Kershner award winners announced

In November of 2017, the AAAHC Institute for Quality Improvement announced the 6 finalists (3 from Surgical/Procedural and 3 from Primary Care) for the 2017-2018 Bernard A. Kershner Innovations in Quality Improvement (the “Bernies”) award program.

Each finalist submitted a fully developed and implemented quality improvement study and were recognized at Achieving Accreditation, March 16-17, in Tampa, Florida, where the individual studies were presented in poster format. Submissions are divided into surgical/procedural and primary care categories. The AAAHC Institute’s expert panel selected one winner for each, and attendees at Achieving Accreditation had the opportunity to cast a vote, based on their health care setting, for a People’s Choice award.

SURGICAL/PROCEDURAL AWARD TO…. The Bernie for surgical/procedural care was awarded to “Cutting the Cost on Miochol” by Kyle Friedman, RN, BSN from the Danbury Surgical Center in Danbury, Connecticut.

PRIMARY CARE AWARD TO…. The Bernie for primary care was awarded to “Travel to Obtain Health Care and USCG C-130 Hercules Aircraft Utilization,” by CDR Ken West, RN, CCRN.

for the study, “Travel to Obtain Health Care and USCG C-130 Hercules Aircraft Utilization,” by CDR Todd L. Emerson and HS2 Nathan Goodrich.

You may view the expert panel surgical care and primary care winners’ submissions and facility profiles on pages 2 and 3 of this issue.

To review all finalists’ posters, please visit: http://www.aaahc.org/institute/QI-awards/.

A message from the AAAHC President and CEO

As the leader in ambulatory accreditation, AAAHC promotes patient safety and drives quality improvement. We are invested in you. Part of that investment involves not only listening to what our supporters say but also listening to our critics.

Earlier this year, Kaiser Health News and USA Today released an article critical of outpatient surgery centers. Initially, 38 news outlets across the country picked up the story, including a live interview with a lead reporter on the CBS This Morning news show on March 2. Fortunately, or unfortunately, the story did not attract public interest. Within three days after the initial coverage, the article ran very few times with virtually no social media shares.

The AAAHC supports the Ambulatory Surgery Center Association’s response in which my colleague, ASCA CEO Bill Prentice, presented a strong rebuttal to the claims made in the reporting, writing that these stories focused on a relatively small number of tragic errors, while ignoring the overwhelming beneficial outcomes found in ambulatory surgery centers.

Here’s the thing. At the AAAHC, we encourage patients to embrace their health care choices. Ambulatory care centers offer high-quality affordable care and are a convenient, safe alternative to the traditional hospital environment. The fact is, the very existence of these centers more than 45 years ago was driven by patient demand for more convenient, cost-effective and safe quality care. AAHC accreditation is one way that ambulatory practices can demonstrate that they have earned this trust.

Formed in 1979—well before government regulation of ASCs—health care providers and medical societies established the AAAHC to ensure safe, high-quality patient care was delivered in the outpatient setting through compliance to rigorous, nationally recognized health and safety standards.

Through our accreditation program, we collaborate with you to establish the processes, procedures, and quality improvement metrics to integrate quality and safety into the fabric of your operation. And, AAAHC accreditation means you have willingly opened your doors to an informed, expert third-party evaluation of your performance.

Because good patient care is essential to all of us.

During the past eight months, I have had the opportunity to address several Achieving Accreditation education program audiences and many of our clients, reaching nearly 1,000 people. I shared that the training we are providing and the time our surveys spend with individuals within continued on page 4
THE ORGANIZATION: Danbury Surgical Center (DSC), which opened in 1984, is a multi-specialty ambulatory surgical center affiliated with Surgical Care Affiliates (SCA) located in Danbury, CT. The facility has four operating rooms and two procedure rooms. DSC specializes in orthopaedics, ophthalmology, endoscopy, pain management, urology, and podiatry. Currently, DSC performs over 6,500 cases annually.

THE STUDY: The purpose of the study was to reduce pharmaceutical costs by switching from Miochol to Miostat during routine ophthalmology surgery. Analysis of the data collected showed that a total of 345 units of Miochol was purchased from October 2015 – September 2016. The cost per unit of Miochol is $78.92 while the cheaper alternative, Miostat, costs $8.15 each. The data suggested a potential annual savings of approximately $24,415.65 by substituting with Miostat.

