



ACCREDITATION ASSOCIATION  
*for* AMBULATORY HEALTH CARE



# 2019 AAAHC Quality Roadmap

A report on accreditation  
survey results



quality every day  
**1095** STRONG

# Quality Roadmap 2019

## A report on accreditation survey results; a valuable resource for continued improvement

Dear Colleagues,

The *AAAHC Quality Roadmap* provides a thorough analysis of data from more than 1,250 surveys conducted using the current 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.

I encourage you to use this report on current Standards survey findings as a tool for guiding your own quality improvement initiatives. In addition, 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 the 1,095 days of your accreditation term.

Together, we are *1095 Strong, quality every day.*

Sincerely,



Noel M. Adachi, MBA  
President and CEO



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# I. Get the Most Value from this Report

## Use this Report for Benchmarking

Our *1095 Strong, quality every day* philosophy is a call-to-action to provide you with what you need to operationalize quality practices. Organizations that earn AAAHC Accreditation embody the spirit of *1095 Strong, quality every day*, an ongoing commitment to high-quality care and patient safety throughout the 1,095 days of the accreditation term.

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

The *AAAHC Quality Roadmap* presents actionable data 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 QI studies or other corrective actions that may be necessary
- Building a quality improvement culture that is integrated with your day-to-day operations and based on the *1095 Strong, quality every day* philosophy

## Standards and Elements

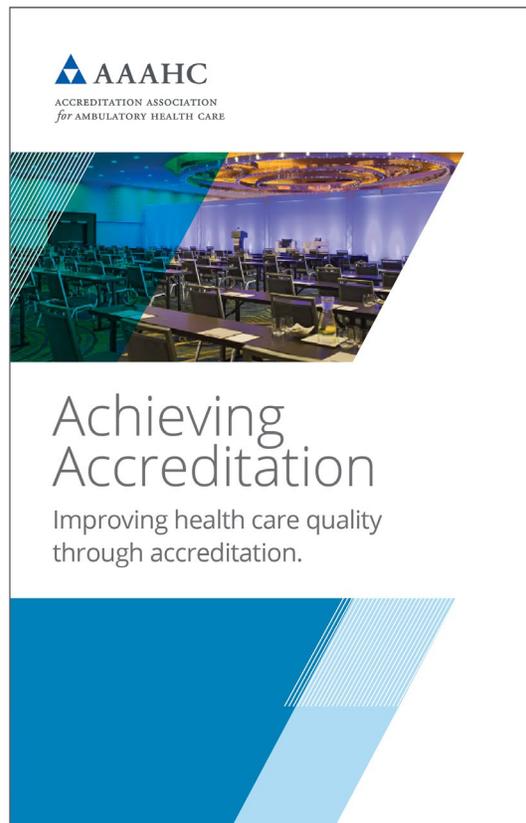
In 2018, AAAHC revised the presentation of Standards to include “elements of compliance,” the presence of which can be evaluated as yes, no, or not applicable (NA).

Following each Standard is a ratings chart that defines how many elements must be present to achieve specific compliance ratings. The intent of these changes is to create greater transparency with regard to what AAAHC surveyors will be looking for and to allow organizations the ability to conduct a self-assessment that should align closely to that of the onsite surveyor or survey team.

## About the AAAHC Institute

AAAHC established the Institute for Quality Improvement in 1999. Formerly a non-profit subsidiary of AAAHC, the Institute is now a department within AAAHC.

The Institute supports AAAHC activities by offering national benchmarking studies, producing patient safety and disease management toolkits, developing content for educational programs, recognizing AAAHC-accredited organizations’ exemplary quality improvement studies through the *Bernard A. Kershner Innovations in Quality Improvement Award* program, analyzing and reporting on AAAHC survey data for the *Quality Roadmap*, and representing AAAHC in national quality meetings and with national quality organizations.



### Did you know?

AAAHC has an immersive two-day program to help organizations prepare for AAAHC Accreditation. Learn more at [aaahc.org/achieving](https://www.aaahc.org/achieving)

## II. Data Description

This report is based on analysis of surveyor compliance ratings of current AAAHC Standards during onsite surveys March 1 – December 31, 2018 of organizations seeking initial or reaccreditation, including ambulatory surgery centers in the Medicare Deemed Status program. For these organizations, we also included frequent deficiencies related to CMS Conditions for Coverage.

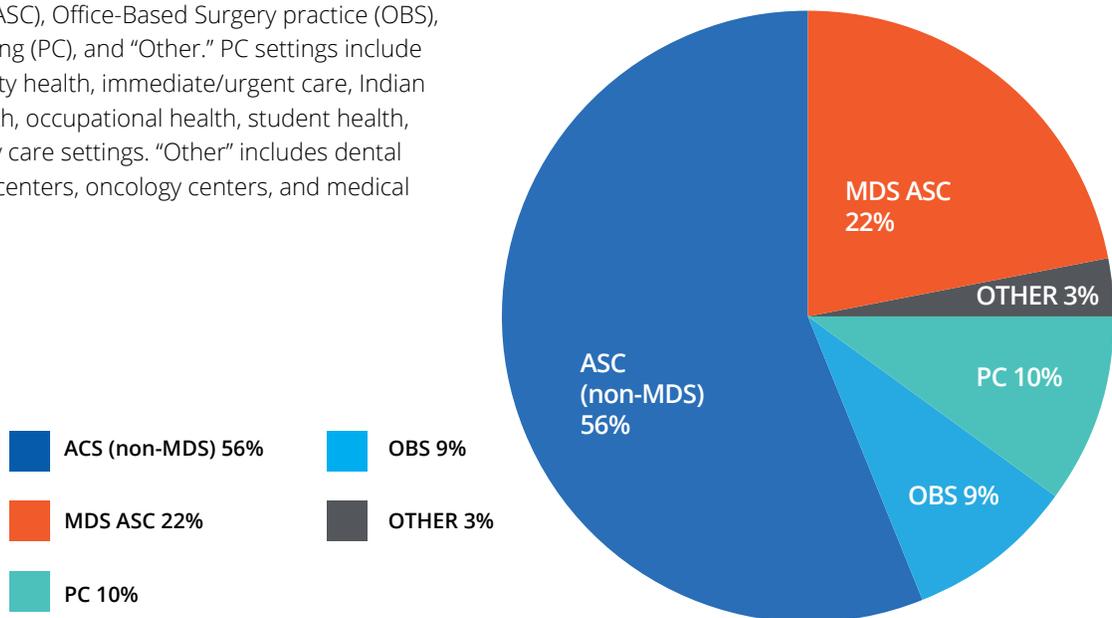
Survey results for the Bureau of Prisons or organizations seeking accreditation through the AAAHC Health Plan or Federal Employee Health Benefits Plan program are not included. This report also does not include intra-cycle surveys. Often, these are focused surveys that do not include all core Standards (Chapters 1-8 of the *Accreditation Handbook*).

