AAAHC Quality Roadmap 2018
A report on accreditation survey results
Quality Roadmap 2018
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Dear Colleagues,

The AAAHC Quality Roadmap provides a thorough analysis of data from more than 900 surveys conducted using the 2017 Standards. With this tool, you can identify themes that deserve special attention in your organization as you pursue ongoing quality improvement throughout the accreditation cycle. In this way, we can learn from each other and take corrective action as necessary.

As the President and CEO of AAAHC, it is my pleasure to provide this information as a resource to our accredited organizations. Our goal is to increase your understanding of AAAHC Standards and provide useful benchmarks to help your organization improve the quality of care you provide to patients. While the report indicates that most facilities surveyed are in compliance with the majority of Standards, it also includes a number of focus areas for improvement that warrant your attention.

We continue to see that facilities have challenges with quality improvement studies, credentialing and privileging, and documentation management. We welcome your feedback on how we can assist you in better understanding the Standards and building compliance into the fabric of your quality improvement and assurance plans.

Please take the opportunity to look more closely at these 2017 AAAHC Standards survey findings and take advantage of the broad portfolio of educational programs and quality improvement resources that AAAHC offers to help you comply with our best practice Standards—not just on the day of your survey but throughout your accreditation term.

Sincerely,

Noel Adachi, MBA
President and CEO
2018 AAAHC Quality Roadmap

I. Get the Most Value from this Report

AAAHC Quality Roadmap presents data that is actionable that you can use as a tool for:

- Comparing these findings to your last onsite survey report and your annual self-assessment.
- Understanding the most common deficiencies relevant to your setting.
- Reviewing policies, procedures, and practices to ensure they reflect best practices and relevant AAAHC Standards.
- Leveraging patient safety toolkits and other resources available from AAAHC to improve and assure quality.
- Sharing and discussing the findings with others within your organization to drive decision-making on quality improvement (QI) studies or other corrective actions that may be necessary.

II. Data Description

This report is based on an analysis of surveyors’ ratings of compliance with 2017 AAAHC Standards during onsite surveys of organizations seeking initial or re-accreditation, including ambulatory surgery centers in the Medicare Deemed Status program. For these organizations, we also included frequent deficiencies related to CMS Conditions for Coverage.

Results of surveys for organizations seeking accreditation through the AAAHC Health Plan, Federal Employee Health Benefits Plan or Bureau of Prisons program are not included. This report also does not include intra-cycle surveys.

Often, these are focused surveys that do not include all core Standards (Chapters 1-8 of the Accreditation Handbook).

The data represent 926 complete surveys. The chart to the right shows the distribution of surveys for this period by the most commonly self-identified organizational types: ambulatory surgery center (ASC), Medicare Deemed Status ASC (MDS ASC), office-based surgery facility (OBS), primary care setting (PC), and “Other.” PC settings include military, community health, immediate/urgent care, Indian health, occupational health, student health, and other primary care settings. “Other” includes dental practices, diagnostic imaging centers, freestanding emergency centers, medical group practices, and office-based anesthesia practices.

Under the 2017 Standards, surveyors describe organizational performance against the AAAHC Standards as substantially compliant (SC) [compliant (C) for MDS surveys], partially compliant (PC), or non-compliant (NC).

This report provides an analysis of the highest and the lowest compliance findings for those Standards that were applicable to at least 95% of the organizations surveyed. While this report looks in depth at those Standards with the highest incidence (10% or more) of PC and NC ratings by surveyors, most organizations that seek AAAHC accreditation successfully achieve a three-year term.

Report Overview

- Section III: High compliance Standards
- Section IV: Compliance deficiencies for all 926 surveys
- Section V: Additional data on compliance deficiencies specific to surgical/procedural settings identified as ASC, MDS ASC, or OBS; detailed information on deficiencies across primary care settings with Student Health Service (SHS) organizations separated as a distinct group
- Section VI: Additional high deficiencies specific to MDS ASCs Life Safety Code Standards
- Section VII: An analysis of the most frequently cited deficiencies among Patient Centered Medical Home Standards (AAAHC, 2017 Accreditation Handbook for Ambulatory Health Care, Chapter 25)
- Section VIII: Glossary of acronyms
- Section IX: AAAHC resources that address the issues the deficiencies found in this report; use these tools as compliance guidance for AAAHC Standards
III. Overall Findings – High Compliance Standards

For the period of this report, the highest compliance findings (100% rated SC across all non MDS organization types or 100% rated C across all MDS organizations) indicate that AAAHC-accredited organizations demonstrated high compliance with several Standards and have shown improvement in key areas compared with last year’s findings. For organizations surveyed under the non-MDS Standards, these key areas include providing timely consultation and referrals for their patients, verifying that patients understand how to use newly issued medical devices, and having an agreement with another provider group or nearby hospital for the transfer of a patient in the event of an emergency. For organizations surveyed under the MDS Standards, key area improvements in which there was 100% compliance included providing timely patient transfer information, investigating all patient grievances, and using performance measures to improve outcomes.

