2016-2017 Bernies winners announced

In November 2016, the AAAHC Institute for Quality Improvement announced the six finalists for the 2016-2017 Bernard A. Kenhorst 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 submission is 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 PAMP Surgery Associating Fremont

The Bernie for surgical/procedural care was awarded to Palo Alto Medical Foundation (PAMP) Surgery Center Fremont for “The OR Fit Crew: A NASCET Template for O.R. Efficiency” (page 2). PAMP Surgery Center Fremont also won the People’s Choice Award in this category.

PRIMARY CARE AWARD TO UNIVERSITY OF OHIO

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

The People’s Choice award for primary care went toPremier Health Center for LivingWell 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 receiving 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, surveys 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 process 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-prescriptions 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 medications 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 at 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 checklist 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 checklist 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 misconceptions as to the parameters of the updated CMS code.

The Accreditation Handbook for Medicare Deemed Status Surveys 11/2016 Update, Facilities that qualify as NFWS (built or permitted 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 editions 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. For 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

ASCs may use any other formal risk assessment system they have; it not is a requirement to choose one of these two options.
2016 Bernard A. Kershner Innovations in Quality Improvement Award Submission Surgical/Procedural Care
Organization: Palo Alto Medical Foundation - Surgery Center Fremont
PQI Study: The O.R. Pit Crew: A NASCAR Template for O.R. Efficiency by Robin Menefee RN BSN MBA Director and Nathalie Waele RN MSN CNL

THE ORGANIZATION: Palo Alto Medical Foundation 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, echocardiographic, and general surgical and GI procedures. Surgery Center Fremont completed 8,800 cases in 2016.

THE STUDY: Aiming to improve OR turnover time to 15 minutes or less, this study looked outside of the health care model for a solution. 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 23.5 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 PQI: The Palo Alto Medical Foundation follows Lean methodology. This approach engaged the entire facility in PQI planning and development. Each team member can start a process to correct or streamline to improve workplace safety and efficiency. Regular Lean morning sessions are held to encourage staff members to contribute ideas and bring up 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 operational efficiency and culture.

Element 1: Purpose
- Background:
  - Staff and efficient turnover improve the experience for staff, patients, doctors, and surgeons.
  - Benefits of efficient turnover:
    - High staff, physician, and patient satisfaction
    - Increased surgeon productivity
    - Effective use of scarce resources
- Purpose: To introduce the operating room turnover process and efficiency, and shorten turnover times.
- For the purpose of this project, a turnover is defined as "turnover out to wheel in".

Element 2: Performance Goal
The performance goal is to achieve and maintain an average turnover time of 15 minutes or less.

TURNOVER IN 15 MINUTES

Element 3: Data Collection Plan
- Baseline data was gathered between September 2015 to December 2015.
- 10% data points were collected and 80% of the data collected by the Lean traffic controller at a daily meeting using a data collection tool.
- Cause for extended turnover times identified.
- When data collection is done, it is identified for discussion at team audits.

Element 4: Evidence of Data Collection
Turnover times were tracked on a daily basis by the center's Lean Traffic Controller using the Lean traffic controller tool to identify any unusual events.

Element 5: Data Analysis
- The average turnover time from September 2015 to December 2015 was 22.5 minutes.
- Primary reason for delays from the data collected tool were:
  - MD late
  - Regional Blocks
  - Instrument turnover

Element 6: Comparison with Goals
- In comparison, by the goal of 15 minutes, the data collected tool was:
  - Average turnover time was 22.5 minutes (Figure 2).
  - To reach the goal of 15 minutes, the current performance had to be improved by 95%.

Element 9: Additional Corrective Action and Re-Measurement
- By re-measurement, the main cause for extended turnover times were 1) regional blocks or pre-op and 2) inefficient OR turnover times.
- Re-measurement data showed that turnover times had decreased to 17.6 minutes, an improvement of nearly 5 minutes per case.
- Re-measurement data showed that turnover times had decreased to 17.6 minutes, an improvement of nearly 5 minutes per case.

Element 10: Communication of Findings
At daily engagement huddles, the staff and leadership update team members on any turnover improvements. Positive feedback and opportunities are shared and discussed with the team.