The data represent 1,299 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 practice (OBS), Primary Care setting (PC), and “Other.” PC settings include military, community health, immediate/urgent care, Indian health, tribal health, occupational health, student health, and other primary care settings. “Other” includes dental practices, fertility centers, oncology centers, and medical group practices.

For organization types ASC (non-MDS), PC, OBS, and “Other,” surveyors used a binary rating of “Yes” or “No” to assess whether each “Element” of a Standard was met. The compliance rating [fully compliant (FC), substantially compliant (SC), partially compliant (PC), minimally compliant (MC), and non-compliant (NC)] was automatically calculated based on the number of “Yes” ratings and the total number of “Elements” within a Standard. Under the current AAAHC Standards for MDS ASC organizations, surveyors described organizational performance against the AAAHC Standards as compliant (C), 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.\*

### Organization Type



\*While this report looks in depth at those Standards with the highest incidence (10% or more) of PC, MC, and NC ratings for non-MDS surveys and PC and NC ratings for MDS surveys, most organizations that seek AAAHC accreditation successfully achieve a three-year term.

# III. Overall Findings – High Compliance Standards

For the period of this report, the highest compliance findings (99% rated FC 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. As you continuously assess your organization's performance, these high compliance Standards may be a useful starting point.

These areas have shown improvement:

## Non-MDS Standards

- Providing patients with the opportunity to participate in decisions involving their care
- Having health care professionals trained in use of emergency equipment and a safe evacuation plan
- Identifying a purpose for the organization's quality improvement program
- Providing ongoing staff development and improvement

## MDS Standards

- Having resuscitation equipment available for administering at least 90% oxygen
- Ensuring a physician or dentist is present in the facility or immediately available by telephone when patients are present
- Providing appropriate education to operators of newly-acquired devices or products to be used in patient care
- Complying with state and local building codes and regulations

## A. Non-MDS High Compliance Standards

In addition to improvements stated above, non-MDS AAAHC-accredited organizations continue to be well-organized (Standard 2.I.A) and have staff that practice professionally and ethically (Standard 4.B). These organizations also provide ongoing professional staff development (Standard 2.III.G) and have policies and procedures in place to transfer patients to a hospital in the event of an emergency or unplanned outcome (Standard 4.G). In addition to these Standards, 99% of organizations were rated FC with the following "Elements" within specific Standards:

- Patients are treated with respect, informed about their diagnosis, share in treatment decisions, given opportunity to change providers, and notified of the

grievance process. Patients are also made aware of interpretation services (Standards 1.A.2-4; 1.B.1, 1.B.3)

- Patients are notified of their responsibility to provide accurate information about their health, including any medications taken, and follow agreed-upon treatment plans (Standards 1.C.1-2). Patients are also informed about the services provided and the credentials of health care professionals (Standards 1.D.1 and 1.D.5)
- Health care professionals are trained in emergency equipment (Standard 10.I.C.1.a) and have direct access to current drug information (Standard 11.D.4). Organizations also have written policies on the need for anesthesia support (Standard 10.I.D.2)
- Organizations state their mission, goals, and objectives; review all legal and ethical matters; establish policies on the rights and responsibilities of patients; have independent credentialing and privileging processes; provide ongoing professional development and improvement of staff; provide staff with standard operating procedures; and have policies to ensure efficient management of the organization. (Standards 2.I.B.1, 2.I.B.7, 2.I.C.3, 2.II.A.6, 2.III.G.1-2, 3.A.2.a, and 3.A.5-8)
- Patients receive appropriate care and timely consultations/referrals, and are informed of diagnosis, treatment, and preventive measures (Standards 4.D.2.a-b., 4.D.5-6 and 4.F.1)
- Organizations manage risk by identifying the purpose of their QI program; documenting policies on coverage after normal working hours; conducting periodic review of all litigation, patient complaints/grievances and clinical records policies; and reviewing and acting upon adverse incidents (Standards 5.I.A.4, 5.II.B.3-4, 5.II.B.6, 5.II.E.1-2, 5.II.E.4)
- Clinical records are easily accessible to authorized personnel and consistently include patient's name, date-of-birth, gender, responsible party, and purpose of visit (Standards 6.C.3-4, 6.E.1, 6.E.3-5 & 6.F.3)
- Organizations ensure patient comfort and safety by prohibiting smoking in their facilities; making reasonable accommodations for disabled individuals; having a safe evacuation plan for emergencies; and having resuscitation equipment available which includes oxygen and emergency drugs and supplies (Standards 8.E.3-4, 8.H.2, 9.F.1 and 9.F.4)

## B. MDS High Compliance Standards

Similarly, MDS AAAHC-accredited organizations are legally constituted and conduct periodic review of all litigation (Standards 2.I.C.1 and 5.II.C.5); have staff that practice professionally and ethically (Standard 4.B) treat their patients with respect (Standard 1.A); inform patients of fee, payment, and grievance processes (Standards 1.D.2, 1.I.5-6); investigate all grievances (Standard 1.M.5); and have policies and procedures in place to transfer patients to a hospital in the event of an emergency or unplanned outcome. (Standards 2.I.J.1 & 2.I.K.1). Organizations also:

- Provide up-to-date clinical, educational, and research information, and continuing education opportunities for personnel and patient education. (Standard 2.I.H.17, 2.III.I, 2.III.I.1-1.2)
- Employ methods to ensure the orderly flow of information within the organization, define functional relationships among administration, nursing, and other areas, and ensure nursing needs of all patients are met (Standard 3.I.B.6, 3.II.A.2 and 3.II.B.1)
- Designate a person to be in charge of clinical records (Standard 6.C)
- Ensure clinical records are easily accessible to authorized personnel and consistently include responsible party (Standard 6.D.5 and 6.P)
- Provide appropriate education to operators of newly-acquired devices or products to be used in patient care (Standards 7.II.Q-Q.2)
- Comply with state and local building codes and regulations (Standard 8.I.A.1)

- Ensure patient safety by having: resuscitation equipment available which includes a device that can administer at least 90% oxygen (Standard 9.H.2); a physician or dentist present or immediately available by telephone when patients are present in the facility (Standard 10.I.L.2); a provision for isolation or immediate transfer of patient with a communicable disease (Standard 10.O.1); administration of blood and blood products performed by only physicians or registered nurses (Standard 10.I.P & 10.I.P.1); identification of the intended procedure and the correct site during the pre-procedure timeout (Standard 10.I.T.2-3); direct access to current drug information (Standard 11.L); and pathology and medical laboratory services directed by a qualified physician (Standard 12.D) and laboratory tests performed in a timely manner (Standard 12.B.1)

### *Did you know?*

The Advanced Orthopaedic Certification program is a specialty program focused on patient outcomes and built on accreditation requirements. Learn more at [aaahc.org/certification](https://aaahc.org/certification)



