced, the overall length of stay was only reduced by 4%. We suspect our inability to correlate the data is most likely related to a variety of other factors that were not isolated out during the study such as patient resting comfortably in recovery for an extended period instead of anxiously recovering in pain; and/or block schedule and volume changes; or orientation of new PACU staff during the study period, which impacted length of stay due to overall timing limitations.

Narcotic Usage

During the 6-month period *prior to implementation ...*

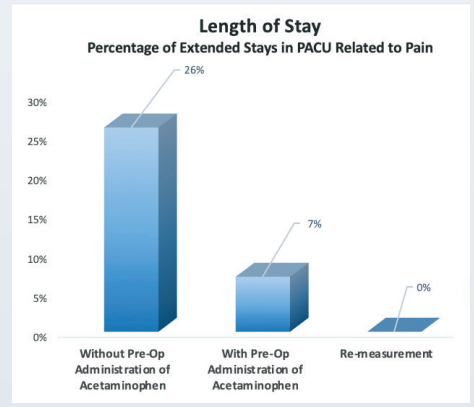
- 7.6% (5) of patients required zero narcotic pain medication in PACU

During the 6-month period *after implementation ...*

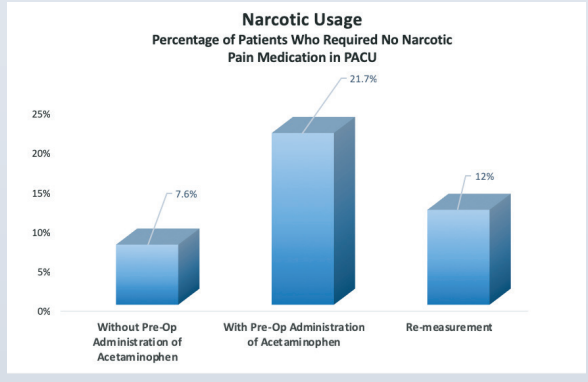
- 21.7% (14) required zero narcotic pain medication in PACU

While goals were not established for the following data analyses, we also found the following: **The administration of acetaminophen pre-operatively eliminated the need for any patient to receive three different IV narcotics in PACU (a decrease of 7.6%). The same results were obtained during the re-measure phase of the study.**

PERFORMANCE TO GOAL



Goal Surpassed: 19% reduction in extended stay due to pain.



Goal Surpassed: 14% decrease in patients who required narcotics in PACU

CORRECTIVE ACTION

All patients undergoing Laparoscopic Cholecystectomy, unless contraindicated, now receive 1000mg PO Acetaminophen pre-operatively per surgeon pre-op order. As a result of this study, the surgeon practice has extended the protocol to all of their facility patients with the exception of procedures where patient self-report of post-operative pain is a consistent 0-1 without the intervention and if contraindicated by patient health status.

RE-MEASUREMENT

With a group of 34 patients, the same data was collected during the 3-month re-measurement period.

- Less than 1% of patients required an extended length of stay due to pain (26% improvement over baseline)
- 12% (4 patients) required no narcotic in PACU (4.4% improvement over baseline)

In considering re-measure data, the QAPI committee determined the findings represented a sustained significant improvement in overall pain control management in this population. No changes were recommended to the previously adopted protocol for pre-operative acetaminophen administration.

ADDITIONAL CORRECTIVE ACTION

None required, although Process Improvement Committee is currently studying post-op nausea reduction strategies for this population.

COMMUNICATION FINDINGS

The project was presented to the QAPI Committee on January 17, 2017 and approved by the board of managers on January 25, 2017. The results of the study were shared widely with the medical staff and their practice staff. In addition to internal communication, results were also shared with community through social media outlet and facility website blog titled "Take a Couple Tylenol and Call Me in the Morning." ***csasurgicalcenter.com***

Primary Care
ForwardDental
by Jesley Ruff, MD

Caries Risk Assessment Quality Improvement Study (1, 2, 3)

Presented by:
Jesley Ruff, DDS, MPH
Julie Lynch, MS, BSN, RN
Kimberly Grensavitch, BA, RDH

THE ORGANIZATION: Comprised of over 80 general dentistry doctors and specialists, 140 dental hygienists, and 65,000 patients, ForwardDental is a Wisconsin-based, dental group practice. Clinical teams live in the communities they serve, providing a singular focus on therapeutic relationships and the needs, preferences, and values of patients. ForwardDental has been in operation for over three decades and has been accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) for over two decades. The facility offers a wide range of oral health services including general dentistry, orthodontics/braces, oral surgery, periodontics, endodontics, and cosmetic and pediatric dentistry.

