An Overview of the AAAHC Accreditation Standards for Ambulatory Health Care

For the Michigan Primary Care Association
Lansing, Michigan
July 16, 2015

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Today’s Presenters

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Today’s Presenters

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AAAHC Accreditation

Accountable
Accessible
Affordable
Health
Care Accreditor

All About Assisting Health Centers!!
The AAAHC now accredits over 6000 ambulatory health care organizations. 398 sites achieved Medical Home recognition.
AAAHC

Private, independent, not for profit

Peer-based Accreditation Program

Experienced CHC medical professionals as your surveyor(s)

Over 6000 accredited organizations
### Types of Organizations Accredited by AAAHC

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Why choose AAAHC?

Consultative and educational approach

- Ask questions, and receive solutions, ideas, answers
- Explain your unique organization’s implementation of a particular standard – what “works” for your setting
- Full participant in summation conference

The on-site survey takes place on a mutually agreed upon date, not a surprise!

Written report of survey findings provides the blueprint for continued improvement and transformation to becoming a Medical Home.
AAAHC Philosophy

Discovery vs. inspection
Consultative vs. prescriptive
Collaborative vs. dictatorial

350 surveyors nationwide:
✓ Actively involved professionals
✓ Extensive ambulatory healthcare experience
✓ Initial mentored training
✓ Re-credentialed every 2 years
Goals of Today’s Program

1. Gain an understanding of AAAHC Standards

1. Learn about the AAAHC survey process

2. Review quality studies and gain insight into making them meaningful for your center
Today’s Program Agenda

Morning
- Medical Home - Chapter 25
- Core Chapters 1-8
- Key requirements
- What do surveyors look for
- Common problems

Afternoon
- Test your IPC IQ
- Quality Management and Improvement, Chapter 5 Standards
- Review sample QI studies
- Application process
What’s in Your Medical Home?

Chapter 25, Medical Home Standards
A brief history of the Medical Home

1967: American Academy of Pediatrics introduces concept (www.aap.org)

So what are the five *principles* of an AAAHC Medical Home?

1. Focus on provider/patient relationship
2. Make patient the center of care
3. Provide accessible, comprehensive, coordinated and continuous care
4. Quality and Safety
5. Collect and report data that are meaningful to the patient

AAAHC Chapter 25 Medical Home has five major Standards:

- Relationship
- Accessibility
- Comprehensiveness of Care
- Continuity of Care
- Quality
"The problem with communication is the illusion that it has occurred."

George Bernard Shaw
Relationship - Communication

- Listens carefully
- Interacts with patient about making lifestyle changes and supporting wellness
- Provides instructions for taking care of specific health concerns
- Communicates effectively about patient’s health care
- Includes family/significant other when appropriate
Relationship - Understanding

- Spends sufficient time with the patient
- Physician is as thorough as patient feels is needed
- Provider knows important facts about the patient’s health history
- Patient satisfaction, assessment
- Patient is engaged in decisions
Relationship - Collaboration

- Patient knows the members of his/her team
- The family is included, as appropriate, in patient care decisions, treatment and education
- The patient is an integral part of the team (“with” the patient, not “to” or “for” the patient) - Accountability
Relationship “vital signs”

Patient-centeredness
Communication
Team delivery of care
In concert with patients as partners in their own care
Surveyors look for patient-centeredness:

- Reflected in patient rights and responsibilities documents
- Websites and literature
- Through patient interviews
- Review of patient satisfaction surveys
- Hours of availability to meet patient needs
Surveyors look for communication:

- Length of appointment times to meet patient needs
- Summaries of conversations documented in clinical record
- Copies of instructions given to patients
- Patient satisfaction survey results
Relationship “vital signs”

Surveyor will observe team delivery of care:

- Use of team “huddles”
- Can patient identify team members?
- Are all patient interactions documented in the clinical record?
Standards

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Relationship “vital signs”

Surveyors will observe clinical decision making in concert with patients as partners in their own care:

- May have signed “contract” with patient
- Patient’s goals are documented
- Consideration of significant other or caregiver when making decisions
AAAHC Medical Home Standards

Relationship

Accessibility

Comprehensiveness of Care

Continuity of Care

Quality
The Medical Home practice must have written standards to support:

- Provider availability
- Patient after-hour access to care
- Clinical record content
- Treatment plan information

Patient perception of access is continually assessed; attention to dissatisfaction
Accessibility Standards

- Patients have access to, and input into, their treatment plans
- Patients have access to the content of their clinical records
- Patients know how to access care and how to gain advice - from routine to urgently needed care - 24/7
“Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.”