Achieve a higher level of recognition

Strengthen the care you deliver with Advanced Orthopaedic Certification

Total Joint Replacement / Complex Spine

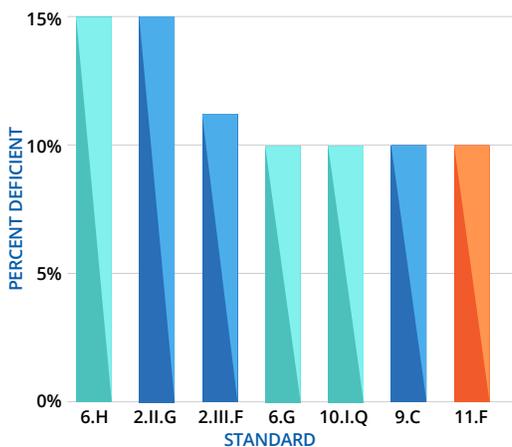
[aaahc.org/certification](https://aaahc.org/certification)

The image is a promotional graphic for AAAHC's Advanced Orthopaedic Certification. It features the AAAHC logo (a blue triangle with a white 'A' inside) and the text 'ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE'. To the right, it says 'quality every day 1095 STRONG' with a red diagonal line. The background is a teal-to-white gradient with a photo of a doctor in a white coat looking at a tablet. The text 'Achieve a higher level of recognition' and 'Strengthen the care you deliver with Advanced Orthopaedic Certification' is overlaid in white. At the bottom, it lists 'Total Joint Replacement / Complex Spine' and the website 'aaahc.org/certification'.

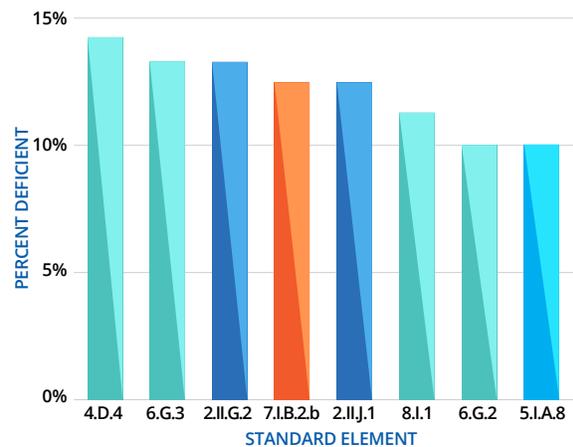
# IV. High Deficiency Standards - 2018 AAAHC non-Medicare Deemed Status (MDS) Surveys

The following findings are for the 1,016 organizations surveyed under the current AAAHC non-MDS Standards. These include Standards rated as less than substantially compliant (SC) 10% or more of the time, as a percent of all ratings for the Standard.

## Common Standard Deficiencies— Current AAAHC non-MDS Standards



## Common Element Deficiencies— Current AAAHC non-MDS Standards



These overall results are consistent with findings from previous years, including deficiencies related to: credentialing and privileging, documentation, quality improvement, and patient safety/safe injection practices. However, overall, non-MDS organizations are demonstrating improvement with conducting quality improvement studies (5.I.C) including re-measurement (5.I.C.8); conducting scenario-based drills (8.I.1); and reducing the risk of health care-acquired infection through

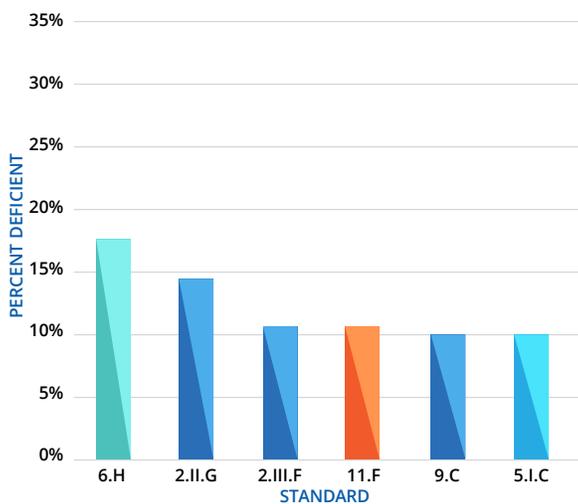
an infection prevention and control program that requires adherence to CDC or other nationally recognized safe injection practices guidelines. (7.I.B.2.b). Please note that because 733 of the 1,016 organizations included are ASCs, these organization types are over-represented in the overall results. Details on the deficiencies found in each of the topic areas in the preceding graph, as well as additional deficiencies found in specific settings, are discussed in the next section.

# V. Common Findings in Surgical/Procedural Settings & Primary Care

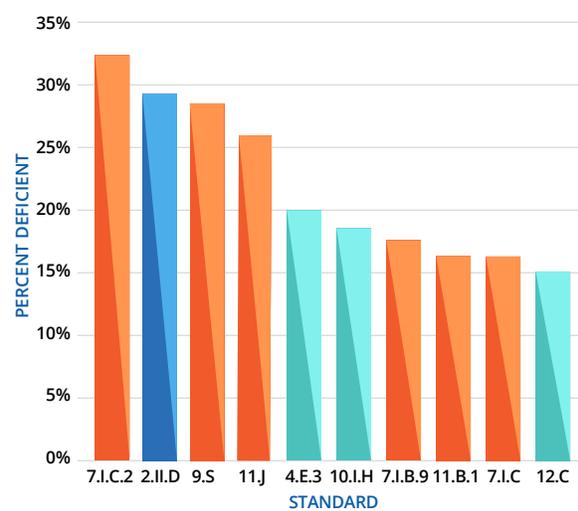
The graphs below represent AAAHC Standard deficiencies of 10% or greater for organizations surveyed under the current non-MDS AAAHC Standards Handbook and 15% or greater for organizations surveyed under the current MDS AAAHC Standards Handbook. The graphs below and on the next page are findings for the 733 non-MDS ASCs, 283

MDS ASCs, and 117 OBS organizations surveyed under the current AAAHC Standards. The graphs on the next page display findings from the 131 Primary Care organizations surveyed under the current AAAHC Standards and Student Health which represents 65 of the 131 Primary Care organizations.