THE STUDY: Due to the increased caries risk assessment for children ages 0-17, a diverse, cross-functional team convened to develop, implement, and integrate a caries risk assessment registry. The Quality Assurance Council and governing clinical leadership reviewed, vetted, and authorized the mission, strategy, policies, objectives, and caries risk assessment instrument. Study processes were aligned with AAAHC quality improvement guidelines and Standards for Quality Improvement Reporting Excellence (SQUIRE). Group leadership, doctors, and practice locations receive a monthly, quarterly, semi-annual, and annual dashboard comprised of quality indicators, including the percentage of children risk-assessed. The communication and study processes were designed to foster patient and provider engagement, shared decision making, and healing relationships which promote well-being. Based on the data collected and shared, risk assessment increased over 30% in the two initiating practice locations. At the end of the study, 4,353 children had been entered in the registry.

APPROACH TO QI: At ForwardDental, quality improvement is designed to create an environment that fosters critique, comment, and active participation from all team members. Continuous improvement is sought by assessment, development, and implementation of redesigned, reengineered processes for front-line practices. Organizational functions and systems are the beneficiaries of improvement activities. Topics for QI studies are identified by individuals at all levels of the organization: clinical, administrative, and cross-functional roles. Governance directs the quality management and improvement program. Studies must align with the organizational mission, vision, and core values which are embodied in the needs, preferences, and values of the community of patients served.

Element 1: Purpose

PURPOSE: Develop and implement caries risk assessment instrument to facilitate prevention and disease management for children ages 0-17

Supporting purpose: Develop and implement recording and tracking mechanism (i.e. registry) feedback, decision support instrument (i.e. dashboard) to facilitate caries risk assessment quality improvement

- **Background: Dental caries** remains the most common chronic condition among children and is a significant public health issue with adverse consequences
- **National Health Statistics, Centers for Disease Control (CDC) data:** 3 out of 5 persons aged 12-19 years had dental caries in permanent teeth
- **Prevention caries:** early identification, evidenced based disease management
- **Health registries:** prevalent in medicine for public health and quality improvement
- **Oral health registries:** quality improvement and peer reviewed publication lacking
- **Patient, clinical team relationship:** risk assessment fosters communication, enhances shared engagement and nurtures healing relationships
- **Quality Improvement goal:** Short term – quality care and experience; Intermediate term – burden of disease; Long term – value.

Element 2: Performance Goal

PERFORMANCE GOAL(S):

Initial: 75% of children ages 0-17 at quality improvement pilot sites are caries risk assessed (CRA) at the comprehensive examination.

Aspirational: 90% of children ages 0-17 at all ForwardDental practice sites are caries risk assessed (CRA) at the comprehensive examination.

Supporting: 75% of children ages 0-17 at all ForwardDental practice sites are caries risk assessed (CRA) at comprehensive examination and entered into the caries risk assessment registry (CRAR).