Non-MDS High Compliance Standards

Overall, non MDS AAAHC-accredited organizations treat patients with respect, consideration, and dignity (Standard 1.A). These organizations are overall well managed (Standards 3.A.4-5, 3.A.12) and demonstrate high compliance in several key patient care areas:

- Maintain clinical records for each patient (Standard 6.C)
- Provide timely consultation and referrals (Standard 4.E.6)
- Verify that a patient understands how to use a newly issued medical device (Standard 7.II.L)
- Maintain a written agreement with a physician or provider group with admitting privileges to a nearby hospital in the event of an emergency where the patient needs to be transferred to the hospital (Standard 4.I)
- Consistently provide convenient access to reliable, up-to-date information about the services they provide (Standard 2.III.J.1)

MDS High Compliance Standards

Similarly, MDS AAAHC-accredited organizations fully inform patients regarding their diagnosis, evaluation, treatment and prognosis (Standards 1.D.3 and 1.E) and inform patients about the services available, payment policies and methods for providing feedback, as well as investigating all grievances made by patients or the patient’s caregiver (Standards 1.I.2-3, 1.I.5-6, 1.I.11, and 1.M.5). Organizations also have:

- Provide timely patient transfer information (Standard 4.F)
- Designate a person to manage the accuracy, timely retrieval, and security of the patient’s clinical record (Standard 6.C.2 & 6.C.4.a, 6.D.1, 2, 3 & 5, 6.O)
- Demonstrate a concern for the cost of care (Standard 4.I)
- Are legally constituted (Standard 2.I.C), efficiently managed (Standard 3.I.B.4-5)
- Demonstrate in compliance with state licensure requirements (2.I.D)
- Maintain an effective procedure for the immediate transfer, to a local, Medicare-participating hospital, of patients requiring emergency medical care beyond the capabilities of the ASC (2.I.J and 2.I.K.1)

Organizations provide convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization and encourage health care professionals to participate in educational programs and activities (2.III.I).

Health care professionals in these organizations practice their professions in an ethical and legal manner and use performance measurement to improve outcomes (Standards 4.B, 4.E.4, 4.E.6-7). Organizations also consistently have a written infection prevention and control program (Standard 7.I.B.7).

Organizations participating in the AAAHC MDS accreditation program demonstrate high compliance practices related to direct patient care including:

- Appropriate monitoring equipment for the intended anesthesia care (Standard 9.H)
- Continual evaluation and documentation of patients’ oxygenation, ventilation, and circulation (Standard 9.L)

Additionally, whenever patients are present in the facility, organizations ensure that health care professionals trained in the use of emergency equipment and basic life support (BLS) are present and at least one physician or dentist is present or immediately available by telephone (Standard 10.L). Organizations consistently provide a safe environment for treating surgical patients, including: adequate safeguards to protect the patient from cross-infection and adequate space, equipment, supplies, and personnel (Standard 10.I.O).
IV. Overall Findings – High Deficiency Standards

The following findings are for the 926 organizations surveyed under the 2017 AAAHC Standards. These include Standards rated as deficient greater than 11% of the time, as a percent of all ratings for the Standard.

These overall results are consistent with findings from previous years, including: credentialing and privileging, documentation, quality improvement, and patient safety/safe injection practices deficiencies. However, overall, organizations are demonstrating improvement with conducting quality improvement studies (5.I.C) and documenting allergies and untoward drug reactions in the patient’s clinical record (6.F/6.D.9). Please note that because 730 of the 926 organizations included are ASCs (both MDS and non-MDS ASCs), these organization types will be over-represented in the overall results. Details on the deficiencies found in each of the topic areas in the above graph, as well as additional deficiencies found in specific settings, are discussed in the next section.
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V. Common Findings in Surgical/Procedural Settings & Primary Care

The graphs below represent AAAHC Standard deficiencies of greater than 10%. The graphs on the left are findings from for the 508 non-MDS ASCs, 222 MDS ASCs, and 97 OBS organizations surveyed under the 2017 AAAHC Standards. The graphs on the right display findings from the 71 primary care organizations surveyed under the 2017 AAAHC Standards. Student Health, which is also displayed in the graphs on the right represents 36 of the 71 primary care organizations.

A. Credentialing, Privileging, Peer Review

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

Deficiencies in any of these areas can lead to providers performing services or procedures for which they need additional qualifications, more experience, and/or performance improvement. These can be immediate threats to patient safety and increase risk of liability.