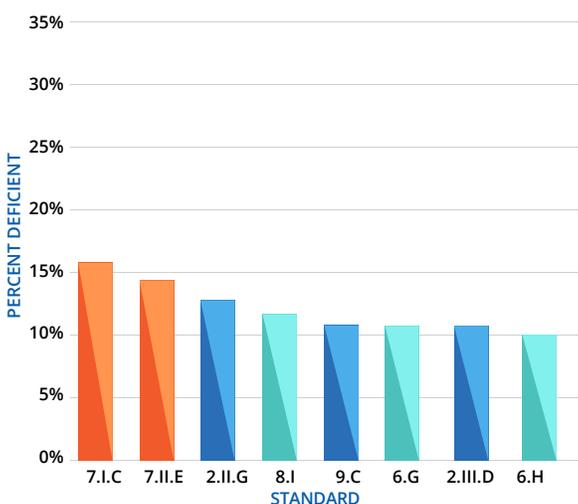
## Non-MDS ASC



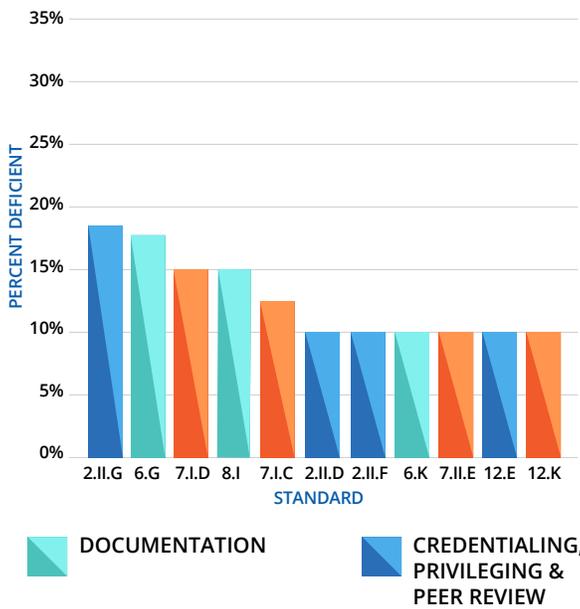
## MDS ASC



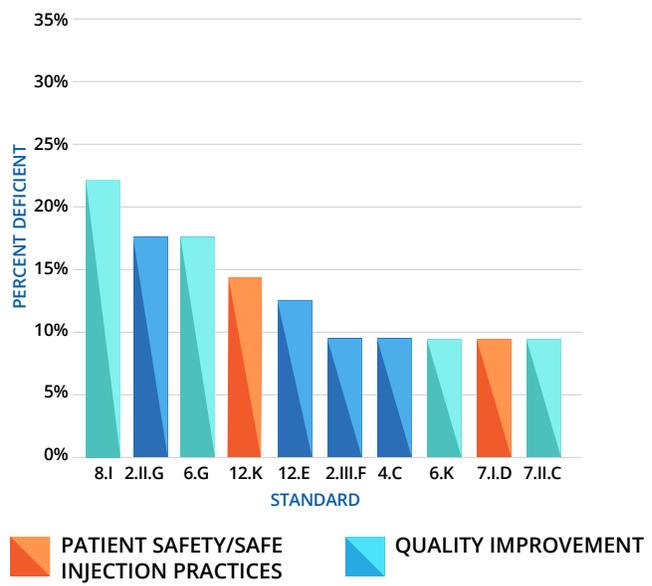
## Office-Based Surgery (OBS)



## Primary Care



## Student Health



**Did you know?**  
 AAAHC offers benchmarking studies which can help you identify your performance goals for quality improvement. Learn more at [aaahc.org/quality/benchmarking-studies/](https://aaahc.org/quality/benchmarking-studies/)

**AAAHC**  
 ACCREDITATION ASSOCIATION  
 for AMBULATORY HEALTH CARE

**AAAHC Institute  
 Benchmarking Studies**  
 Add value to your quality improvement efforts

Identify gaps by comparing your processes and outcomes to similar organizations  
 Strengthen your own quality improvement studies while fulfilling AAAHC Standards

## 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 and/or similar privileges 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

Non-MDS	
2.II.D	Upon receipt of a completed and signed initial application, primary or secondary source verification of credentials is conducted in accordance with the organization's written procedures for credentialing.
2.II.F	Upon receipt of the completed reappointment application, primary or secondary source verification of items listed in Standards 2.II.B.3-6 is conducted.
2.II.G	The governing body approves appointment and reappointment decisions.
2.III.D	Ongoing monitoring of important aspects of the care provided by physicians, dentists, and other health care professionals is conducted.
2.III.F	The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in Chapter 2.II.
4.C	All personnel assisting in the provision of health care services are appropriately qualified and supervised and are available in sufficient numbers for the care provided.

9.C	Anesthesia services are appropriately supervised.
12.E	Laboratory services are conducted by qualified personnel.
MDS	
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 personnel. [416.45(a)]

### Intent of Standards

The purpose of the above Standards is to ensure that during the appointment and reappointment processes, health care professionals identified by the governing body are qualified to provide services offered by the organization and those services are appropriately staffed and supervised. 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 licensure, 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.

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.

## Surveyor Findings and Hints for Compliance

Surveyor comments (*italicized*) associated with deficiencies and recommendations to increase compliance are summarized below. See section X for resources on these topics.

### Credentialing

- *Credentialing files did not contain written requests or approvals for specific procedure*
- *There is no, incomplete/missing, inconsistent, or outdated evidence of primary or secondary source verification/ documentation (such as the applicant's license, DEA, NPDB, BCLS/ACLS/PALS, and education)*

### Recommendations for Compliance

- + Keep explicit written procedures for requests and approvals and follow these consistently. This includes ensuring credential files document who is privileged to provide anesthesia and who is privileged to supervise others who provide anesthesia services
- + Do not exclude contract and allied health providers
- + Keep up-to-date on time-sensitive information (e.g., state license, DEA registration, medical liability coverage) by reviewing at a minimum at expiration, appointment, and re-appointment

### Privileging

- *There was no written procedure for applying for and obtaining staff privileges*
- *Privileges granted for procedures were outside the scope of the center's procedures*
- *Privileges granted to perform procedures were not available as part of the provider's scope or from a category not requested*
- *Allied health or contracted providers were not granted privileges or there are inconsistent privileges to supervise these providers*
- *Temporary privileges were granted for an extended time period (usually greater than 6 months)*
- *Length of privileges granted misalign with appointment period*

### Recommendations for Compliance

- + When services are added, or when services are no longer provided, review and edit privileging forms to

reflect these changes. Organizations should also update privileging forms if privileges change for the provider

- + An organization can only privilege its providers for procedures approved by the governing body and that the facility is equipped to safely perform
- + Supporting documents should include: the organization's privileging form and approved privilege list
- + An organization may not rely on another organization to grant privileges to its provider staff
- + Documentation of initial privileging and reappointment must include a specific time period for which the privileges are granted. This documentation should be date specific and must also include which privileges are requested and which privileges are granted
- + Ensure the documentation of specific privileges (e.g., anesthesia, fluoroscopy, laser, and supervision)
- + Communicate to staff the privileges granted to providers

### Peer Review

- *Peer references not present in provider's initial credentialing file*
- *There were no peer review processes for monitoring clinical incidents (e.g., infection rates, complication rates) or quality data collection in general*
- *Peer review was not conducted for allied health or contracted providers*
- *Peer review information was not used by governing body approval for credentialing or reappointment*

### Recommendations for Compliance

- + 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
- + The peer review process should be an ongoing review of all providers and should not be limited to incident-based review
- + Privileged health care providers participate in the development of peer review criteria
- + The results of peer review must be part of the credentialing process, communicated to the governing body, and incorporated into the QI program

## Adequate Staffing and Training

- *Inadequate staffing to meet patient needs – many unfilled allied health provider positions*
- *No documented competency for allied health providers*
- *Lack of annual competency testing for specific competencies: glucometer calibration, urine pregnancy, blood hemoglobin, and glucose testing.*

### Recommendations for Compliance

- + To demonstrate annual competency testing on waived testing, the organization can provide annual testing on unknowns for each waived test that all personnel participate in. These can be graphed to ensure accuracy.
- + Keep annual competency testing with the other annual competencies done by the organization and ensure that new staff are also tested.