- **National Survey (NIH National Institute of Dental and Craniofacial Research PBRN):** 71% of dentists conduct a caries risk assessment (CRA) on children
- **State Survey (Texas)** 40% of dentists conduct caries risk assessment (CRA) but do not document the child's risk status
- **Dental Group Practice (2015 American Dental Partners):** 26% of children ages 0-17 were caries risk assessed (CRA) at comprehensive examination
- **National Benchmark:** None exist for either CRA or CRAR

Element 3: Data Collection Plan

- **Electronic Dental Record (EDR)** December 2015: data collected to determine percentage of all children 0-17 caries risk assessed at comprehensive evaluation
- **Electronic Dental Record (EDR)** January 2016: data collected to determine percentage of children 0-17 at quality improvement pilot sites are caries risk assessed at the comprehensive examination

Element 4: Evidence of Data Collection

- **Electronic Dental Record (EDR):** December 2015 19% of children 0-17 at all ForwardDental practice sites caries risk assessed at comprehensive examination
- **Electronic Dental Record (EDR):** December 2015 0% of children 0-17 at all ForwardDental practice sites were caries risk assessed at the comprehensive examination and entered into the caries risk assessment registry (CRAR)
- **Electronic Dental Record (EDR):** January 2016 54% and 60% of children 0-17 at two quality improvement pilot sites were caries risk assessed at comprehensive examination

Element 5: Data Analysis

Constraints, challenges and resistance to the quality improvement initiative:

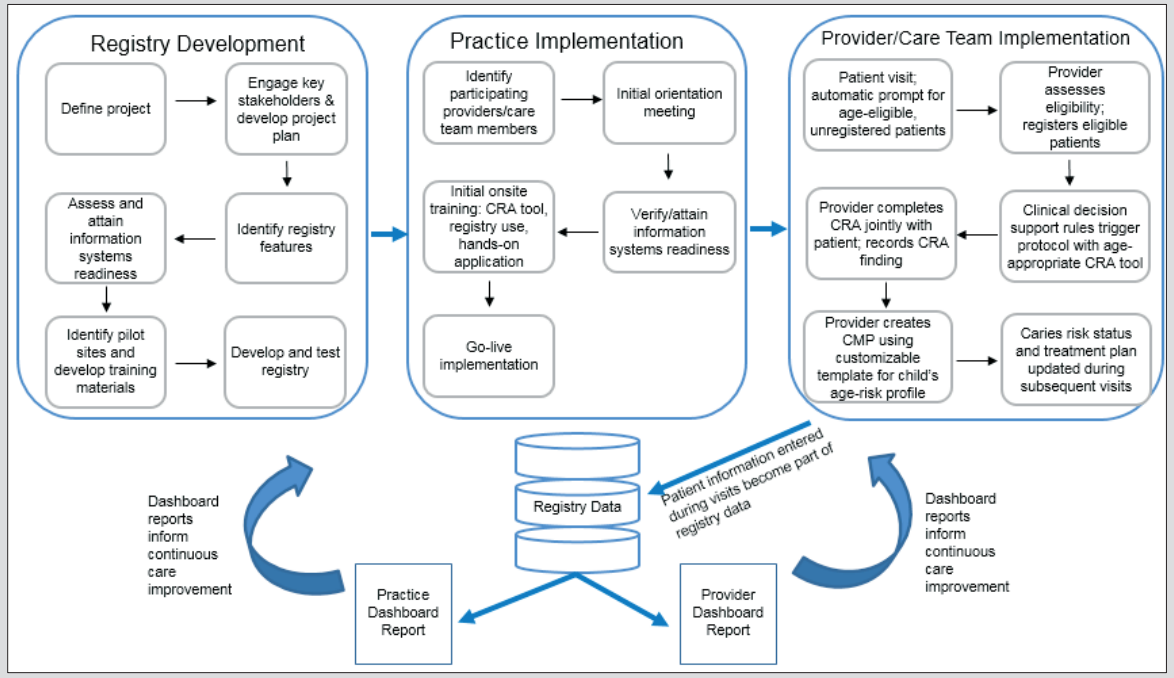
- **Legacy systems and thinking:** acquisition of and adjustment to reengineered technology; apprehension of new methodologies
- **Normative culture, tradition, routine, extant programing:** adaptation to new role responsibilities, accountabilities, processes, culture, and rewards
- **Normative practice, flow and throughput:** modification, addition and or subtraction of redesigned procedures, clinical practices, and realignment of incentives
- **Calibration:** communications, education, consistency of messaging and training, constancy of understanding and interpretation
- **Fear of change, powerlessness, loss of control and autonomy:** adjusting to re-defined roles