Standards

| 2.II.B.5.b | Members of the medical or dental staff must apply for reappointment every three years, or more frequently if state law or organizational policies so stipulate. The reappointment process includes: Upon receipt of the completed reappointment application, the organization will conduct primary or secondary source verification of items listed in Standard 2.II.B.3.c-f. At the time of reappointment consideration by the governing body, the entire reappointment application and peer review results and activities, completed in accordance with Chapter 2.III, will be considered. |
| 2.III.I | The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in Chapter 2.II. |

Intent of Standards

The purpose of the above Standards is to ensure that during the reappointment process health care professionals identified by the governing body are qualified to provide services offered by the organization. This includes ensuring that reappointments take place at least every three years or more frequently if state or organizational policies require, and conducting verification of current state license, DEA registration, medical liability coverage which meets governing body requirements, and NPDB information. During reappointment, the governing body must consider this verification, along with a complete reappointment application and results of peer review activities.
It is important to note that Standard 2.III.I is one of the component requirements of 2.II.B.5.b, therefore, if Standard 2.III.I is cited as a deficiency, Standard 2.II.B.5.b will also be cited.

Surveyor Findings
Surveyor comments associated with deficiencies for these Standards included:

- No formal documentation of consideration of peer review findings during re-appointments and/or not found in credentialing files
- Exclusive reliance on chart review as the sole means of peer review
- Peer review is only conducted when there is an issue or after re-appointment
- No or tardy (after re-appointment date) primary/secondary source verification, including but not limited to NPDB and DEA information

Hints for Compliance: 2.II.B.5.b and 2.III.I

Peer review, first and foremost confirms a provider’s competence and is, therefore, a vital component of providing high quality and safe patient care. Peer review also assists in identifying high and low performers compared to an organization’s goals for use in quality improvement activities.

- Documentation of initial privileging and reappointment must include a specific time period for which the privileges are granted. This documentation must also include what privileges are requested and what privileges are granted.
- The peer review process should not be limited to review of clinical records but should also incorporate other items such as infection rates, patient satisfaction survey results, and compliance with medical staff rules and regulations.
- Providers are required to participate in determining the criteria for peer review.
- The results of peer review must be part of the credentialing process and communicated to the governing body.
- Supporting documents include a list of privileges used by the organization, Governing Board, and Credentialing Committee minutes.

Standards

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

Surveyor Findings

- No documentation of privileges granted for supervision of CRNAs or RNs.
- Allied health providers not privileged.
- Inappropriate (hospital related procedures) privileging for physicians at the ASC.
- Approval of privileges not requested.
- No dates documented for appointment and expiration.
- No documentation in the governing body minutes regarding approval of credentials or granting of privileges to providers.
Hints for Compliance: 2.II.D

- An organization may not rely on another organization to grant privileges to its medical and dental staff.
- An organization can only privilege its physicians and dentists for procedures approved by the governing body and that the facility is equipped to safely perform.
- Ensure the documentation of specific privileges e.g., anesthesia, fluoroscopy, laser, and supervision.
- When services are added, or when services are no longer provided, review and edit privileging forms to reflect these changes. Organizations should also edit privileging forms if privileges change for the provider.
- Communicate to staff the privileges granted to providers.
- Supporting documents should include: the organization’s privileging form and approved privileging list.

Standards

| 9.C, 9.C.1, 9.C.2 | The organization ensures the appropriate supervision of anesthesia services. (1) The governing body has approved one or more qualified physicians or dentists as responsible for the supervision of anesthesia services and has granted privileges for supervision to those responsible for it. (2) Other qualified health care professional must be directly supervised by a physician or dentist who has been granted privileges for supervision. |

Surveyor Findings

- Failure to grant specific privileges for supervision of others who are directed to administer anesthesia (e.g., RN administered-conscious sedation)
- Failure to grant specific privileges for the types of anesthesia services provided by a surgeon or proceduralist (e.g., topical, local, blocks)


- Ensure credential files document who is privileged to provide anesthesia and who is privileged to supervise the provision of anesthesia services.
- Include documentation of BLS, ACLS, and PALS in the credential files.

See section VIII for resources on credentialing, privileging, and peer review.

