2020 AAAHC Quality Roadmap

A report on accreditation survey results
Dear Colleagues,

The AAAHC Quality Roadmap provides a thorough analysis of data from more than 1,480 surveys conducted using the 2018 Standards (which were applied in 2019). 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 several focus areas for improvement that warrant your attention.

Although the deficiencies are similar to previous years’ findings, a few new areas reached the 10% threshold. Of particular note, given the current pandemic, are additional high deficiencies related to infection prevention/safe injection practices and emergency preparedness. Health care organizations should heighten focus on infectious disease protocols and emergency plans, including preparing for disasters and treating patients with COVID-19. Additionally, we continue to see that facilities have challenges with quality improvement studies, credentialing and privileging, and documentation management. Consistent with AAAHC Standards of compliance, all organizations across all settings should remain vigilant about practices that impact employee and patient safety and the quality of care delivered. This has never been more important.

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 2019 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 every day, throughout the 1095 days of your accreditation term.

Sincerely,

Noel M. Adachi, MBA
President and CEO
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I. Get the Most Value From This Report

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 ensure 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

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/
II. Data Description

This report is based on an analysis of surveyors’ ratings of compliance with 2018 AAAHC Standards during onsite surveys (January 1 – December 31, 2019) 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.

Results of surveys for organizations seeking accreditation through the AAAHC Health Plan or Federal Employee Health Benefits programs are not included. This report also does not include intracycle surveys. Often, these are focused surveys that do not include all core Standards (Chapters 1-8 of the Accreditation Handbook).

The data represent 1,488 complete surveys including a wide distribution of organizational types including: 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, diagnostic imaging centers, fertility centers, office based anesthesia organizations, and medical group practices.

Under the 2018 AAAHC Standards (which were applied in 2019) 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 then automatically calculated based on the number of “Yes” ratings and the total number of “Elements” within a Standard. 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. 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.
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.

**For organizations surveyed under the non-MDS Standards, these key areas included:**

- Supporting ongoing professional development and improvement of staff performance
- Assisting patients with the transfer of their care from one health care professional to another
- Providing appropriate education to intended operators of newly acquired devices or products to be used in the care of patients
- Maintaining strict confidentiality on any record that contains clinical, social, financial, or other data about a patient, except when otherwise required by law
- Ensuring pharmaceutical services are directed by a qualified licensed provider

**For organizations surveyed under the MDS Standards, key areas of improvement in which there was 100% compliance included:**

- Implementing preventive strategies throughout the facility targeting adverse patient events and ensuring that all staff are familiar with these strategies
- Improving the professional competence and skill as well as the quality of performance of health care professionals and professional personnel
- Providing convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization
- Encouraging health care professionals to participate in educational programs and activities, as demonstrated in the organization’s policies or procedures
- Ensuring that concern for the cost of care is present throughout the organization

### A. Non-MDS High Compliance Standards

In addition to the improvements noted, 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, and are informed of their responsibility to follow the agreed upon treatment plans. Patients are also informed about services, fees, payment policies and credentials of health care professionals. (Standards 1.A.2-4; 1.C.2, 1.D.1, 1.D.1.3-5)
- Organizations state their mission, goals, and objectives; review all legal and ethical matters; ensure that official organizational documents are properly filed, secured, and safeguarded; have procedures to permit responses to inquiries from entities such as government agencies, attorneys, consumer advocate groups, and the media. (Standards 2.I.B.1, 2.I.B.7, 3.A.7-8)
- Organizations manage risk by documenting policies on coverage after normal working hours and conducting periodic review of all litigation. (Standards 5.II.A.4, 5.II.B.3)
- A designated person oversees clinical records and the health information system. There are written policies on the confidentiality, timely access, and release of patient records. Patients are given the opportunity
to approve or refuse release of records, except when release is permitted or required by law. Clinical records consistently include patient’s name, date of birth, gender, and responsible party. (Standards 6.A.1-2, 6.B.3, 6.B.6, 6.C.3-5, 6.D.1, 6.E.1, 6.E.3, 6.E.5)

- Organizations ensure safety by having a policy requiring the presence of BLS (basic life safety) trained and currently certified personnel when patients are present, and designating a person responsible for ensuring clinical education occurs prior to the use of any newly acquired devices or products to be used in the care of patients. (7.II.C.3, 7.II.J.2)