Element 6: Comparison of Current Performance to Performance Goal

Current Performance: 19% of children 0-17 at all ForwardDental practice sites caries risk assessed at comprehensive examination; 54% and 60% of children 0-17 at quality improvement pilot sites caries risk assessed at comprehensive examination did not initially meet our performance goals:

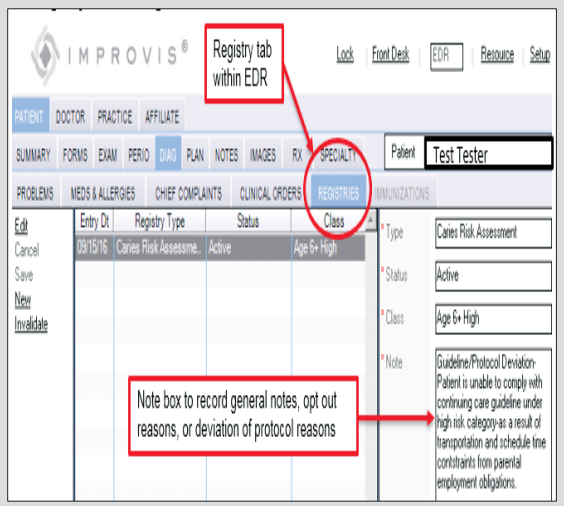
Performance Goals:

- **Initial: 75% of children 0-17 at quality improvement pilot sites are caries risk assessed (CRA) at the comprehensive examination**
- **Aspirational: 90% of children 0-17 at all ForwardDental practice sites are caries risk assessed (CRA) at the comprehensive examination**
- **Supporting: 75% children 0-17 at all ForwardDental practice sites are caries risk assessed (CRA) at comprehensive examination and entered into the caries risk assessment registry (CRAR)**

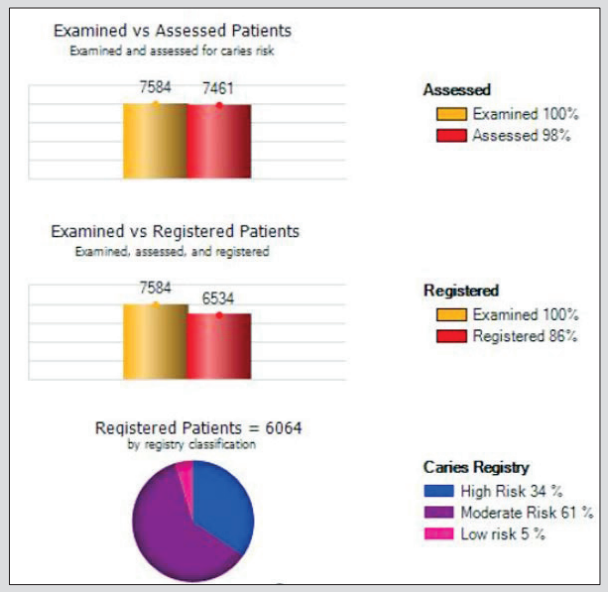


- In 2015 American Dental Partners, Inc. observed low rates of CRA documentation: only 26% of 2,123 children aged 0-17 received a comprehensive oral evaluation had a documented CRA

EDR Sample



Dashboard Report- 2018 Q4



We would also like to thank:

Jill Boylston Herndon, PhD; Roger A. Horton, DMD, MS; Dawn C. Mathwig, RDH; Audra Leonard; Krishna Aravmudhan, BDS, MS; Robert Trettin, DDS; John Werwie, DDS; James Ludke DDS; Hana Alberti DDS; Danielle Kober, RDH; Sharon Roble, Anita Hoppe, John Draxler, Peter Young, all of our front-line clinical and administrative team members and most important the community of patients we are privileged to serve.