- This requirement exists in four subchapters: Accessibility, Comprehensiveness, Continuity of Care, and Quality
Accessibility Standards

- Access and provider availability according to patient’s needs and wishes
- Innovative scheduling, i.e., open scheduling, time blocks for same day appointments
- New opportunities for communicating and interacting with patients and Medical Home team members
  - Portals, website interaction, education programs
Accessibility

Are the patient’s expectations of access being met by the Medical Home?

“Your appointment with the doctor is at eleven-fifteen, but his appointment with you is at twelve-fifteen.”
Accessibility “vital signs”

**Written standards**

24/7

Attention to **dissatisfaction**
Accessibility “vital signs”

Surveyor will look for written standards that support:

- Provider availability
- Treatment plan information, advice, routine care, urgent care
- Clinical record contents
Accessibility “vital signs”

Surveyor will look for confirmation of access:

- Scheduling patterns, same day appointments
- Evidence that patients are informed about obtaining access when the practice is not open
Accessibility “vital signs”

Surveyors will look for: Attention to **dissatisfaction**

- Resolution of patient dissatisfaction
- Monitoring of patient satisfaction survey results leads to QI studies when appropriate
Comprehensiveness of care

Medical Home services includes the full depth and breadth of health care. This includes...
Comprehensiveness Standards

Medical Home team responsible for providing or arranging for care:

- All life stages
- All elements
  - Wellness and healthy lifestyle
  - Health risk appraisal and health risk assessment
  - Behavioral health
  - Physical health: preventive, acute, chronic, and end-of-life
- Education and self-management tools
- External resources are known, utilized and coordinated
Comprehensiveness of care

What does the Medical Home do when the patient’s needs go beyond the scope of practice within the Medical Home?

- Know your community resources
- Identify your patient population needs and available programs outside of your Medical Home or of your community
Comprehensiveness
“vital signs”

“Cradle to grave”
Healthy lifestyle and wellness
End-of-life care
Community resources
Patient-centered clinical record
Surveyors will look for evidence of “cradle to grave” care

- Have a *written* policy defining your pediatric population when providing care
- Community resources list, referral relationships
Comprehensiveness

“vital signs”

Surveyors will look for evidence of

*Healthy lifestyle and wellness*

- Clinical record evidence of discussions and goal setting, and resulting treatment plans
Comprehensiveness “vital signs”

Surveyors will look for evidence of “End-of-life care”

- Advance directives as well as documentation of end-of-life discussions
- Available list of known community resources
- Working relationship with referral sources
Comprehensiveness
“vital signs”

Surveyors will look for evidence of patient-centeredness in clinical records

- Provider will document patient statements and goals
- Copy of clinical record shared with patients
AAAHC Medical Home Standards

Relationship
Accessibility
Comprehensiveness of Care
Continuity of Care
Quality
Continuity of care

- How does the Medical Home provide coordination of care to meet the needs of its patients?
- How does the Medical Home provide continuity of care to meet the needs of its patients?
Continuity of care

Documentation is critical to ensure continuity of care in the Medical Home

- Hospitalizations, consultations, referrals, follow-ups, missed appointments and after-hours encounters are documented
- Results of diagnostic studies and their follow up
Continuity of care

- Electronic data management is continually assessed as a tool for facilitating the continuity of care Standards
- Patients are seen by the same Medical Home provider/team the majority of the time
Continuity “vital signs”

50% of visits with provider or Medical Home team

Active management of referrals and consults

Transitions in care are planned and facilitated
Surveyors will look for a minimum of 50% of visits with provider or Medical Home team through:

- Medical record review
- Patient interviews
- Review of scheduling process
Surveyors will look for active and timely management of referrals and consults

- Evidence of policies and procedures
- Transitions of care
- Clinical record review
- Patient /staff interviews
AAAHC Medical Home Standards

Relationship
Accessibility
Comprehensiveness of Care
Continuity of Care
Quality
Medical Home Quality

Quality improvement is demonstrated within the Medical Home as part of an active, integrated, organized, peer-based, patient-centered program.
Medical Home Quality

QI program includes one study every three years to include each of the following topics:

1. Patient/primary care provider relationship
2. Accessibility of care
3. Comprehensiveness of care
4. Continuity and/or coordination of care
5. Clinical study
Quality “vital signs”

Use of evidence-based guidelines and performance measures

Medical Home concepts reflected in quality improvement studies

Satisfaction/dissatisfaction assessment and appropriate actions are taken
AAAHC Core Standards 2015

All of the appropriate portions of the core standards (Chapters 1-8) are applied to all organizations seeking accreditation.
When it’s “key” to the concept of Medical Home...