B. Documentation

Includes: allergies, emergency drills, medication reconciliation, initial orientation, test and tissue removal results

Requirements for documentation appear throughout the Standards. The previous section included a discussion of a lapse in documentation for credentialing, privileging, and peer review. Often, it may be that an organization has a process to meet the requirement of a Standard, but the process does not include follow-through in the form of written documentation. For many Standards that are applicable to all organizations, written documentation is the surveyor’s primary source of confirmation that the requirement is being met.
## Standards

<table>
<thead>
<tr>
<th>3.B.4.a</th>
<th>Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies: (4) Reflect the requirement for documentation of initial orientation and training according to position description. Orientation and training shall be: (a) Completed within 30 days of beginning employment.</th>
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<tbody>
<tr>
<td>4.E.4/4.E.3</td>
<td>The organization facilitates the provision of high-quality health care by: performing medication reconciliation.</td>
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<tr>
<td>6.F/6.D.9</td>
<td>The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistently defined location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.</td>
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<tr>
<td>6.I.6/6.D.12</td>
<td>Entered into patient’s clinical record for each visit: (6) any changes in prescription and non-prescription medication with name and dosage, when available.</td>
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<tr>
<td>8.E/8.II.D.2</td>
<td>The organization conducts scenario-based drills of the internal emergency and disaster preparedness plan.</td>
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<tr>
<td>8.E.2</td>
<td>The organization conducts scenario-based drills of the internal emergency and disaster preparedness plan (2) One of the quarterly drills is a cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization.</td>
</tr>
<tr>
<td>8.E.3/8.II.F.4.b</td>
<td>A written evaluation of each drill is completed.</td>
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<tr>
<td>9.F</td>
<td>The informed consent of the patient or, if applicable of the patient’s representative, is obtained before the procedure is performed. One consent form may be used to satisfy the requirements of the Standard and Standard 10.I.H.</td>
</tr>
<tr>
<td>10.I.G/10.I.H</td>
<td>Specific instructions for discontinuation or resumption of medications prior to and after a procedure are provided to the patient with corresponding documentation in the patient’s clinical record.</td>
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<tr>
<td>10.I.I</td>
<td>With the exception of those exempted in writing by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient’s clinical record.</td>
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<tr>
<td>12.C</td>
<td>The organization has a policy to ensure that test results are reviewed and acknowledged in writing (manually or electronically) by the ordering physician or qualified designee.</td>
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## Intent of the Standards

The purpose of documentation related Standards is to ensure patient safety and quality of care, especially as it relates to medication reconciliation and patient allergies. Documentation also promotes consistency and a means to identify errors or lapses in process, assists in negotiations with payers or liability insurers, and provides essential back-up, should your organization become involved in litigation.
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Surveyor Findings

Surveyors identified the following issues.

Medication reconciliation:
- No resumption of medications in patient instructions or on the reconciliation form
- No discharge instructions re: the dose and schedule of the discharge medication
- No newly prescribed medications included
- No form provided to the patient upon discharge
- No documentation or it was inconsistent with patient discharge instructions
- No discontinuation of medications recorded and/or included in patient instructions

Allergy documentation:
- Allergies are documented but no specific reaction information is recorded
- No or inconsistent documentation throughout the chart

Emergency drills:
- No documentation that required number of drills were conducted
- Drills not scenario-based
- Drills not regularly evaluated
- Inconsistent documentation of non-CPR drill

Tissue exemption policy:
- No tissue policy on what specimens do not require pathologist examination

Hints for Compliance

➢ Determine one consistent method for documenting allergies. For example, make documentation of medication reconciliation and allergies required fields in EHR system.

➢ Train staff on all allergy documentation requirements.

➢ Conduct chart audits to ensure complete clinical record documentation.

➢ Have a specific place to record the reaction next to the listing of allergies.

➢ Create template form/checklist for drills with a place to describe the scenario and evaluate the drill.

➢ Have an impartial party view drills as performed and conduct an evaluation.

➢ List all types of anesthesia, including local/topical, on the consent form and have the provider circle the one(s) that will be administered.


See section VIII for resources on allergy documentation and emergency drills.

C. Quality Improvement

Part of being a high-performing and accreditable organization is involvement in continuous quality improvement. A well-organized quality improvement (QI) program and effective quality improvement studies are key elements.
See section VIII for resources on allergy documentation and emergency drills.

Part of being a high-performing and accreditable organization is involvement in continuous quality improvement. A

- Informed Consent
- Medication reconciliation:
  - Include supporting documents: completed AAAHC Emergency Drill toolkit forms and written completion of
  - List all types of anesthesia, including local/topical, on the consent form and have the provider circle the one(s)
  - Have an impartial party view drills as performed and conduct an evaluation.
  - Conduct chart audits to ensure complete clinical record documentation.
  - Determine one consistent method for documenting allergies. For example, make documentation of medication
  - reconciliation and allergies required fields in EHR system.

- Surgery/Procedural
  - Tissue exemption policy:
  - Allergy documentation:
    - pathologist examination
    - No tissue policy on what specimens do not require
  - No documentation that required number of drills were conducted
  - No or inconsistent documentation throughout the information is recorded
  - Allergies are documented but no specific reaction

- Ambulatory Health Care, Inc.