## B. Documentation

Includes: allergies, emergency drills, medication reconciliation, test results and referral follow-up

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 facilitates quality patient care and is the surveyor's primary source of confirmation that the requirement is being met.

### Standards

Non-MDS	
6.G	The presence or absence of allergies, sensitivities, and other reactions to drugs, materials, food, and environmental factors is recorded in a prominent and consistently defined location in all clinical records.

6.H	Reports, histories and physicals, progress notes, and other patient information, such as laboratory reports, x-ray readings, operative reports, and consultations, are reviewed and incorporated into the record, as required by the organization's policies.
6.K	Clinical records demonstrate that the organization ensures continuity of care for its patients.
7.II.C	Personnel trained in basic life support (BLS) and the use of cardiac and all other emergency equipment and supplies are present in the facility when patients are present.
8.I	Scenario-based drills of the internal and external emergency and disaster preparedness plan are conducted.
MDS	
4.E.3	The organization facilitates the provision of high-quality health care by: (3) Performing medication reconciliation.
10.I.H	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.
12.C	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.

### Intent of the Standards

The purpose of documentation-related Standards is to ensure patient safety and quality of care, especially as it relates to continuity of care, emergency preparedness, 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 the organization become involved in litigation.

### Surveyor Findings and Hints for Compliance

Surveyor comments (*italicized*) associated with deficiencies and recommendations to increase compliance are summarized below. See section X for resources on these topics.

## Medication Reconciliation

- Medication reconciliation performed sporadically
- No newly prescribed medications listed
- No discontinuation of medications recorded and/or included in patient instructions
- 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 form provided to the patient upon discharge or no documentation or documentation was inconsistent with patient discharge instructions

### Recommendations for Compliance

- + Determine one consistent method for documenting medications and incorporate into organization's policies, procedures, and staff training. For example, make documentation of medication reconciliation required fields in EHR system.
- + Include supporting documents, completed AAAHC Medication Reconciliation toolkit forms

## Emergency Drills

- No documentation that required number of drills conducted
- CPR drills not scenario-based and/or missing or expired BLS or CPR certification
- Drills not regularly evaluated, or evaluations were very short/missing
- Inconsistent documentation of non-CPR drills
- Only fire drill was scenario-based
- No drill conducted in the second quarter
- Create template form/checklist for drills that includes: who is participating, a description of the scenario, an evaluation of the drill, and steps to improve

### Recommendations for Compliance

- + Have an impartial party view drills while they are being performed and conduct an evaluation
- + Include supporting documents: completed AAAHC Emergency Drill toolkit forms

## Allergy Documentation

- Allergies, sensitivities, and reactions not consistently updated at every visit
- Allergy stickers on the paper charts not dated
- Missing sensitivities/allergies to products/materials (e.g., environmental factors, food)
- Allergies are documented but no specific reaction information recorded
- Inconsistent allergic reaction documentation (e.g., nurse's note and anesthesia record did not match)

### Recommendations for Compliance

- + Determine one consistent method for documenting allergies and incorporate into policies, procedures, and staff training. For example, make documentation of allergies required fields in EHR system.
- + Have a specific place to record the reaction next to the listing of allergies
- + Train staff on all allergy documentation requirements

## Clinical Records

- No Health & Physical (H&P)
- Incomplete H&P (i.e., no listing of diagnosis, impression, medications, care plan, past medical history)
- No update to H&P on day of procedure
- Inconsistent dating prior to placing record and attestation of review by the physician
- Missing radiograph to confirm extraction
- Labs, EKGs, etc. not consistently signed off by ordering physician or qualified designee
- Operative report not signed by operating surgeon
- No documentation of ER transfer follow-up
- No discharge summaries included

### Recommendations for Compliance

- + Conduct chart audits to ensure complete clinical record documentation. When clinical records are incomplete, consider using to establish a QI study goal or peer review criteria.

## C. Quality Improvement (QI)

Part of being a high-performing and accreditable organization is involvement in continuous quality improvement. A well-organized QI program and effective quality improvement studies are key elements.

### Standards

Non-MDS	
5.I.C	The organization demonstrates that continuous improvement is occurring by conducting quality improvement studies when the data collection processes described in Standard 5.I.B indicate that improvement is or may be warranted.

### Intent of the Standard

The purpose of this Standard is to ensure steps are taken to correct/improve performance when improvement is needed. Organizations should be 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. Once an organization determines a QI study is warranted, the organization 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 and Hints for Compliance

Surveyor comments (*italicized*) associated with deficiencies and recommendations to increase compliance are summarized below. See section X for resources on performance measurement and benchmarking.

- *Excessive or sole reliance on quality activity versus a quality improvement study*
- *No completed studies*
- *Unclear (not quantified) goals*
- *No evidence of data collection and, therefore, no comparison to goal possible*
- *No clearly identified corrective actions or re-measurement*
- *Corrective action was not pertinent to the issue examined in the study*
- *Re-measurement after the corrective action differed from initial measurement*
- *Results of study not reported to governing body or discussed with staff*

### Recommendations for Compliance

- + Use QI worksheets in AAAHC Handbook as a guide to develop QI studies and to review completed QI studies
- + Examine internal and external benchmarking activity results for outliers and use to develop QI studies
- + Review performance-related data on an ongoing basis (Standard 5.I.B) to identify trends or specific incidents that present opportunities for improvement
- + 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.



## D. Infection Prevention/Safe Injection Practices

Deficiencies with infection prevention and safe injection practices Standards 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

Non-MDS	
7.I.C	The infection prevention and control program is under the direction of a designated and qualified health care professional with training and current competence in infection prevention and control.
7.I.D	Safe processes are used for the cleaning, decontamination, high-level disinfection, and sterilization of instruments, equipment, supplies, and implants.
7.II.E	All products, including medications, reagents, solutions, and supplies that have a manufacturer's printed expiration date are monitored and disposed of in compliance with facility policy and manufacturers' guidelines.
11.F	Procedures are in place to prevent errors from look-alike, sound-alike and high-alert medications, if present.
12.K	Sufficient space, equipment, and supplies are provided to perform the volume of work with optimal accuracy, precision, efficiency, and safety.
MDS	
7.I.B.9	The written infection prevention and control program is: [416.51(b)] (9) The result of a formal, documented infection prevention risk assessment to ensure that the program is relevant to the organization.
7.1.C/ 7.I.C.2	The infection control and prevention 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.