The pit crew roles are:
- The collector follows the flow and coordinates theflow and coordinates the Collector follows the flow and coordinates the flow to ensure a smooth turnover.
- The pit boss directs the team.
- The sweeper manages the efficient flow of items from one area to another.

Figure A. Lean Traffic Controller tool.
Figure B. Pit Crew Roles
Figure C. Lean Traffic Controller tool.

*Continued measurement in 2017 has shown monthly averages of 14.8 minutes, exceeding the performance goal.
Timeliness of Obtaining Surgical Clearance Documentation
D. Craig Rosfjord, BSN, RN, PHN  Mankato Surgery Center

Element 1: Evidence of Data Collection
- From 3/4-6/16 through 4/12-16 all Numeric Communication Sheets were required for analysis and data collection.
- From 3/4-6/16 through 4/12-16 all Variance Report forms were included for inclusion.
- All data collected that criteria were verified by an audit in Annual Claims of the Centers for Medicare & Medicaid Services: criteria, surgical notes, H&P, Anesthesia record, preoperative medication checklist, labs, etc.
- The data that criteria were entered in an Excel spreadsheet.

Element 5: Data Analysis
- Number of days required: 24.
- Total number of surgical procedures: 41,72.
- Surgical Clearance Documentation received: 3 days: 89.06%.
- Most common variance or occurrence: Patient received a surgical clearance prior to 24 hours pre-op.
- Variance Forms that included an occurrence of late or missing surgical clearance documentation: 66.37%. 15.53%.
- Total number of days without an occurrence: 24.
- Identified the clinic that presented the highest number of occurrences: 3 occurrences 32.66% of the occurrences.
- Most common variance: 15 occurrences 16 occurrences on 11 non-physician assistant.
- Most common surgeon 7 different surgeons from 2 different departments.
- Average number of days per case on day 1, the average was 17.7 cases per day.
- Most common day of the week: Tuesday 15% 33% and Friday 15%.
- 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 <60% surgical clearance documentation was 2 days.
- Data analysis shows that 60% is the most problematic to reach 3 days at 87.5%.
- “Clinic” was identified with the highest number of occurrences.
- Identified within 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 First surgical clearance check appointment.
- The clinic department managers will develop a comprehensive list of all documents required for surgical clearance and distribute to Clinic nursing staff and pulmonary educator.
- The clinic department managers will educate physicians and non-physician assistant on the goal of receiving <60% surgical clearance documentation 3 days.
- A clinic manager will create a primary care provider 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

Element 9: Additional Corrective Action and Re-measurement
- To measure sustained improvements, additional re-measurement will be conducted at 2 and 6 months, annually or as 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 to the inpatient Education Board.
- 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 EOB.
**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**

<table>
<thead>
<tr>
<th>Data Culture Taken and Sent to Lab</th>
<th>Data Culture Report was Received back from the lab</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1, 2015</td>
<td>May 6, 2015</td>
</tr>
<tr>
<td>Semi-Disposable Valve Number</td>
<td>Results</td>
</tr>
<tr>
<td>1</td>
<td>No growth after 2 days.</td>
</tr>
<tr>
<td>2</td>
<td>Micrococcus &amp; related genera &gt;100 colonies of bacteria present.</td>
</tr>
<tr>
<td>3</td>
<td>No growth after 2 days.</td>
</tr>
<tr>
<td>4</td>
<td>No growth after 2 days.</td>
</tr>
</tbody>
</table>

**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**

Percent of Cultures that Contained No Growth After 2 Days

<table>
<thead>
<tr>
<th>Percent of Cultures that Contained No Growth After 2 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 1, 2015</td>
</tr>
<tr>
<td>May 6, 2015</td>
</tr>
<tr>
<td>100% negative cultures achieved, GOAL MET.</td>
</tr>
</tbody>
</table>

**Element 9: Additional Corrective Action and Re-measurement**

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

**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.
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 require HPV, most often as teens or young adults (CDC, 2015)
• College students may qualify for catch-up HPV vaccinations (CDC, 2016)
• Many male college students are surprised to learn that they qualify for the HPV vaccine (SHC Focus Group, 2013)
• Providers forget to offer the HPV vaccine at routine visits, leading to missed opportunities (SHC Focus Group, 2013)

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

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

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

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

Element 4: Evidence of Data Collection
SHC Focus Group:
Sec handout

Baseline Chart Audit:
20 participants received HPV vaccine, dose 1
136 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

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
340 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 6-17.