Element 7: Corrective Action

- **Mission, values:** ensure collective, cohesive alignment and constancy of purpose on practice, patient and project – **no compromise on values**
- **Team Leadership:** cross functional, diversity of thought, respectful debate, mission alignment, develops, monitors, champions; plan strategy policies and objectives
- **Social operating system (means of communication):** all meetings begin with a recitation of the mission; all discussions align to the purpose
- **Team - front-line stakeholders:** know the why, when, where, and how; understand their roles and responsibilities, every voice is equal, dignified and counts
- **Education:** November 2015 orientation teleconference; November-December onsite education of CRA and CRAR at pilot locations
- **Education reinforcement:** One on one onsite education targeting constraints and challenges 3 months after initial orientation
- **Survey evaluation: Sent to leadership, champions and pilot site(s) front-line team members to assess understanding, challenges, constraints and opportunities**
- **Education - frontline team:** CRA, CRAR supports rather than supplants clinical judgement, personalized care, autonomy, vetting and credentialing guidelines
- **Process redesign:** Strategies integrate CRAR into normative clinical care process-improve patient activation and engagement.
- **System reengineer:** An EDR clinical decision rule ("Clinical Protocol Alert") notifies the clinical team that an eligible patient is ready for entry in the registry
- **Communication:** pilot sites, teams received CRAR dashboard reports; patients examined vs. patients assessed, and patients examined vs. patients registered
- **Scale:** Online training was offered and completed for all ForwardDental sites
- **Spread:** October 2016 all ForwardDental practices received CRAR education

Element 8: Re-Measurement

- April 2017: 83% of children ages 0-17 at all ForwardDental practice sites are caries risk assessed (CRA) at the comprehensive examination
- April 2017: 67% of children ages 0-17 ForwardDental practice sites are caries risk assessed (CRA) at the comprehensive examination an entered in the registry
- April 2017: 87% and 92% of children ages 0-17 at the two quality improvement pilot sites are caries risk assessed (CRA) at the comprehensive examination
- **December 2018: Achieved Initial, Aspirational and Supporting Goal(s)** 98%, children ages 0-17 at all ForwardDental practice sites are caries risk assessed (CRA) at the comprehensive examination and 86% are entered in the registry

Element 9: Additional Corrective Action

- **Celebrate achievement of goals:** then sustain, control, improve
- **Sustain: Dashboard-transparency of data –** supplied monthly, quarterly at practice
- **Control: Social Operating System (means of communication) –** Information shared at practice, doctor, administrative and leadership meetings
- **Improve: Education –** from group technical training to individualized mentorship
- **Improve: Point of Intervention –** Information quality prompts developed to facilitate patient engagement, shared decision making, personalized care, healing relationships

Element 10: Communication of Findings

- **Social Operating System (means of communication) cascaded:** CRAR initiative and indicators became an agenda item at meetings at all organizational levels and modes of communication (doctor, dental hygiene, practice manager, leadership, emails, on-site training, webinars)
- **Organization transparency:** Group leadership, doctors and practice locations receive monthly, quarterly, semi-annual, and annual dashboards comprised of quality indicators; including the percentage of children risk assessed
- **Professional transparency:** Panel presentation at the American Dental Association Dental Quality Alliance: 2017 "Collaboration in Quality Measurement for Improved Oral Health" Conference
- **Public/patient/community transparency:** 2018 membership in Wisconsin Collaborative for Healthcare Quality (WCHQ) publicly reports nationally recognized medical measures. 2019 will begin reporting ForwardDental caries risk assessment measure
- **Peer Reviewed Publication, Quality Innovator Spotlight Series** (see publications nearby)

Publications:

(1) Herndon, J. B., Aravamudhan, K., Stephenson, R. L., Brandon, R., Ruff, J., Catalanotto, F., & Le, H. (2016). Using a stakeholder-engaged approach to develop and validate electronic clinical quality measures. *Journal of the American Medical Informatics Association*, *24*(3), 503-512.

(2) Ruff, J. C., Herndon, J. B., Horton, R. A., Lynch, J., Mathwig, D. C., Leonard, A., & Aravamudhan, K. (2018). Developing a caries risk registry to support caries risk assessment and management for children: A quality improvement initiative. *Journal of public health dentistry*, *78*(2), 134-143.