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.B.1	Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws. [416.48(a)] (1) Drugs are prepared and administered according to established policies and acceptable standards of practice. [416.48(a)]
11.J	The organization must have policies in place for safe use of injectables and single-use syringes and needles that at minimum include the CDC or comparable guidelines for safe injection practices. [416.51(a)]

### Intent of the Standards

The purpose of these Standards is to ensure that organizations reduce the risk of infection by developing and regularly reviewing risk assessment programs, having a designated ICP provider oversee the program, training staff in all aspects of the program, having policies/procedures to prevent errors from look-alike, sound-alike and high-alert medications, and using nationally recognized guidelines to develop the organization's policies and procedures related to infection control, cleaning and disinfection, and safe injection practices.

### Infection Prevention and Control (IPC) Program

- *No evidence of IPC training or competency*
- *The governing body has not indicated the specific training and current competence required to direct the program, nor has the governing body specifically appointed individual responsible for administration*
- *IPC training is documented but no evidence of competency testing*

- *Patient specimens placed on an unprotected shelf that also contains the testing equipment, hand sanitizer, and paper towels*
- *Insufficient (or no) monitoring and documentation of cleaning, HLD and sterilization; failure to follow manufacturer's instructions for use*
- *Sterile packages missing both internal and external indicators*
- *Hinged forceps autoclaved in closed position*
- *Biological indicator testing done monthly, instead of weekly, per CDC guidelines*
- *Sterilized instruments found near dirty sink*
- *Missing processing date of sterilized packs*

### **Recommendations for Compliance**

- + Review policies on infection control and prevention to ensure they are up-to-date, provide for clean laboratory and storage space, and are being followed
- + IPC training and competency testing should occur at hire, and at least annually, or when guidelines or manufacturers' instructions change
- + Ensure new and existing staff (including providers) receive infection prevention training at regular intervals, including as national guidelines change and with sufficient frequency for reinforcement
- + Ensure compliance with OSHA regulations for bloodborne pathogens

### **Risk Assessment**

- *No formal infection control risk assessment completed*
- *No active surveillance of hand hygiene*
- *Reliance on self-reported post-op infections; no active surveillance process*

### **Recommendations for Compliance**

- + Observe hand hygiene frequently using different staff as observers (similar to "secret shoppers") to get accurate data.
- + Implement an active infection risk assessment and surveillance process.

### **Adequate Space, Equipment, and Supplies**

- *Patient specimens placed on an unprotected shelf that also contains the testing equipment, hand sanitizer, and paper towels*
- *Urine pregnancy test kits in use had expired*
- *The area for the laboratory is small and there is no room for patients to sit for blood draws*
- *Very small laboratory and storage space; biohazardous waste for disposal, lab pick-up boxes and dirty laundry stored in the dirty area of the lab*
- *Single patient glucometer used on multiple patients*
- *Laboratory refrigerator does not have a device to support continuous temperature monitoring*

### **Recommendations for Compliance**

- + Have separate clean and dirty areas.
- + Lab specimens should be sealed and monitored so that they are not compromised by uncontrolled temperatures, waste, soiled laundry, etc., and do not compromise clean equipment and products.

### **Safe Injection Practices (SIP)**

- *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*
- *Redrawing medication with a used needle and syringe*
- *Single-use eye drops used on multiple patients*
- *IV hub not sterilized each time anesthesia administered*
- *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 lists developed for look-alike/sound-alike or high alert medications
- A list of look-alike/sound-alike medications exists, however, individual medications not labeled for ease of identification
- Look-alike/sound-alike and high alert lists are available and posted in the pharmacy but not in the other locations where medications are stored such as the nursing station and emergency cart

**Recommendations for Compliance**

- + Observe and enforce safe injection practice guidelines especially with multi-dose vial storage/administration and syringe labeling in the procedure room or other patient care areas
- + Use AAAHC Safe Injections Practices toolkit risk assessment form
- + Instate a sharps policy for compliance and provide sufficient sharps containers, which are monitored and emptied so that they do not overflow

**Instrument/Equipment Reprocessing**

- Insufficient (or no) monitoring and documentation of cleaning, HLD and sterilization; failure to follow manufacturer's instructions for use
- Sterile packages missing both internal and external indicators

- Missing processing date of sterilized packs
- Sterilized instruments found near dirty sink
- Biological indicator testing done monthly, instead of weekly, per CDC guidelines
- Precleaning activities not complete, for example: hinged forceps autoclaved in closed position

**Recommendations for Compliance**

- + Observe equipment and instrument cleaning, HLD and/or sterilization, and appropriate record keeping.
- + Perform competency testing on hire and at least annually or when equipment, guidelines, and/or manufacturers' instructions change
- + 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 X for resources on safe injection practices and medication reconciliation.

**Did you know?**

The AAAHC philosophy—*1095 Strong, quality every day*—provides ongoing engagement throughout the three-year accreditation cycle by means of valuable and meaningful tools, resources, and education that continually improve the quality of care.

Learn more at [aaahc.org/education/1095-learn/](http://aaahc.org/education/1095-learn/)



quality every day  
**1095 STRONG**

Strengthen your commitment to patient safety & continuous quality improvement

Adherence to rigorous standards of care and safety will help to ensure you deliver quality every day — 1,095 days of your accreditation cycle



Ongoing Engagement / Excellence & Relevance / Accelerated Readiness / Accountability / Surveyor Expertise

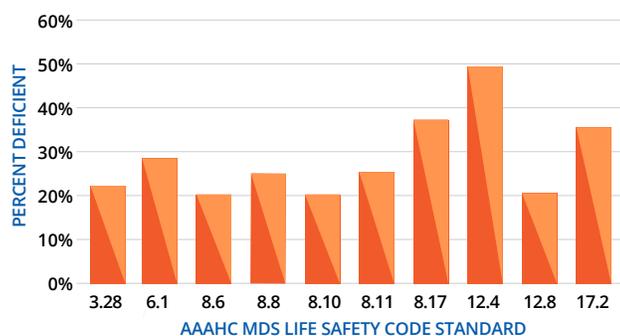
[aaahc.org](http://aaahc.org)

# VI. Additional Deficiency Findings: MDS ASC Life Safety Code Standards

This Life Safety Code® (LSC) Survey, which is part of the Medicare Deemed Status Survey, assesses facility compliance with structural and operational requirements. 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 graph below represents deficiencies greater than or equal to 20% found in the 283 MDS ASC surveys conducted.

## Medicare Deemed Status (MDS) Life Safety Code Standards: Percent Deficiency (>20%)



### Life Safety Code Standards

See the Physical Environment Checklist in the AAAHC MDS Handbook for additional information.