Prior to switching to the cheaper alternative Miostat, the ophthalmologists operating at DSC were concerned about Miostat causing post-op nausea and vomiting (PONV). Data was collected using a post-operative patient survey to determine if any patients experienced PONV after receiving Miostat. Results determined no correlation between Miostat and PONV. The ophthalmologists unanimously agreed to switch and exclusively use Miostat. The change to Miostat met the goal of switching products to save $70.77 per unit or an estimated $24,415.65 per year.

APPROACH TO QI: The purpose of Danbury Surgical Center’s quality improvement program is to ensure high quality patient care and outcomes. DSC maintains an active, ongoing, integrated, organized, peer-based program of quality management and improvement that links peer review, quality improvement activities, and risk management in an organized, systematic way. The center’s leadership drives the program, ensuring its alignment with the mission, vision, and strategic objectives of DSC and SCA.
Primary Care Winslow Indian Health Care Center
by Jun Park, PharmD; Lindsay Sampson, PharmD; and Peter Laluk, PharmD

THE ORGANIZATION: Winslow Indian Health Care Center (WIHCC), originally a tuberculosis sanatorium built in 1931, serves the health care needs of Native Americans in the southwestern portion of the Navajo Nation. In addition to both primary care and urgent care, the facility offers a wide range of specialty services, such as cardiology, neurology, and podiatry. WIHCC works closely with the local hospital, which extends privileges to WIHCC medical staff to care for Native American patients, and serves a population of just over 16,000 patients, with over 150,000 direct care visits for FY 2017.

THE STUDY: A major factor in readmissions is non-adherence to medication treatment. Per a FY 2014 WIHCC chart review, one out of every three Winslow patients seen at an inpatient facility was readmitted (33%). The goal of the study was to reduce readmission rates of this facility to the national average of ≤20% of hospital admissions. Pharmacy developed a medication reconciliation program for discharge medications with a focus on patients with the top four conditions for readmission (infections, cardiovascular issues, substance abuse, and asthma/COPD). Since the transition care and medication reconciliation program’s inception, readmission rates have decreased from 33% (1/3) in FY 2014 to 10% for FY 2016.

APPROACH TO QI: The quality management program is developed under the authority of the board of directors which guides the strategic initiatives, mission, and vision for WIHCC. A quality improvement study may involve one or more departments and/or disciplines and may be initiated by a department, a standing committee, a task force, or an ad hoc basis with the support of the director of quality management. Study results are then presented to leadership, the board of directors, and relevant workforce and built upon for continuous quality improvement.

Improving Readmission Rates Through Medication Reconciliation

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION

Transition of Care Service: Post-Discharge Medication Reconciliation

Jun Park, PharmD, Lindsay Sampson, PharmD and Peter Laluk, PharmD

Winslow Indian Health Care Center

1. Purpose
Implementing regular medication reconciliation after discharge is an important way to prevent medication errors and centering patients on their new medications. This process reduces discrepancies, reduces the risk of adverse drug interactions, and helps providers recognize duplication and complexity of a medication regimen. This in turn may improve patient adherence to the regimen and reduce hospital readmission rates.

2. Performance Measure
The goal of the reconciliation initiative and transition of care program is to reduce readmission rates of this facility to the national average of ≤20% of hospital admissions.

3. Data Collection

- Based on an extensive chart review for hospital admissions in FY 2014, WIHCC identified high risk of hospital readmission.
- These were attributed to lack of medication compliance, existence of chronic disease treatment, prescriptions of duplication therapy, and limited communications between inpatient and outpatient providers.
- To gauge improvement, extensive chart review was performed on all patients who were readmitted at an inpatient setting.
- The number of medications were trended, including the potential reasons for the medication management, duplication therapy, noncompliance, existence of therapy, and most common conditions for readmission (cardiovascular, infectious diseases, depression, buprenorphine, etc.) were also tracked.