(3) Dental Quality Alliance/ American Dental Association Quality Innovators Spotlight Ruff- https://www.ada.org/en/science-research/dental-quality-alliance/dqa-improvement-resources Personalized Care: Caries Risk Assessment

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AAAHC Celebrates 40 Years

On March 22, 1979, AAAHC was founded largely to address a gap in ambulatory health care quality assurance with the mission to improve patient care through accreditation. AAAHC has spent the last 40 years reaching further and thinking ahead in order to move the needle and drive improvement in health care quality and patient safety. Today, AAAHC is the leader in ambulatory health care accreditation with more than 6,100 organizations accredited.

We would like to share with you insights about the value of AAAHC Accreditation from two of our longest-standing accredited organizations.

Colleen M. Jahnel, director of Quality Assurance, Compliance, and Health Information from Boynton Health, said, "Boynton Health at the University of Minnesota recently received its three-year reaccreditation from AAAHC following an onsite site survey in May 2019. This reaccreditation continues Boynton Health's long-standing commitment to the accreditation process. Boynton Health has been accredited by AAAHC since 1979—the year AAAHC was founded. Having worked at Boynton Health during all but the very first accreditation site visit, I have come to realize the benefit of being accredited. I believe choosing to undergo an optional accreditation, reflects a health care facility's dedication and commitment to meeting standards that demonstrate a higher level of performance and patient care.

"At Boynton Health we use the AAAHC standards and associated required written policies and procedures to set a framework for standing committees to create their annual work plan. The work plan is presented to the Executive Leadership team (governing body) for review. During this review, goals are set for the committee and potential topics for quality improvement studies are addressed.

"If we have sufficiently incorporated the AAAHC Standards into our ongoing operations and have engaged all staff in the process, an upcoming reaccreditation site visit should not strike fear in the hearts of our health care facility employees. The consultative nature of the AAAHC surveyors and the fact that surveyors are often from a similar health care setting, such as college health, makes for a collaborative experience."

Northwest Surgicare, Ltd. was first awarded AAAHC Accreditation in October of 1979. "In our ever-changing industry, we here at Northwest Surgicare in Arlington Heights, Illinois value the stamp of approval from AAAHC, " said Brent Fitzgerald, CEO of the facility. "As we continue to strive toward excellence in service and great outcomes the standards set by and encouraged by AAAHC have been immeasurable. We stand for integrity of service and appreciate our 40-year relationship."

As AAAHC celebrates 40 years of advancing the standard of ambulatory health care and looks ahead to the increasing value we will provide to our accredited organizations, we want to thank all of our accredited organizations for the trust you have placed in AAAHC. Your commitment to quality and patient safety promotes our mission and the delivery of *1095 Strong, quality every day*. Together we will drive the change and strengthen the future of health care. ▲