- Organizations ensure patient comfort and safety by having reception areas and restroom facilities that are appropriate for patient and visitor volume, prohibiting smoking in their facilities, and providing adequate lighting and ventilation in all areas. Organizations also have a comprehensive written emergency and disaster preparedness plan to address internal and external emergencies, appropriate resuscitation equipment available which includes oxygen and a device such as a self-inflating hand resuscitator bag, and a manual defibrillator or automated external defibrillator (AED). (Standards 8.E.1, 8.E.3-5, 8.H.1, 9.F.1-2, and 9.F.4)

- Organizations have written policies on the need for anesthesia support, post-procedural care, and staffing requirements to ensure that registered nurse(s) or other health care professionals assisting in the provision of surgical services are available in sufficient numbers. (Standard 10.I.D.2-4)

B. MDS High Compliance Standards

Similarly, MDS AAAHC-accredited organizations have staff that practice professionally and ethically (Standard 4.B); treat their patients with respect (Standard 1.A); conduct periodic review of all litigation (Standard 5.II.C.5); inform patients of services available and payment policies (Standards 1.I.3 and 1.I.6); 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); and have concerns for the costs of care throughout the organization (Standard 4.I).

Organizations also:

- Inform the patient or the patient’s caregiver of the patient’s right to make informed decisions regarding the patient’s care (Standard 1.L.2). Inform patients of their responsibility to be fully informed about their treatment or procedure, the expected outcome and methods for providing feedback, including complaints (Standards 1.D.3, 1.I.11). Provide convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization (Standards 2.III.I.1-2) and review all legal and ethical matters concerning the organization and its staff (Standard 2.I.H.8)

- Employ methods to ensure recordkeeping procedures are adequate to provide accounting controls over assets, liabilities, revenues, and expenses, and the orderly flow of information within the organization (Standard 3.I.B.5.a). Provide an effective program addressing bloodborne pathogen post-exposure evaluation and treatment (Standard 3.II.H.4.b)

- Clearly establish QAPI program safety expectations (Standard 5.I.B.5). Periodically review clinical records and clinical record policies (Standard 5.II.C.8). Set priorities for performance improvement activities that affect health outcomes, patient safety, and quality of care (Standard 5.II.E.3)

- Ensure clinical records contain name and date of birth (Standard 6.D.1 and 6.D.3)

- Ensure patient safety by requiring: 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); administration of blood and blood products performed by only physicians or registered nurses (Standard 10.I.P.1); and all patients are discharged in the company of a responsible adult (Standard 10.I.X.3)
IV. High Deficiency Standards - 2019 AAAHC non-Medicare Deemed Status (MDS) Surveys

The following findings are for the 1,128 organizations surveyed between January 1 – December 31, 2019 under the 2018 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

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, non-MDS organizations are demonstrating improvement with credentialing and privileging (2.II.G) including incorporating peer review into the appointment and reappointment process (2.III.F, 2.II.G.2); reviewing and incorporating H & P, labs, progress notes and other patient information into the clinical record (6.H) including the documentation of allergies and other sensitivities (6.G.3); and conducting medication reconciliation (4.D.4). Please note that because 791 of the 1,128 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 above graphs, 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 (or the top 5 deficiencies for non-MDS ASCs which include deficiencies of 9% or greater) for organizations surveyed from January 1 – December 31, 2019 under the 2018 non-MDS AAAHC Standards, and 15% or greater for organizations surveyed under the 2018 MDS AAAHC Standards. The first 3 graphs are findings for the 791 non-MDS ASCs, 360 MDS ASCs, and 138 OBS organizations surveyed under the 2018 AAAHC Standards. The last 2 graphs display findings from the 161 primary care organizations surveyed under the 2018 AAAHC Standards and student health which represents 64 of the 161 primary care organizations.

Non-MDS ASC

MDS ASC

Office Based Surgery (OBS)
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
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, and 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.

Intent of Standards

The purpose of these Standards is to confirm that during the appointment and reappointment processes, the governing body ensures that health care professionals 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 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. 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.