4. Evidence of Data Collected

Admission taking place during FY 2014 accounted for over 1,000 patients. Extensive chart reviews were performed on former patients, and for remaining data were created and tabulated in an excel sheet to identify conditions that led to medication errors later contributed to readmission (e.g. duplication therapy, noncompliance, existence of therapy).

5. Data Analysis

Table 1: Condition for Readmission

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Patients</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>150</td>
<td>15%</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>200</td>
<td>20%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>100</td>
<td>10%</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>50</td>
<td>5%</td>
</tr>
</tbody>
</table>

6. Comparison to Industry Goal

For the FY 2014 WIHCC chart review, one out of every three Winslow patients seen at an inpatient facility was readmitted (33%). The national average for this time period was one in five patients being readmitted (20%).

7. Corrective Action

Applying this information, pharmacy developed a medication reconciliation program for discharge medications with a focus on patients with the top four conditions for readmission (infections, cardiovascular issues, substance abuse, and asthma/COPD). Patients were identified using electronic discharge notifications from facilities such as HHC and LOMC and with Clinical Care Coordination. Pharmacists would perform a review of discharge and WIHCC records, extract patients when necessary for follow-up and document that interaction in EHR. The medication reconciliation template (see Example 1 below) was completed, and the patient’s PCP and Clinical Care Coordinator were notified electronically to cocina the care.

Example 1: EHR Medication Reconciliation Template

- Identification
- Admission date
- Discharge date
- Medications received during hospitalization
- Dosage
- Frequency
- Routes
- Start date
- Stop date
- Baseline values
- New value
- Change from baseline
- Interventions
- Follow-up

8. Re-measurement

Since the transition of care and medication reconciliation program’s acceptance, readmission rates have decreased from 33% (1/3) in FY 2014 to 10% for FY 2016. This reduction in medication reconciliation also correlated with improved patient satisfaction and improved the overall health of the patients by monitoring adherence to medication therapy.

Table 2: Re-measurement Data Comparison

<table>
<thead>
<tr>
<th>Year</th>
<th>National Average</th>
<th>Fiscal Year 2014</th>
<th>Fiscal Year 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>20%</td>
<td>33%</td>
<td>10%</td>
</tr>
<tr>
<td>2014</td>
<td>20%</td>
<td>33%</td>
<td>10%</td>
</tr>
<tr>
<td>2015</td>
<td>20%</td>
<td>33%</td>
<td>10%</td>
</tr>
<tr>
<td>2016</td>
<td>20%</td>
<td>33%</td>
<td>10%</td>
</tr>
</tbody>
</table>

9. Additional Corrective Action(s) and Continued Re-measurement

- Ensuring documentation to ensure information is shared between providers and patients and their caregivers.
- Improving face-to-face education, and follow-up for discharged patients.
- Using electronic records in shared information and providing summary of care.
- Pharmacy staff was involved to ensure medication reconciliation to patient post-discharge.

10. Communication of Findings

- The initial data (including factors contributing to readmission rates) led to the implementation of the Winslow Indian Health Care Center’s Post Discharge Medication Reconciliation Program.
- The pharmacy department was involved in developing the training material and disseminating the information to medical staff.
- The study was presented to the Winslow Indian Health Care Center’s Board of Directors and the Winslow Indian Health Care Center’s Clinical Care Coordinators.
- The Winslow Indian Health Care Center’s Post Discharge Medication Reconciliation Program has received recognition from the Drug Enforcement Administration, United Health Care, and the Centers for Medicare and Medicaid Services.

- Results of this quality improvement work were also presented to the WIHCC management team and the Board of Directors.

KERSHNER WINNER
A message from the AAAHC President and CEO
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facilities pursuing accreditation isn’t just about the performance on the day of their survey or the certificate they receive. The AAAHC and the patients these clients serve expect quality integrated into everything they do—every day. Achievement of the three-year, AAAHC accreditation demonstrates a facility’s commitment to adhere to high quality standards during every day of that three-year cycle—1,095 days in which you are providing care to a mother, a child, a brother, a colleague, someone’s loved one—all of whom are trusting you and your colleagues to deliver on your promise of better outcomes.