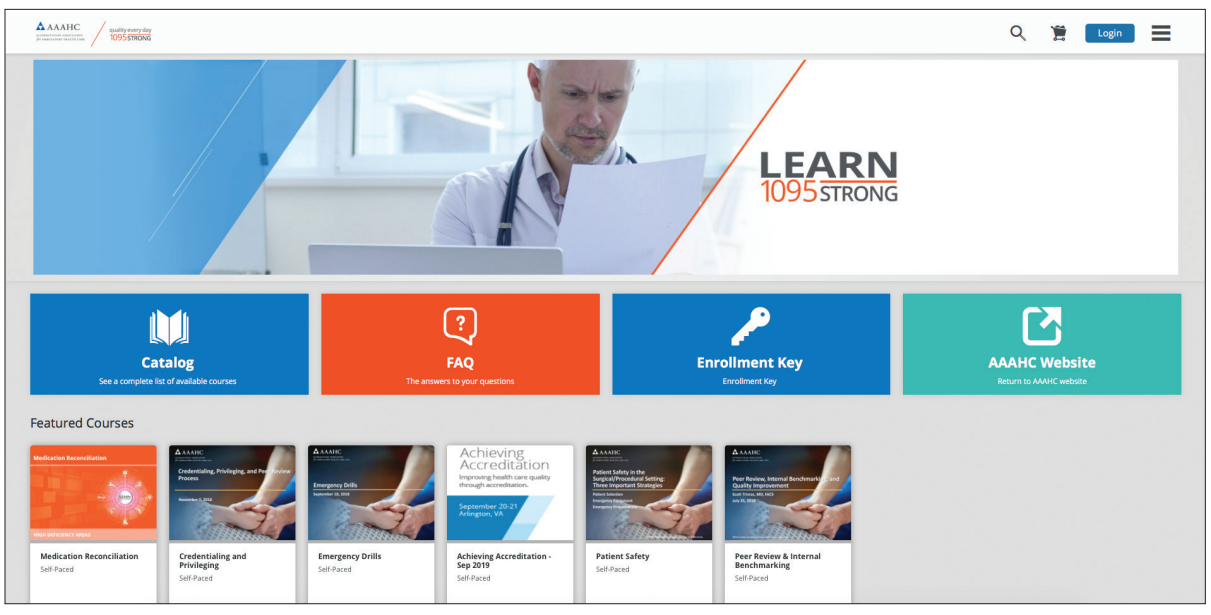
Introducing 1095 Learn

The AAAHC is pleased to introduce our newly launched learning management system (LMS), **1095 Learn**, a product of our *1095 Strong, quality every day* philosophy. The rollout of our LMS supports *1095 Strong*, a call to action spearheaded by AAAHC to equip ambulatory leaders with the best of what they need to operationalize quality practices. 1095 Learn provides AAAHC-accredited organizations with the best resources to customize quality practices and ongoing engagement throughout all 1,095 days of the accreditation or certification cycle. Health care providers will have access to education opportunities such as eLearning, webinars, and workshops that will provide value and empower you and your facilities to continually improve quality.

To register, go to learn.aaahc.org. Choose a course you are interested in and follow the purchasing process to sign up a new user account and register for a course. You do not need to provide any credit card information if you choose a free course. For further clarification on the process, please read "How do I create a new user account?" in the FAQs. To celebrate the launch of 1095 Learn, we are offering temporary free access to two of our most successful recorded webinars:

- Credentialing & Privileging
- Emergency Drills

In addition, the newly launched LMS features a brand new eLearning on medication reconciliation, an issue that is critical to continuity of care and patient safety in both surgical and primary care settings. ▲



Calendar

Quarterly Conference Schedule

August 18-20, 2019
National Association of Community Health Centers (NACHC), Chicago

September 4-6, 2019
California Ambulatory Surgery Association (CASA), Monterey Bay

October 24-26, 2019
Becker's ASC, Chicago

Training and Education

September 20-21, 2019
Achieving Accreditation, Arlington, VA

December 6-7, 2019
Achieving Accreditation, Las Vegas, NV

1095 Learn

Credentialing & Privileging

Emergency Drills

Medication Reconciliation

Patient Safety

Peer Review & Internal Benchmarking

NEW! Quality Improvement 101

Go to https://learn.aaahc.org/#/public-dashboard to register for *Achieving Accreditation* and for up-to-date listings of all available eLearning, webinar and workshop opportunities.

Message from the President & CEO

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For the 2018-2019 Bernard A. Kershner Innovations in Quality Improvement Award program, AAAHC received dozens of entries. On behalf of the AAAHC, I applaud the efforts of these organizations who recognize the value and importance of integrating quality improvement into the fabric of their organization—*every day*. Our AAAHC Institute Quality Advisory Committee and staff team spent numerous hours reviewing the submissions and evaluating their comprehensiveness.

Congratulations to this year's award winners! And thank you for sharing your program and results with your AAAHC-accredited colleagues. The benefit of your efforts will extend beyond your own organization to others facing the same challenges. *Your efforts demonstrate 1095 STRONG!* ▲