Standards

<table>
<thead>
<tr>
<th>Non-MDS</th>
<th>MDS</th>
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<tr>
<td>2.II.D</td>
<td>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)]</td>
</tr>
<tr>
<td>2.II.G</td>
<td>The governing body approves appointment and reappointment decisions.</td>
</tr>
<tr>
<td>2.III.D</td>
<td>Ongoing monitoring of important aspects of the care provided by physicians, dentists, and other health care professionals is conducted.</td>
</tr>
<tr>
<td>2.III.F</td>
<td>The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in Chapter 2.I.</td>
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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 are no written procedures for credentials verification
- 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 in credentialing process
+ Keep up-to-date with 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
- Reappointed providers did not complete an application
- Privileges granted for procedures were outside the scope of the center’s procedures
- Privileges granted to perform procedures were outside the provider’s education and training
- Allied health or contracted providers were not granted privileges
- Medical Director signed off on own reappointment application
- 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 review information was not used by governing body for approval for credentialing or reappointment
- Peer review was not ongoing or trended over time
- No evidence peer review was used to develop internal benchmarks
- Peer references missing 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

**Recommendations for Compliance**

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

Includes: allergies, medication reconciliation, and test 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

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<thead>
<tr>
<th>Non-MDS</th>
<th>6.G</th>
<th>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.</th>
</tr>
</thead>
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<tr>
<td></td>
<td>6.H</td>
<td>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.</td>
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<tr>
<td></td>
<td>10.I.Q</td>
<td>Patients are provided with written instructions for self-care prior to and after surgery/procedure.</td>
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</table>

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<tr>
<th>MDS</th>
<th>4.E.3</th>
<th>The organization facilitates the provision of high-quality health care by: (3) Performing medication reconciliation.</th>
</tr>
</thead>
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<tr>
<td></td>
<td>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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</table>

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 not performed or performed sporadically
- No single source medication reconciliation form used resulting in inconsistencies
- 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
- Medication reconciliation does not include any OTC and/or herbal supplements
- No discharge instructions re: the dose, strength, and frequencies of the discharge medication
- No form provided to the patient upon discharge
- 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. Or, use one consistent form for medication reconciliation that the patient receives upon discharge
- Include supporting documents: completed AAAHC Medication Reconciliation toolkit forms

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.
Allergy Documentation

— Allergies are documented but no specific reaction information recorded
— Allergies, sensitivities, and reactions not consistently updated at every visit
— Inconsistent use of “NKDA” and “NKA"
— No evidence that “NKA” designation included allergies to both drugs and other materials (e.g., environmental factors, food)
— 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

— Not following organization policy on conducting H&P within 24-hours of procedure
— No update to H&P on day of procedure
— H&P signed by provider but not date- and time-stamped
— Inconsistent dating prior to placing in record and attestation of review by the physician
— 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
— Results of referrals not in clinical record

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

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 components.

Standards

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<th>Non-MDS</th>
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<tr>
<td>5.I.A</td>
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<tr>
<td>5.I.C</td>
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<tr>
<td>5.I.D</td>
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</table>

Intent of the Standard

The purpose of these Standards is to ensure organizations have a quality improvement program that includes ongoing data collection, analysis of trends, examination of performance versus external peers (i.e., external benchmarking), and steps 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, goals are developed using external benchmarking, whenever possible, 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 performance 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.

— No annual review of QI program to ensure program’s purpose and effectiveness
— QI program does not include quality measures to be measured or tracked
— QI program does not include how QI activities will be integrated into other organization programs
— Excessive or sole reliance on quality activity (performance goals are met on initial measurement) versus a quality improvement study (including implementation of corrective action[s], re-measurement[s], meeting performance goals, and reporting to the governing body and other relevant providers/staff)
— No completed studies (see directly above)
— Unclear (not quantified) goals
— No external benchmarking
— 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 QI activities/studies not reported to governing body or shared with staff

Recommendations for Compliance

+ Develop a QI program with a clear purpose and goals, and ensure it aligns with the organization’s overall purpose and mission and is reviewed annually
+ Define the QI Program quality activities to be addressed, and how success will be measured
+ 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
+ Develop external benchmarking based on national practice guidelines, peer-review journal review, registries, other national data collection organizations (e.g., AAAHC, ACHA, GPRA, ASC QC, CDC, WHO)
+ 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 and is relevant to the services the organization provides and the patients the organization serves, 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 Standards specific to infection prevention and safe injection practices place patients at risk and are a 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