Element 10: Communication of Findings
• Project presented to:
  - SHC governing body and staff 5-16
  - Intermountain West HP 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, Texas, the Westlake Health & Wellness Center offers a Patient Centered Medical Home approach as preferred by the employer and their families. The center provides a variety of health and wellness services including adult primary and pediatrics, Dovey testing, X-ray examinations, 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, two medical assistants, in addition to two revenue cycle and a physical therapist. They also offer comprehensive dental services provided by two full-time dentists and three dental hygienists.

The facility is operated by Premise Health network which manages more than 100 worksite-based health and wellness centers in 12 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 baseline established for each of the three screenings. Colin data from 948 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 notes for “abnormal” 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 (NP 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 AAHC Healthcare Findings and ger n with each standard and how it is actualized at the site. The QI is really ubiquitous at Westlake Health & Wellness Center and throughout Premise Health.

Premise Health
Premise Health is a leading workplace health and patient engagement company dedicated to improving the cost and quality of employee health care. We serve more than 200 worksite-based health and wellness centers across the country.

The Westlake Health & Wellness Center is a Patient-Centered Medical Home (PCMH) certified by Premise Health, located in a Zona Rosa shopping center in Kansas City, Missouri.

The goal of the 2015-2016 business review was 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 baseline established for each of the three screenings. Colin data from 948 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 notes for “abnormal” 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 (NP 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 AAHC Healthcare Findings and ger n with each standard and how it is actualized at the site. The QI is really ubiquitous at Westlake Health & Wellness Center and throughout Premise Health.

Element 1: Purpose
- The purpose of the study was to examine several practices and reduce the frequency of TSH, HbA1c, and vitamin D screening.

Element 2: Benchmarks & Goals
- The benchmark was achieved by reducing the percentage of abnormal results for vitamin D. "Abnormal" was defined as less than 20 ng/mL.
- The goal was to reduce the percentage of abnormal results for TSH, HbA1c, and vitamin D.

Element 3: Data Collection
- The data was collected using a web-based electronic health record system.
- The data was reviewed and analyzed to determine the percentage of abnormal results for each metric.

Element 4: Evidence of Data Collection
- The data was collected for more than 3,000 exams performed in 2015 and 2016.
- The data showed a decrease in the percentage of abnormal results for TSH, HbA1c, and vitamin D.

Element 5: Data Analysis
- The data was analyzed to determine the percentage of abnormal results for each metric.
- The data was compared to the benchmark and goals set for each metric.

Element 6: Comparisons with Goals
- The percentage of abnormal results for TSH, HbA1c, and vitamin D was compared to the benchmark and goals set for each metric.
- The data showed a decrease in the percentage of abnormal results for each metric.

GOAL ACHIEVED
- The goal of reducing abnormal results for TSH, HbA1c, and vitamin D was achieved.

Element 9: Additional Corrective Action and Re-Measurement
- There was an additional corrective action implemented.
- The results were re-measured.

Element 10: Conclusion
- The results were shared with the Westlake Health & Wellness Center clinical staff and the client.
- The results were also shared with the region for peer review of TSH and vitamin D testing.

INCOMING HEALTH CARE QUALITY THROUGH ACCREDITATION

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION
A Multi-Disciplinary Approach to Condition Management

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 <9
  - 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: 1,238
- Patients were identified as having hyperlipidemia: 1,750

Element 5: Data Analysis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Goal</th>
<th>2013-2014 Results</th>
<th>2014-2015*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>HbA1c</td>
<td>67.37%</td>
<td>65.19%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>BP</td>
<td>68.13%</td>
<td>66.50%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>LDL</td>
<td>65.00%</td>
<td>65.52%</td>
</tr>
</tbody>
</table>

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.

Element 8: Re-Measurement

- Results were calculated and the organization's benchmarks were used for comparison.

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.