- The purpose of these Standards is to ensure that organizations are regularly monitoring the effectiveness of their QI program to determine whether the program’s purpose and goals are being met, whether goals or approaches to the goals should be revisited—in general, whether the organization’s QI program is on the right track. If an organization is annually (or more frequently) reviewing its QI program and documenting this process, this demonstrates compliance with the Standards. Specifically, once an organization determines a QI study is warranted, the organizations must design and implement corrective action and re-measure to see whether the corrective action achieved the goal set by the organization. Without re-measurement, the QI study is incomplete.

- Surveyor Findings
  - Surveyors identified several issues including:
    - No annual evaluation of QI program
    - Excessive or sole reliance on QA vs. QI
    - No completed studies
    - Unclear (not quantified) goals
    - No clearly identified corrective actions or re-measurement
    - Re-measurement after the corrective action differed from initial measurement

- Hints for Compliance
  - Assess QI studies—especially goals—against SMART criteria:
    - Specific: The goal is clear and easy to understand. It translates into action by using words like “increase” or “decrease.”
    - Measurable: The goal is objective and can be assessed by gathering quantitative data, e.g., 25%, 20 minutes, all, none.
    - Achievable: Those responsible for the goal have the knowledge, skills and resources to deliver the result.
    - Relevant: The goal “matches” the purpose, e.g., improves compliance, increases patient satisfaction, or saves money.
    - Time-bound: The goal has a completion date, e.g., by 12/31, third quarter.
  - Review of performance-related data on an ongoing basis (Standard 5.I.B) to identify trends or specific incidents that present opportunities for improvement.
  - Review recent QI studies using the QI worksheets in AAAHC Handbook.
  - Engage in internal and external benchmarking activities and review written QI program annually.

See section VIII for resources on performance measurement and benchmarking.
D. Infection Prevention/Safe Injection Practices

Infection prevention and safe injection practices Standards deficiencies place patients at risk and are a huge potential liability for organizations. Organizations must address these issues promptly and on an ongoing basis to ensure compliance with Standards and delivery of high quality patient care.

Standards

7.I.B.4 The organization has established a written program to identify and prevent infections and there is a formal, documented infection prevention risk assessment to ensure that the program is relevant to the organization.

7.I.D, 7.I.D.2/7.I.C.2 The infection prevention and control program reduces the risk of health care-acquired infection as evidenced by education and active surveillance, consistent with: (2) CDC or other nationally-recognized guidelines for safe injection practices.

7.I.E/7.I.D Medical staff and dental staff members, allied health practitioners, employees, volunteers, and others receive infection prevention education and training and comply with requirements.

7.I.F.1 Processes for the cleaning, disinfection, and sterilization of instruments, equipment, supplies, and implants adhere to: (1) nationally recognized guidelines.

9.S A safe environment for providing anesthesia services is ensured through the provision of adequate space, equipment, supplies, medications, and appropriately trained personnel. Written policies must be in place for safe use of injectables and single-use syringes and needles. All equipment should be maintained, tested, and inspected according to the manufacturer’s specifications. A log is kept of regular preventive maintenance.

11.I/11.J The organization must have policies in place for safe use of injectables and single-use syringes and needles that, at minimum, include CDC or comparable guidelines for safe injection practices.

Intent of the Standards

The purpose of these Standards is to ensure that organizations reduce the risk of infection by requiring that organizations develop and regularly review risk assessment programs, train staff in all aspects of the program, and use nationally-recognized guidelines to develop the organization’s policies and procedures related to infection control and safe injection practices.
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Surveyor Findings
Surveyor identified issues included:

- IPC policy not based on nationally-recognized guidelines
- Not following CDC, APIC, or other requirements adopted as policy
- Not treating a multi-dose medication opened and drawn in a patient treatment area as a single dose vial
- Opening, dating, and saving multi-dose vials on anesthesia carts for future use
- Splitting of single-dose vials
- Not sterilizing medication vial stopper before drawing the medication
- Not labeling (name, dosage, date, time, person drawing the medication, etc.) medication drawn up prior to the procedure
- Not immediately using pre-drawn medication, per clinical practice guidelines or manufacturer’s instructions
- No sharps safety policy and/or no appropriate sharps container
- No documentation of ongoing surveillance/monitoring activities of infection prevention and control program
- Insufficient (or no) monitoring and documentation of cleaning, HLD and sterilization; failure to follow manufacturer’s instructions for use

Hints for Compliance

- Review policies on infection control and prevention to ensure they are up-to-date and are being followed.
- Ensure new and existing staff infection prevention training at regular intervals, including as national guidelines change and with sufficient frequency for reinforcement.
- Ensure compliance with OSHA regulations/bloodborne pathogens.
- Observe equipment and instrument cleaning, HLD and/or sterilization, and appropriate record keeping.
- Provide supporting documentation such as: completed AAAHC Safe Injection Practices toolkit risk assessment; CDC, AORN, SGNA, and/or ASGE SIP guideline/forms/worksheets.