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<tr>
<th>Non-MDS</th>
<th>MDS</th>
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<tr>
<td><strong>7.I.B</strong></td>
<td><strong>7.1.C/7.1.C.2</strong></td>
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<tr>
<td>The written infection prevention and control program describes how infections and communicable diseases are prevented, identified, and managed.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>7.I.C</strong></td>
<td><strong>9.S</strong></td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
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<tr>
<td><strong>7.II.E</strong></td>
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<td>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.</td>
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<td><strong>11.F</strong></td>
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<td>Procedures are in place to prevent errors from look-alike, sound-alike and high-alert medications, if present.</td>
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<td><strong>11.B.1</strong></td>
<td></td>
</tr>
<tr>
<td>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)]</td>
<td></td>
</tr>
<tr>
<td><strong>11.J</strong></td>
<td></td>
</tr>
<tr>
<td>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)]</td>
<td></td>
</tr>
<tr>
<td><strong>11.M</strong></td>
<td></td>
</tr>
<tr>
<td>If look-alike or sound-alike medications are present, the organization identifies and maintains a current list of these medications, and actions to prevent errors are evident.</td>
<td></td>
</tr>
</tbody>
</table>

Intent of the Standards

The purpose of these Standards is to ensure that organizations reduce the risk of infection by developing and regularly reviewing infection prevention and control programs, having a designated Infection Prevention and Control (IPC) 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.

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.

Infection Prevention and Control (IPC) Program

- No evidence of IPC designee training or competency
- IPC designee training is not up to date or relevant
- The governing body has not indicated the specific training and current competence required to direct the program
- The governing body has not designated/approved a provider to oversee IPC
- IPC designee is not trained in the cleaning and sterilization of surgical instruments
- Insufficient (or no) monitoring and documentation of cleaning, HLD and sterilization; failure to follow manufacturer’s instructions for use
Recommendations for Compliance

+ IPC training and competency testing should occur at hire, and at least annually, or when guidelines or manufacturers’ instructions change
+ Devote resources to IPC designee to ensure adequate, ongoing training and competency testing
+ 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
+ Perform competency testing on hire and at least annually or when equipment, guidelines, and/or manufacturers’ instructions change
+ Implement an active infection risk assessment and surveillance process

Safe Injection Practices (SIP)

— Not following CDC, APIC, or other requirements adopted as policy for hand hygiene and safe injection practices
— Not cleaning hands after gloves are removed
— No SIP or hand hygiene training or surveillance program
— 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, OR, and PACU for future use, as opposed to keeping MDV in designated clean area away from patient care or treating the MDV as an SDV because it has been in an unclean patient care area
— Splitting of single-dose vials without required hood
— Redrawing medication with a used needle and syringe
— Single-use eye drops used on multiple patients
— Open and undated vials of insulin in refrigerator in patient treatment area
— 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 (especially propofol) and carrying them in lab coat pocket
— Not immediately using pre-drawn medication, per clinical practice guidelines or manufacturer’s instructions
— Not following organization policy on handling and disposing of expired materials
— Expired medications found on anesthesia cart, emergency cart and in the refrigerator
— The pain management cart stores a drawer full of drugs that are not separated or identified as look-alike/sound alike
— Many different local anesthetics with different names and strengths are mixed and stored all together
— No lists developed for sound-alike/look-alike or high alert medications
— A list of look-alike/sound-alike medications exists, however, individual medications not labeled for ease of identification per list/policy
— 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
+ Use tall man lettering (TML) technique (e.g., fentanyl* / SUFentanil ; epinephrine* / ePHEDrine) in list of look-alike/sound alike medications
+ Observe hand hygiene and SIP frequently using different staff as observers (similar to “secret shoppers”) to get accurate data
+ Use designated and approved expired medication disposal methods

General Hints for Compliance

+ 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.
E. Emergency Preparedness

Deficiencies with emergency preparedness Standards place patients, staff and visitors at risk in emergency situations and are a 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 in a safe environment.