Element 10: Communication

- This study was shared with the following entities:
  - Quality Team
  - Governing Body
  - Premise Health Leadership
  - Center for Living Well Leadership

**References**

5. Reference: NCHS. (2013). National Health Interview Survey....
6. From the American Heart Association’s Arthritis and Cardiovascular Disease Committee and the Council on Cardiovascular Disease in the Young, the Council on Cardiovascular and Renal Disease, the Council on Clinical Cardiology, and the Council on Women in Cardiology. Hypertension. 2013. 60:880-903.

Premise Health
Keep your edge

**Premise Health: Center for Living Well Family Healthcare**

**Management**

**In a Primary Care Setting**

**Kathleen McKim, RN, BSN, 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 wellness, chronic care and educational coaching programs.

The center is operated and staffed by Premise Health, 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, Premise Health manages 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.

**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 oversees the implementation of the quality plan.

**Key Findings**
- A multidisciplinary approach, integrated services, and collaboration of care with better tracking and follow up resulted in improvements in three performance goals.
- 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.
- 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 1:** Purpose

- The purpose of this study was to assess the effectiveness of a multi-disciplinary approach to managing 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

- 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 <9
  - 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

- 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: 1,238
- Patients were identified as having hyperlipidemia: 1,750

**Element 5:** Data Analysis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Goal</th>
<th>2013-2014 Results</th>
<th>2014-2015*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>HbA1c</td>
<td>67.37%</td>
<td>65.19%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>BP</td>
<td>68.13%</td>
<td>66.50%</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>LDL</td>
<td>65.00%</td>
<td>65.52%</td>
</tr>
</tbody>
</table>

**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.

**References**

5. Reference: NCHS. (2013). National Health Interview Survey....
6. From the American Heart Association’s Arthritis and Cardiovascular Disease Committee and the Council on Cardiovascular Disease in the Young, the Council on Cardiovascular and Renal Disease, the Council on Clinical Cardiology, and the Council on Women in Cardiology. Hypertension. 2013. 60:880-903.
Surveyor Spotlight

In 2008, Lt. Colonel Endül Seera, 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. Seera began surveying for AAHAC. “My job in the Air Force was on the Inspector General team where I began working side-by-side with surveyors from AAHAC. 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. Seera is privileged to survey AGC’s, office-based surgical settings, and stand-alone organizations. He hopes to add Indian Health and Great Grant, and he is joining a cohort of surveyors who will fulfill AAHAC on-site responsibilities for Bureau of Prisons healthcare facilities (see below).

“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 frowned and these young adults are expected to succeed in their endeavors as adults with a highly variable background in adult skills. This causes stress,” said Dr. Seera, “which can show up as illnesses or symptoms suggestive of illnesses although a large percentage have a psychological etiology.”

A CONSULTATIVE APPROACH

Dr. Seera considers the consultative approach used by AAHAC 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 PRIORITIZED APPROACH

“When I am not surveying or working in cardiac/pulmonary rehabilitation and urgent care, Dr. Seera enjoys spending time with his two adult children and his wife, his 52 years. He also spends time exercising and at one time was a competitive powerlifter. One of his present ambitions, combining these passions, was a competition in which he and his sons competed and 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 reminded 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. Seera is an ophthalmic oncology 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 strong tie between his background and experience in ophthalmic medicine and his role as a surveyor for AAHAC.

“That is my professional life, I take on multiple perspectives, from clinician to patient to surveyor, and in all of them I see a link to AAHAC standards. All are concerned with promotion of health and safety in the workplace.”

U.S. Bureau of Prisons awards AAHAC contract

The federal Bureau of Prisons (BOP) has awarded AAHAC 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 populations.

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

AAHAC 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 AAHAC was attended by 312 Bureau of Prisons healthcare staff and providers.

Meet the AAHAC Staff

Tarin English, Manager, Accreditation Services

“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 AAHAC primarily responsible for releasing decisions and managing the Standard 2.1.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 AAHAC 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. That’s a joke that I should get one of these ‘take my 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 surveymen and organization.” The communicators are 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 AAHAC. For example, feedback from 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 AAHAC.”

“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 fluidity and allows for customization.”

G alex

In addition to improve, Tarin recently stood up at a venue in Chicago. “A member of the group asked if I’d be interested, and I always am up for a challenge. I didn’t respond 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 it 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 AAHAC.”

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