See section VIII for resources on safe injection practices and medication reconciliation.
VI. Additional Deficiencies Findings: MDS ASCs

AAAHC MDS Life Safety Code

This Life Safety Code (LSC) Survey, which is part of the Medicare Deemed Status Survey, assesses facility compliance with structural and operational requirements, and is a part of the complete Medicare Deemed Status survey. Organizations need to address high deficiencies in LSC Standards to ensure that the delivery of patient care is provided in a safe and sanitary environment.

The above graph represents deficiencies greater than or equal to 20% found in the 222 MDS ASC surveys.

Life Safety Code Standards
See the Physical and Environmental Checklist in the AAAHC MDS Handbook for additional information.

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<tr>
<td>6.1</td>
<td>Doors to rooms storing flammable, combustible, toxic, noxious, or corrosive materials (except routine office supplies) are self-closing or automatic closing (released by activation of the fire alarm system, and any/all other installed hazard detection devices or systems).</td>
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<td>8.8</td>
<td>The governing body has conducted a qualified risk assessment of the operating rooms and found some or all to not represent wet areas requiring special protection against electrical shock.</td>
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<td>8.11</td>
<td>Self-contained battery-powered lights are provided at the following locations: One or more in each location where deep sedation or general anesthesia is administered. At the EES transfer switch location(s). At interior locations of alternate power interior generator sets. At locations of alternate power battery-based sources (SEPSS per NFPA 111).</td>
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<tr>
<td>8.17</td>
<td>Emergency and Standby Power System (EPS) equipment (generator set) is selected, located, installed, and maintained in full compliance with the 2010 edition NFPA 110, including but not limited to the following:</td>
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<td>- The generator set is located in a room dedicated to EES equipment and is separated from the remainder of the building by construction with a minimum 2-hour fire rating or is located in an exterior enclosure (or fixed housing integral with the generator set) capable of preventing the entrance of snow or rain and resisting high wind speeds.</td>
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<td>- EPS equipment and separate Stored Emergency Power Supply System (SEPSS) equipment may occupy the same interior space.</td>
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<td>- The locations housing EPS equipment are located to minimize the possibility of damage from flooding, including that from firefighting, sewer or storm water backup, and similar adverse events or consequences.</td>
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<td>- Interior EPS locations provide at least 36-in. working clearance on all sides as necessary to accommodate inspection, testing, or maintenance activities. Clearances are measured from the skid rails’ greatest extension in the direction of access.</td>
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<td>- The EPS is heated as necessary to maintain water jacket temperatures specified by the manufacturer.</td>
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<td></td>
<td>- Interior locations of EPS equipment are provided with adequate tempered airflow to assure the room does not exceed EPS manufacturer-specified temperature ranges when standing by or while running at rated load.</td>
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12.4 Pipes, conduits, bus ducts, cables, wires, air ducts, HVAC ducts, and similar building service equipment that pass-through fire-rated barriers or smoke partitions are protected as follows:
The space between NEW penetrating items and fire rated vertical and horizontal assemblies is protected by a firestop system or device tested in accordance with ASTM 814 or ANSI/UL 1479. Exceptions to this requirement include:
- Where penetrations are part of an assembly rated in accordance with ASTM E 119 or ANSI/UL 263.
- Where vertical penetrations are enclosed in shaft with fire rating equal or greater than of the floor system.
- Where concrete, grout, or mortar fills the full depth of the space between 6-in. diameter (maximum) cast-iron, copper, or steel pipes and an opening no larger than 1 SF in fire resistant concrete or masonry assemblies.
- Where firestopping materials protect the penetration of rated assemblies by steel cables, ferrous cables, copper cables, steel jacketed cable or wire, cast-iron pipe, steel pipe, copper pipe, or steel conduit or tubing under conditions specified in NFPA 101 section 8.3.1.1.4.