Standards

<table>
<thead>
<tr>
<th>Non-MDS</th>
<th>MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.C</td>
<td>8.II.D.2</td>
</tr>
<tr>
<td>The facility is designed to provide safe exiting in an emergency.</td>
<td>The organization conducts quarterly scenario-based drills of the emergency and disaster preparedness plan. (Note: This is in addition to fire drills as required by the Life Safety Code.) [416.54(d)(2)]</td>
</tr>
</tbody>
</table>

Intent of the Standards

The purpose of these Standards is to ensure that organizations are prepared for all types of emergencies (e.g., CPR, fire, active shooter, natural disasters such as earthquakes, pandemics) and can provide safe exits for patients and staff. As part of their internal and external emergency and disaster preparedness plan, organizations should conduct scenario-based drills on a quarterly basis.

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.

**Emergency Preparedness/Drills:**

- Four drills conducted but not quarterly and not scenario-based
- No documentation that required number of drills conducted
- No disaster and emergency drill conducted
- CPR drills not scenario-based
- Drills not regularly evaluated, or evaluations were very short/missing
- No follow-up on deficiencies noted during drill
- Inconsistent documentation of non-CPR drills
- Only fire drill was scenario-based
- No drill conducted in the second quarter
- No exit sign over designated fire door exit
- Stairwell fire-rated door was blocked open with doorstop
- Facility does not have appropriate number of illuminated exit signs within its space
- Battery-operated emergency power capability is not tested regularly
- Exit signs missing in hallways

**Recommendations for Compliance**

+ 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
+ Have an impartial party view drills while they are being performed and conduct an evaluation
+ Include supporting documents: completed AAAHC Emergency Drill toolkit forms
+ Check state and local building code requirements for exit signs and emergency preparedness requirements
VI. Additional Deficiencies: 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. 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 15% found in the 360 MDS ASC surveys.

Medicare Deemed Status (MDS) Life Safety Code Standards: Percent Deficiency (>15%)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.4</td>
<td>Smoke &amp; Fire</td>
</tr>
<tr>
<td>17.2</td>
<td>Fire Emerg Plan</td>
</tr>
<tr>
<td>6.1</td>
<td>Hazardous Area</td>
</tr>
<tr>
<td>8.11</td>
<td>Electrical Sys</td>
</tr>
<tr>
<td>12.8</td>
<td>Smoke &amp; Fire</td>
</tr>
<tr>
<td>3.28</td>
<td>Means of Egress</td>
</tr>
<tr>
<td>8.10</td>
<td>Electrical Sys</td>
</tr>
</tbody>
</table>

Life Safety Code Standards

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

<table>
<thead>
<tr>
<th>MDS</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.28</td>
<td>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 onsite.</td>
</tr>
<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>
</tr>
</tbody>
</table>

8.10 Self-contained rechargeable-battery-powered lights comply with the following:
- The control and battery charging functions of the unit (fixture) are wired to the branch serving general lighting in the space.
- The unit's battery capacity provides lighting for 90 minutes or more during normal power loss.
- The units are tested monthly for 30 seconds and annually for 90 minutes.

8.11 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).
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 8.3.5.1.1(4).

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 door 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:
| 12.8 (cont.) | • 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. |
|---|---|
| 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.  

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**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/)
VII. Common Findings in Behavioral Health

Surveyors evaluated 95 organizations between January 1 and December 31, 2019 under the 2018 Behavioral Health Standards (AAAHC Accreditation Handbook Chapter 17).

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

**Behavioral Health Standard Deficiency (>5%)**

- **17.I.1**: 17.I.4
- **17.I.2**: 17.S.3
- **17.H.1**: 17.H.4

**Behavioral Health Standard Elements Percent Deficiency (>5%)**

- **17.I.1**: 16%
- **17.I.4**: 14%
- **17.I.2**: 12%
- **17.S.3**: 10%
- **17.H.1**: 8%
- **17.H.4**: 6%
- **17.H.2**: 4%
- **17.H.3**: 2%
- **17.H.5**: 0%