As CEO of AAAHC, a major part of my role is to serve you by ensuring that:
• Our Standards fulfill CMS requirements and reflect best practice.
• We provide the tools that enable your compliance.
• Our surveys are fair, consistent, timely, and educational.
• AAAHC accreditation brings value to your business and patient safety goals.

I also believe I have a responsibility to the patients you serve by assuring them that they can have confidence in the quality and services provided by institutions accredited by the AAAHC. Together, we can strengthen the care you provide. ▲

AAAHC Announces Strategic Governance Structure
NEW BOARD LEADERSHIP IMPLEMENTED TO SUPPORT GROWTH, INNOVATION
After nearly 40 years, the AAAHC, the leader in ambulatory health care accreditation, has enacted a new governance model that transitions the organization to a focused 13-member Board of Directors plus the AAAHC CEO/President as ex officio without vote. With the new governance structure, the AAAHC is evolving from its association model that had served the organization well for many years to a new model that will better position AAAHC to expand in the health care accreditation industry. The newly-appointed 2018-2019 officers bring extensive experience and expertise in patient-centric ambulatory care to their leadership roles.

• Arnauld Valeden, MD, Board Chair
• Ira Cheifetz, DMD, Chair-Elect
• Timothy J. Peterson, MD, Secretary/Treasurer
• Kenneth M. Sadler, DDS, MPA, Immediate Past Board Chair

“Governance model will strengthen our ability to best serve organizations that are seeking continuous improvement in the quality of patient care delivered in the ambulatory setting,” said Arnauld Valeden, MD, AAAHC incoming board chair. “The new governance structure will drive the development and implementation of a multi-year strategic plan to better position AAAHC for enhanced growth and to continue its commitment to health care quality through accreditation.”

The nine elected non-officers possess a diverse scope of knowledge, and they will continue to focus on engagement and growth opportunities across all specialties.

• W. Patrick Davey, MD
• Jan Davidson, RN, MSN
• Lawrence Kim, MD
• Joy Himmel, PsyD
• Mark Mandell-Brown, MD
• S. Teri McGillis, MD
• Dennis Schultz, MD
• David Shapiro, MD
• Edwin Slade, DMD, JD

“This is an historic event in the life of any association,” said Noel M. Adachi, president and chief executive officer. “I am very proud of the action our board has taken to advance AAAHC – a decision which is to the benefit of the organization and in service to our mission. I look forward to working with the new board to help lead our organization as we continue to support high-quality patient care.”

HCI winds downs operations as AAAHC renews focus on Standards and educational offerings
Since 1999, Healthcare Consultants International, Inc. (HCI) has been providing consultative assistance to health care facilities seeking accreditation. As an AAAHC wholly-owned subsidiary, HCI has been a valuable resource in assisting facilities pursuing Standards compliance, quality improvement, and accreditation. During the past seven years, HCI Managing Director Kristine Mighion, MD, expanded its services to provide hundreds of facilities assistance in preparing for accreditation, applying for Medicare certification, and implementing organization-wide quality improvement.

Recently, however, in a concerted effort to heighten AAAHC focus on developing and promoting relevant standards for a broadening spectrum of health care facilities, the HCI and AAAHC Board leadership decided to suspend HCI’s consulting operations effective December 31, 2017. During 2018, our accredited facilities and those pursuing initial accreditation will experience an expanded menu of accredited facilities and those pursuing initial accreditation. As of December 31, 2017, HCI decided to suspend its consulting operations effective December 31, 2017.

AAAHC: Out and About
June 14-16
Becker’s Orthopedic, Spine, and Pain Management
Chicago
September 14-15
Achieving Accreditation®
Washington, DC
November 30-December 1
Achieving Accreditation®
Las Vegas

“For more information, visit aaahc.org and select the “Education” tab.

Training and Education Recorded webinar presentations
• 2018 Standards Part I of II: Core Chapters for Non-Medicare surveys
• 2018 Standards Part II of II: Adjust Chapters for Non-Medicare surveys
• Safe Injection Practices GIPP: Common AAAHC Standard Deficiencies & What YOU Need to Know to Avoid Them and Ensure Patient Safety

Purchase the recordings at: http://www.aaahc.org/en/education/Webinars/