12.8 Doors in fire-rated construction are protected as required for the fire resistance of the barrier in which they occur, as follows:
- Doors in rated assemblies are self-closing and close with a positive latch when released from any position. If a rated door is held open, it is by a device that will automatically release it upon activation of an automatic sprinkler system, upon activation of the smoke and/or fire alarm system, and upon loss of power to the hold-open device.
- Doors in stair/exit enclosures that are held open will automatically close upon activation of a smoke detector, upon loss of power to the hold-open device, or when manually pulled away from the hold-open device. The release of any door in an exit enclosure by a smoke detection device automatically releases all doors held open serving all floor levels from the same stair.
- Fire-rated door assemblies consist of labeled (with fire rating) frames and labeled doors, with or without labeled vision panels. The rating of the overall assembly is determined by the lowest labeled component (door, frame, or vision panel).
- All fire rated doors assemblies are visually inspected at least annually for signs of wear, damage, or other condition that could impair their performance and/or reliability. Such inspection is performed by individuals with demonstrated knowledge and understanding of the requirements and functional components of the rated assemblies being evaluated, and includes:
  - Door and door hardware function and physical integrity
  - Condition of both door faces and swing/access clearances on both sides
  - Space on both sides of the door and the finished floor surface
  - The maximum gap between the closed door and frame jambs and top and/or between the strike side edges of pairs of doors (as applicable)
  - Each door’s opening force and closing speed
  - Fire-rated doors and windows that are no longer in use have been removed and replaced by wall assemblies with fire/smoke resistive rating at least equal to the wall or assembly in which they occur
  - Repairs, adjustments, and/or corrections are made without delay upon identification.

15.12 Smoke and fire dampers are inspected and tested one year after installation, and every four years thereafter. Where fusible links are used, they are removed during testing to simulate full closure.

17.2 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills are conducted quarterly for each working shift to familiarize staff with signals and emergency action required under varied conditions. Drills conducted between 9:00 p.m. and 6:00 a.m. may use a coded announcement in lieu of the audible alarm. Patients are not required, and may not be required, to be moved during drills. All staff members are instructed in life safety (fire and evacuation safety) procedures and devices.
VII. Common Findings in Patient Centered Medical Home (PCMH)

Surveyors evaluated 28 organizations under the 2017 Patient Centered Medical Home Standards (AAAHC Accreditation Handbook Chapter 25).

The highest deficiency Standards (greater than 20% deficiencies) were the following.

<table>
<thead>
<tr>
<th>Standards</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.A.3</td>
<td>Patients are provided with information and explanation regarding the Medical Home approach to care.</td>
</tr>
<tr>
<td>25.B.2</td>
<td>Patients are routinely and continuously assessed for their perceptions about access to the Medical Home (provider availability, treatment plan information, clinical record contents, advice, routine care and urgent care).</td>
</tr>
<tr>
<td>25.C.2.f</td>
<td>Comprehensiveness of care includes: (f) Documented discussions regarding end-of-life or palliative care, as appropriate.</td>
</tr>
<tr>
<td>25.E.6, 25.E.6.a, 25.E.6.b</td>
<td>In addition to the Standards presented in Chapter 5.I, the Medical Home’s quality improvement program includes at least one study every three years on each of the following topics: (a) patient/primary care provider relationship, (b) accessibility to care.</td>
</tr>
</tbody>
</table>

**Intent of Standards**

The purpose of these Standards is to ensure that the services provided are patient-centered, physician-, nurse practitioner- or physician assistant-directed (as permitted by state law/regulation), comprehensive, accessible, continuous, and organized to meet the needs of the individual patients served. The foundation of a Medical Home is the relationship between the patient, his/her family, as appropriate, and the Medical Home. Within the patient-centered Medical Home, patients are empowered to be responsible for their own health care. As used in these Standards, a Medical Home is the primary point of health care for the patient.
VII. Common Findings in Patient Centered Medical Home (PCMH)

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- 25.A.3  Patients are provided with information and explanation regarding the Medical Home approach to care.
- 25.B.2  Patients are routinely and continuously assessed for their perceptions about access to the Medical Home (provider availability, treatment plan information, clinical record contents, advice, routine care and urgent care).
- 25.C.2.f  Comprehensiveness of care includes: (f) Documented discussions regarding end-of-life or palliative care, as appropriate.
- 25.E.6,  25.E.6.a,  25.E.6.b  In addition to the Standards presented in Chapter 5.I, the Medical Home's quality improvement program includes at least one study every three years on each of the following topics: (a) patient/primary care provider relationship, (b) accessibility to care.

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Surveyor Findings

Surveyor findings included:

- No analysis or follow up on patient satisfaction surveys results
- Sporadic (not routine) querying of patients on their perceptions about access to the Medical Home
- PCMH enrolled patients not aware of the Medical Home approach to care and their associated patient responsibilities
- Lack of awareness of prior quality improvement studies
- No or inconsistent end-of-life discussions documentation
- No documentation of discussion with patients regarding advance directives
- No study on patient/primary care provider relationship or accessibility to care

Hints for Compliance

- Educate PCMH patients on expectations regarding patients’ involvement in their own care, including providing reminders at each visit.
- Make discussion of end-of-life a required EMR field.
- Include questions on patient perception of patient/provider relationship and access to care in patient satisfaction surveys prior to the first visit and after several visits. Consider patient phone follow-up within 48-72 hours of a PCMH visit.
- Studies on accessibility of care may include questions about how easy it is to make an appointment, how long from scheduling the appointment to being seen by the provider, and what patients do when the organization is closed.