**Standards and Elements**

### Non-MDS

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.H</td>
<td>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.</td>
</tr>
<tr>
<td>17.H.1</td>
<td>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.</td>
</tr>
<tr>
<td>17.I</td>
<td>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. 2. The informed consent is inclusive of the type and scope of treatment provided, treatment expectations and parameters, confidentiality, potential risks and protections related to treatment, and conditions for the termination of treatment. 4. The consent provides a clear definition of the composition of the treatment team, clear acknowledgement of who within the team will have access to counseling and psychiatric records, and the process for rescinding this authorization if requested.</td>
</tr>
<tr>
<td>17.I.1</td>
<td>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. 2. The informed consent is inclusive of the type and scope of treatment provided, treatment expectations and parameters, confidentiality, potential risks and protections related to treatment, and conditions for the termination of treatment. 4. The consent provides a clear definition of the composition of the treatment team, clear acknowledgement of who within the team will have access to counseling and psychiatric records, and the process for rescinding this authorization if requested.</td>
</tr>
<tr>
<td>17.I.2</td>
<td>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. 2. The informed consent is inclusive of the type and scope of treatment provided, treatment expectations and parameters, confidentiality, potential risks and protections related to treatment, and conditions for the termination of treatment. 4. The consent provides a clear definition of the composition of the treatment team, clear acknowledgement of who within the team will have access to counseling and psychiatric records, and the process for rescinding this authorization if requested.</td>
</tr>
<tr>
<td>17.I.4</td>
<td>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. 2. The informed consent is inclusive of the type and scope of treatment provided, treatment expectations and parameters, confidentiality, potential risks and protections related to treatment, and conditions for the termination of treatment. 4. The consent provides a clear definition of the composition of the treatment team, clear acknowledgement of who within the team will have access to counseling and psychiatric records, and the process for rescinding this authorization if requested.</td>
</tr>
</tbody>
</table>

**Documented Quality Improvement**

**Patient Engagement**
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, and consultation, 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.

— Missing or unsigned behavioral health-specific informed consent form
— Incomplete informed consent excludes type and scope of treatment, potential risks and protections, medical staff access to counseling records, and no process for rescinding authorization
— Inconsistent informed consent use
— A patient-centered treatment plan is developed but not documented in the clinical record
— Treatment plans did not contain:
  • documentation of evaluation for depression upon intake
  • measurable, time-bound goals
  • evidence of client participation
— No formal outcome-based measures of treatment efficiency
— No participation in quality improvement activities/studies
— No participation in peer review

Recommendations for Compliance

+ Implement staff training on QI and coordinate with medical staff collaborative QI activities
+ 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 V.C. “Quality Improvement” (p. 13) for information on conducting QI studies including tips for developing S.M.A.R.T. goals
VIII. Common Findings in Patient Centered Medical Home (PCMH)

Surveyors evaluated 60 organizations between January 1, 2019 and December 31, 2019 under the 2018 Patient Centered Medical Home Standards (AAAHC Accreditation Handbook Chapter 25).

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

**Patient Centered Medical Home (PCMH) Standard Deficiency (>5%)**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Deficiency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.K</td>
<td>16%</td>
</tr>
<tr>
<td>25.J</td>
<td>14%</td>
</tr>
<tr>
<td>25.E</td>
<td>12%</td>
</tr>
<tr>
<td>25.A.1</td>
<td>10%</td>
</tr>
<tr>
<td>25.A.4</td>
<td>8%</td>
</tr>
<tr>
<td>25.J.3.a</td>
<td>6%</td>
</tr>
<tr>
<td>25.J.3.b</td>
<td>4%</td>
</tr>
<tr>
<td>25.J.3.e</td>
<td>2%</td>
</tr>
<tr>
<td>25.K</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Patient Centered Medical Home Percent Standard Element Deficiency (>5%)**

<table>
<thead>
<tr>
<th>Standard Element</th>
<th>Deficiency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.J.3.a</td>
<td>16%</td>
</tr>
<tr>
<td>25.A.1</td>
<td>14%</td>
</tr>
<tr>
<td>25.J.3.b</td>
<td>12%</td>
</tr>
<tr>
<td>25.J.3.e</td>
<td>10%</td>
</tr>
<tr>
<td>25.A.4</td>
<td>8%</td>
</tr>
<tr>
<td>25.J.3.d</td>
<td>6%</td>
</tr>
<tr>
<td>25.F.2.f</td>
<td>4%</td>
</tr>
<tr>
<td>25.H.5</td>
<td>2%</td>
</tr>
<tr>
<td>25.I.2.b</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Standards and Elements**