MDS	
3.28	Fixtures providing emergency lighting of the means of egress are inspected for physical/functional integrity and tested for a period of at least 30 seconds every month (at 3 to 5 week intervals). Battery-powered (alternate source) systems and/or fixtures are tested annually for a minimum duration of 90 minutes. Equipment failing any required inspection or test is repaired or replaced immediately. Written records of inspections, tests and maintenance are kept on-site.
6.1	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).

8.6	<p>Electrical receptacles comply with the following:</p> <ul style="list-style-type: none"> <li>• All receptacles provide at least one, separate and dependable grounding pole.</li> <li>• All receptacles at all patient care positions are listed "hospital grade."</li> <li>• Each patient position in general care areas is provided with at least 8 receptacles.</li> <li>• Each patient position in critical care areas is provided with at least 14 receptacles.</li> <li>• Each patient position in operating rooms is provided with at least 36 receptacles.</li> <li>• Receptacles located in rooms for pediatric use or access are listed as tamper-resistant or are provided with a listed tamper-resistant cover.</li> <li>• Laboratories are provided with at least one duplex receptacle every 3.3 ft. of instrument usage area.</li> </ul>
8.8	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.
8.10	<p>Self-contained rechargeable-battery-powered lights comply with the following:</p> <ul style="list-style-type: none"> <li>• The control and battery charging functions of the unit (fixture) are wired to the branch serving general lighting in the space.</li> <li>• The unit's battery capacity provides lighting for 90 minutes or more during normal power loss.</li> <li>• The units are tested monthly for thirty seconds and annually for 90 minutes.</li> </ul>

8.11	<p>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).</p>
8.17	<p>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:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• EPS equipment and separate Stored Emergency Power Supply System (SEPSS) equipment may occupy the same interior space.</li> <li>• 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.</li> <li>• 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.</li> </ul>

8.17 (cont.)	<ul style="list-style-type: none"> <li>• The EPS is heated as necessary to maintain water jacket temperatures specified by the manufacturer.</li> <li>• Interior locations of EPS equipment are provided with adequate tempered airflow to ensure the room does not exceed EPS manufacturer-specified temperature ranges when standing by or while running at rated load.</li> </ul>
12.4	<p>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:</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Where penetrations are part of an assembly rated in accordance with ASTM E 119 or ANSI/UL 263.</li> <li>• Where vertical penetrations are enclosed in shaft with fire rating equal or greater than of the floor system.</li> <li>• 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.</li> <li>• 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 8.3.5.1.1(4)</li> </ul>

12.8	<p>Doors in fire-rated construction are protected as required for the fire resistance of the barrier in which they occur, as follows:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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).</li> <li>• 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:</li> </ul>
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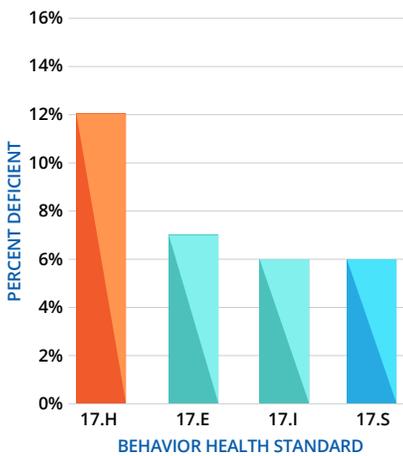
12.8 (cont.)	<ul style="list-style-type: none"> <li>• Door and door hardware function and physical integrity</li> <li>• Condition of both door faces and swing/access clearances on both sides</li> <li>• Space on both sides of the door and the finished floor surface</li> <li>• The maximum gap between the closed door and frame jambs and top and/or between the strike side edges of pairs of doors (as applicable)</li> <li>• Each door's opening force and closing speed</li> <li>• 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</li> <li>• Repairs, adjustments, and/or corrections are made without delay upon identification.</li> </ul>
17.2	<p>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.</p>

# VII. Common Deficiencies in Behavioral Health

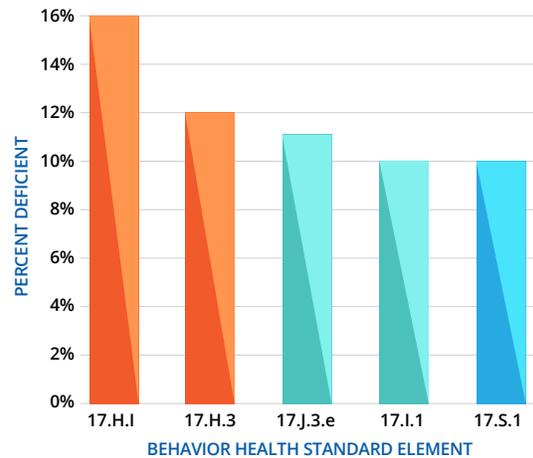
Surveyors evaluated 82 organizations under the current Behavioral Health Standards.

The highest deficiency Standards (greater than 5%) were the following:

Behavioral Health Standard  
Percent Deficiency (>5%)



Behavioral Health Standard Elements  
Percent Deficiency (≥10%)



 DOCUMENTATION

 PATIENT ENGAGEMENT

 QUALITY IMPROVEMENT

## Standards

Non-MDS	
17.E	In-service training and professional development opportunities are provided for professional staff, at minimum, at time of hire and annually thereafter.
17.H 17.H.1 17.H.3	Behavioral health treatment plans are client-centered. As documented in clinical records, the treatment plan: 1. Includes goals of treatment and specific objectives that are achievable, measurable, time-specific and appropriate based on the needs of the client. 3. Is developed with the participation of the client, and there is documented evidence of the client's participation.
17.I 17.I.1	The informed consent of the client is obtained. 1. A written and signed consent form is present in the clinical record at the start of treatment.

17.J.3.e	Clinical records reflect the provision of behavioral health services. 3. The clinical record is periodically updated with documentation related to the assessment and management of: e. Progress on client-centered measurable goals and objectives.
17.S 17.S.1	The behavioral health service actively participates in the organization's peer review, quality improvement, and risk management programs. 1. Written policies are in place for staff input and participation in quality improvement activities.

## Intent of Standards

The purpose of these Standards is to ensure that the services provided are designed to improve and enhance the emotional, mental, and behavioral health of the organization's targeted client population. Services may include but are not limited to counseling or psychotherapy, psychiatry and psychotropic medication evaluation and management, crisis intervention and emergency services, consultation, and outreach, prevention and referral services. These Standards are applicable if any licensed or certified behavioral health clinicians are providing services. This includes: psychiatrists, psychologists, licensed professional counselors, licensed social workers, licensed family and marital therapists, certified addiction counselors or any other certified or licensed behavioral health provider.

## Surveyor Findings and Hints for Compliance

Surveyor comments (*italicized*) associated with deficiencies and recommendations to increase compliance are summarized below.