See section VIII for resources on care coordination.
### VIII. Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>APIC</td>
<td>Association for Professionals in Infection Control and Epidemiology</td>
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<tr>
<td>ANSI</td>
<td>American National Standards Institute</td>
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<tr>
<td>ASTM</td>
<td>American Society for Testing and Materials</td>
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<tr>
<td>ASC</td>
<td>Ambulatory Surgery Center</td>
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<tr>
<td>ASGE</td>
<td>American Society for Gastrointestinal Endoscopy</td>
</tr>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
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<tr>
<td>AORN</td>
<td>Association of periOperative Registered Nurses</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic Life Support</td>
</tr>
<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid</td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Administration</td>
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<tr>
<td>EES</td>
<td>Essential Electrical Systems</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>EPS</td>
<td>Emergency and Standby Power System</td>
</tr>
<tr>
<td>HLD</td>
<td>High Level Disinfectant</td>
</tr>
<tr>
<td>HVAC</td>
<td>Heating, Ventilation and Air Conditioning</td>
</tr>
<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>LSC</td>
<td>Life Safety Code</td>
</tr>
<tr>
<td>MDS</td>
<td>Medicare Deemed Status</td>
</tr>
<tr>
<td>NFPA</td>
<td>National Fire Protection Association</td>
</tr>
<tr>
<td>NPDB</td>
<td>National Practitioner Data Bank</td>
</tr>
<tr>
<td>OBS</td>
<td>Office Based Surgery</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>PALS</td>
<td>Pediatric Advanced Life Support</td>
</tr>
<tr>
<td>PC</td>
<td>Primary Care</td>
</tr>
<tr>
<td>PCMH</td>
<td>Patient Centered Medical Home</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>SEPSS</td>
<td>Stored Emergency Power Supply System</td>
</tr>
<tr>
<td>SHS</td>
<td>Student Health Service</td>
</tr>
<tr>
<td>SGNA</td>
<td>Society of Gastroenterology Nurses and Associates</td>
</tr>
<tr>
<td>SIP</td>
<td>Safe Injection Practices</td>
</tr>
<tr>
<td>UL</td>
<td>Underwriters Laboratories</td>
</tr>
</tbody>
</table>
IX. Roadmap for Improvement 2018

Use this Report for Benchmarking

Your organization can use the data in this report to assess your survey results versus benchmarks in the report. If you have an opportunity for quality improvement, the following resources may be beneficial for intervention.

Guidance for Addressing High-Deficiency Themes

Safe Injection Practices Study

The AAAHC Institute began offering a Safe Injection Practices Benchmarking Study in 2017. Initial findings substantiate the need for many organizations to assess their compliance with national guidelines for safe injection practices and develop quality improvement interventions to improve their compliance with the guidelines.

The AAAHC offers several Safe Injection Practices resources, including:

- Centers for Disease Control and Preventions (CDC) produced Safe Injection Practices Coalition CDs
- A patient safety toolkit on Safe Injection Practices
- Participation in the Safe Injection Practices benchmarking study
- A webinar on Safe Injection Practices

You can use the following resources to help your organization comply with AAAHC Standards. Order or register at www.aaahc.org.

Toolkits

The AAAHC Institute continues to research and release best practice tools for patient safety. The toolkits that address themes in this report include:

- Allergy Documentation
- Credentialing & Privileging
- Emergency Drills
- Medication Reconciliation
- Peer Review & Benchmarking

Each toolkit incorporates a review of the relevant literature, a description of the topic’s importance to ambulatory health care settings, and a relevant and highly visual tool. Toolkits focus on ambulatory surgery settings, primary care settings, or are designed for universal applicability.

AAAHC Institute benchmarking studies

Open to all ambulatory health care centers, participation helps organizations evaluate clinical performance measurement and build quality improvement activities and studies. The AAAHC Institute offers two opportunities, annually, to register for studies, January-June and July-December. Learn more at:


The Quality Improvement educational session at Achieving Accreditation has been redesigned. The focus of this program is to teach participants how to identify topics for good QI studies, develop SMART goals, describe what is going to be measured and how, design corrective actions and recognize all the QI study report components. For more information on attending an Achieving Accreditation meeting go to:

https://www.aaahc.org/en/education/achieving-accreditation/

If your organization is AAAHC accredited and has conducted an exemplary QI study, consider applying for the annual Innovations in Quality Improvement Award Program. Please visit the AAAHC website www.aaahc.org, choose “Quality,” and “Award Program,” to learn more about applying, award criteria, poster presentations, and the Expert and People’s Choice awards.

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