### Non-MDS

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.A.1</td>
<td>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 &quot;team&quot; provider concept has been conveyed to the patient.</td>
</tr>
<tr>
<td>25.A.4</td>
<td>(cont.) appointments are followed, as evidenced in tracking logs, policies, clinical records, and/or other written formats.</td>
</tr>
<tr>
<td>25.E</td>
<td>Patients are provided with information regarding how to obtain medical care at any time, 24 hours per day, every day of the year.</td>
</tr>
<tr>
<td>25.F.2.f</td>
<td>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.</td>
</tr>
<tr>
<td>25.H.5</td>
<td>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.</td>
</tr>
<tr>
<td>25.J</td>
<td>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. b. Accessibility of care. d. Continuity of care. e. Study related to quality of care.</td>
</tr>
<tr>
<td>25.J.3.a</td>
<td>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.</td>
</tr>
<tr>
<td>25.J.3.b</td>
<td></td>
</tr>
<tr>
<td>25.J.3.d</td>
<td></td>
</tr>
<tr>
<td>25.J.3.e</td>
<td></td>
</tr>
<tr>
<td>25.K</td>
<td>There is evidence that electronic data management is continually assessed as a tool for facilitating achievement of the Medical Home Standards.</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.

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 care coordination.

— Patients have not been provided:
  • an explanation/information of PCMH “team” framework
  • enough 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

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Organization/Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>APIC</td>
<td>Association for Professionals in Infection Control and Epidemiology</td>
</tr>
<tr>
<td>ANSI</td>
<td>American National Standards Institute</td>
</tr>
<tr>
<td>ASTM</td>
<td>American Society for Testing and Materials</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Surgery Center</td>
</tr>
<tr>
<td>ASGE</td>
<td>American Society for Gastrointestinal Endoscopy</td>
</tr>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
</tr>
<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>Centers 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>
</tr>
<tr>
<td>EES</td>
<td>Essential Electrical Systems</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<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>
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</tr>
<tr>
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<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>
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<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>
X. Roadmap for Improvement 2020

Use This Report for Benchmarking
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.

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:
- A patient safety toolkit and webinar on Safe Injection Practices
- Participation in the Safe Injection Practices Benchmarking Study

Allergy Documentation Study
The AAAHC Institute began offering an Allergy Documentation Benchmarking Study in 2020. Initial findings substantiate the need for many organizations to assess their compliance with consistently documenting allergies, sensitivities and reactions to medications, OTC and other materials such as latex and food at each patient encounter. Organizations can develop quality improvement interventions to improve their compliance with the AAAHC Standards.

The AAAHC offers several Allergy Documentation resources, including:
- A patient safety toolkit on Allergy Documentation
- Participation in the Allergy Documentation benchmarking study
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:

- Credentialing & Privileging
- Care Coordination
- 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.

### eLearning

The 1095 Learn portfolio is central to learning and development and supports the AAAHC effort to continue advancing the standard of care by engaging with clients more frequently throughout the accreditation term with tools, resources, and education that bring meaningful value when needed.

Digital offerings cover topics such as QI overview, medication reconciliation, emergency drills, peer review, and internal benchmarking. AAAHC-accredited organizations can leverage the 1095 Learn portal to register for upcoming events, eLearning, and recorded webinars.

To learn more about AAAHC eLearning modules go to: 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 an annual subscription with two opportunities each year to join our studies, January-June and July-December. Learn more at: www.aaahc.org/quality/benchmarking-studies/

There is also a 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 event go to: 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, choose “Quality” to learn more about the program.
Notes
Strengthen your commitment to patient safety and 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

For 40 years AAAHC has advanced the standard of ambulatory health care through a quality-focused, peer-based, and educational accreditation process. We provide facilities with relevant standards and education to integrate into the patient care environment and conduct onsite evaluations to assess ongoing compliance. To transform your ambulatory health care, visit aaahc.org or call 847.853.6060.

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