- *No, missing, or inconsistent documentation of training for:*
  - *staff cultural competency*
  - *mandatory reporting policies*
  - *suicide identification, prevention and treatment*
- *Treatment plans did not contain:*
  - *measurable goals*
  - *evidence of client participation*
- *Missing or unsigned informed consent form*
- *No evidence of staff input and participation in quality improvement activities*

## Recommendations for Compliance

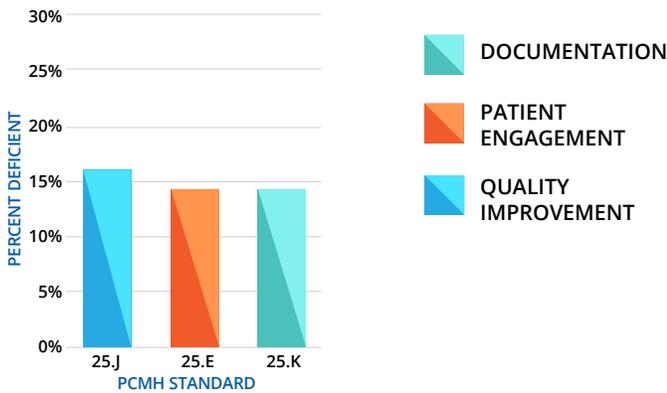
- + Implement staff training that includes cultural competency, mandatory reporting requirements, and suicide prevention and treatment. The training should occur for new hires and annually thereafter or sooner if new information becomes available.
- + Educate patients on expectations regarding involvement in their own care, including their treatment plan and provide reminders to document this at each visit.
- + See section "Quality Improvement" (p. 15) for information on conducting QI studies including tips for developing S.M.A.R.T. goals.

# VIII. Common Deficiencies in Patient Centered Medical Home (PCMH)

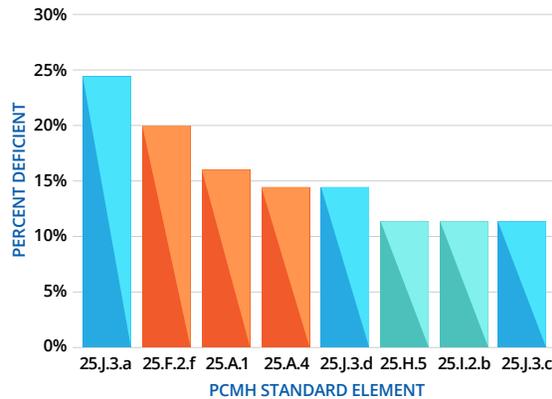
Surveyors evaluated 49 organizations under the current Patient Centered Medical Home Standards (AAAHC Accreditation Handbook Chapter 25).

The highest deficiency Standards (greater than 10%) were the following:

Patient Centered Medical Home  
Percent Standard Deficiency (>10%)



Patient Centered Medical Home  
Percent Standard Element Deficiency (>10%)



## Standards and Elements

Non-MDS	
25.A.1 25.A.4	The Medical Home establishes relationships with its patients. Observation, interviews, and/or document reviews confirm the following: 1. Patients are provided with information and explanation regarding the Medical Home approach to care. 4. The Medical Home provides services within a team framework, and the “team” provider concept has been conveyed to the patient.
25.E	Patients are provided with information regarding how to obtain medical care at any time, 24 hours per day, every day of the year.
25.F.2.f	The Medical Home provides comprehensive care. 2. The Medical Home scope of service includes, but is not limited to: f. Counseling regarding end-of-life or palliative care, as appropriate.
25.H.5	The Medical Home ensures continuity of care for its patients. 5. Tracking and follow-up procedures for referrals, consultations, diagnostic studies, and missed

	appointments are followed, as evidenced in tracking logs, policies, clinical records, and/or other written formats.
25.I.2.b	The Medical Home provides high-quality patient care. 2. Clinical record documentation consistently includes b. Medication review and update including prescription, over-the-counter, and diet supplements, and if indicated, use of recreational drugs and substances.
25.J 25.J.3.a 25.J.3.c 25.J.3.d	The Medical Home assesses and continuously improves services provided. The quality improvement program includes at least one quality improvement study every three years on each of the following topics: a. Patient/provider relationship. c. comprehensiveness of care. d. Continuity of care.
25.K	There is evidence that electronic data management is continually assessed as a tool for facilitating achievement of the Medical Home Standards.

## 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.

## Surveyor Findings and Hints for Compliance

Surveyor comments (*italicized*) associated with deficiencies and recommendations to increase compliance (cross bullets) are summarized below. See section X for resources on care coordination.

- *Patients have not been provided:*
  - *an explanation/information of PCMH “team” framework*
  - *sufficient information on “Medical Home”*
- *No on-call coverage nor coordination of care instructions for patients during after-hours*
- *Lack of documentation on:*
  - *follow-up from referrals*
  - *transition of care through various life stages*
  - *end-of-life discussions*
- *No or missing medication review/reconciliation documentation in clinical record for each visit*
- *No quality improvement studies on comprehensiveness of care, continuity of care, or patient/provider relationship*

## Recommendations for Compliance

- + Educate PCMH patients on expectations regarding involvement in their own care, including providing reminders at each visit.
- + Make discussion of end-of-life a required EMR field or put in a chart reminder.
- + Include questions on patient perception of patient/provider relationship and thoroughness of care including notification of test results and ease of referral process 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.
- + Quality improvement studies on coordination of care may include questions on the frequency of medication reconciliation (i.e., whether it is performed at every visit), whether there are end-of-life discussions, and what patients do when the organization is closed.

## IX. Glossary of Terms

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

## X. Resources for Improvement

You can use the following resources to help your organization comply with AAAHC Standards. Order or register at [www.aaahc.org](http://www.aaahc.org).

### Guidance for Addressing High-Deficiency Themes

#### Safe Injection Practices

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.

AAAHC offers several Safe Injection Practices resources, including:

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

#### 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
- Care Coordination
- Credentialing & Privileging
- Emergency Drills
- Medication Reconciliation
- Peer Review & Benchmarking
- Safe Injection Practices

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.

#### eLearning

AAAHC has also launched **1095 Learn**, its learning management system (LMS) serving AAAHC-accredited organizations. The LMS provides online educational resources and registration for *Achieving Accreditation* which support ongoing quality improvement. To access AAAHC eLearning modules, webinars, and workshops go to:

[learn.aaahc.org](http://learn.aaahc.org)

#### 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:

[www.aaahc.org/quality/benchmarking-studies/](http://www.aaahc.org/quality/benchmarking-studies/)

#### Achieving Accreditation

There is also a newly revamped Quality Improvement educational session at *Achieving Accreditation* conferences. 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:

[www.aaahc.org/education/seminar-achieving-accreditation/](http://www.aaahc.org/education/seminar-achieving-accreditation/)

If your organization is AAAHC accredited and has conducted an exemplary QI study, consider applying for the annual *Bernard A. Kershner Innovations in Quality Improvement Award Program*. Please visit the AAAHC website [www.aaahc.org](http://www.aaahc.org), choose "Quality," and "The Kershner – a QI Award," to learn more about applying, award criteria, poster presentations, and the Expert and People's Choice awards.



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