... it’s shown in *blue* and *italicized*
An accreditable organization recognizes and respects the *basic human rights of patients*. 
Chapter 1: Patient Rights and Responsibilities

Standards address two key areas:

- How patients are treated as people
- Ensuring that patients are fully informed
- Patient engagement, empowerment
- Relationship between patient and Medical Home provider and team is paramount
Chapter 1: Patient Rights and Responsibilities

How patients are treated as people

- Respect, consideration, and dignity
- Privacy, confidentiality
- Reasonable attempts to communicate in language/manner used by patient
- Participation in decision making
Chapter 1: Patient Rights and Responsibilities

Ensuring that patients are fully informed regarding their care

To the degree known, provided with information concerning diagnosis, evaluation, treatment and prognosis

- *After-hours and emergency care*
- *Advance directives (and end of life care)*
Chapter 1: Patient Rights and Responsibilities

Some items surveyors will observe/review:

- Privacy / confidentiality practices
- Policies and procedures, including whether they match information provided to patients
- Patient information/handouts, educational and teaching materials
- Interpreters, use of telecommunications technology or other means of communication
- Marketing/practice promotion
Chapter 1: Patient Rights and Responsibilities

Common problems

- Privacy: curtains, conversations, patient announcement, patient registration
- Reception vs. waiting areas
- Posting of current hours of service
- Up-to-date website information
- Follow through on grievances filed
AAAHC Core Standards

Chapter 2: Governance
Standards address three major topics:

- **Subchapter I**
  General requirements for an organization and its governing body

- **Subchapter II**
  Credentialing and privileging of medical staff members

- **Subchapter III**
  Peer review
Chapter 2, Subchapter I: General Requirements

Governing body

- Legally constituted entity
  - Documented by at least one of the following: articles of organization, articles of incorporation, partnership agreement, operating agreement, legislative or executive act, or bylaws, unless organization is a sole proprietorship

- Names and address of all owners or controlling parties available upon request and furnished to AAAHHC
Chapter 2, Subchapter I: General Requirements

Governing body (cont.)

- Sets direction *(mission)*, future planning
- Ensures adequate, appropriate facilities and personnel
- *Establishes structure, policies, procedures*
- Scope of clinical activities including written policy defining care of pediatric patients
- *Ensures evaluation of the quality of care*
- Reviews and responds to legal, ethical matters
Governing body (cont.):

- Ensures effective *internal communication*
- Maintains financial health and control
- *Determines policy on rights and responsibilities of patients*
- Approves and ensures compliance with applicable laws and regulations
Governing body (cont.):

- Assures that marketing / advertising is not misleading
- Responsible for development and oversight of a risk management program
- Operates facilities safely – including development, implementation and oversight of the infection control and safety programs
Governing body (cont.):

- Notification to AAAHC of significant changes or events
  - Required timeframe for notification is fifteen (15) days
- Representation of accreditation to the public must accurately reflect the AAAHC-accredited entity
Chapter 2, Subchapter I: General Requirements

Governing body (cont.):

- Meets at least annually and keeps minutes or other necessary records

- Reviews specific Items at least annually e.g., programs and P&Ps

- Authority, responsibility to carry out governing body directives are defined
Some items surveyors will observe/review:

- Mission, goals, objectives, long- / short-range planning
- Documentation of ownership and current org chart
- Governing document (e.g., operating agreement/ bylaws)
- Meeting minutes: governing body, committees, staff
- Procedures for ensuring continued compliance with all applicable state/federal regulations
- Scope of clinical activities
- Contracts/agreements with outside entities
Common problems

- Governing body meeting minutes
- Timely notification to AAAHC of significant changes
- Updated P&Ps
- *Lack of pediatric policy*
- Outdated / inaccurate website content
AAAHC Core Standards
Chapter 2, Subchapter II: Credentialing and Privileging
Chapter 2, Subchapter II: Credentialing and Privileging

- The medical staff must be accountable to the governing body
- Governing body establishes and is responsible for credentialing and reappointment process that:
  - Is applied in uniform manner
  - Includes mechanisms for credentialing, reappointment, granting of privileges, suspending or terminating privileges, and appeal of such decisions
Required minimum characteristics of the process:

- Specific criteria for initial appointment and reappointment; expeditious processing of applications
- On a formal application for initial medical or dental staff privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested. At a minimum, the following credentialing and privileging information shall be provided or obtained for evaluation of the candidate:
Minimum information needed for initial credentialing and privileging:

- Verification of education, training, experience
- Peer evaluation of current competence
- Verification of current licensure
- DEA registration, if applicable
- Proof of current medical liability coverage, if required
- NPDB report
- Written attestation from the applicant addressing other pertinent information
Chapter 2, Subchapter II: Credentialing and Privileging

- Upon receipt of a completed and signed initial application, the credentials are verified according to procedures established in the organization’s bylaws, rules and regulations, or policies.

- The organization has established procedures to obtain information necessary for primary or secondary source verification of the credentials and is responsible for obtaining and reviewing this information.
Upon receipt of a completed reappointment application, the organization will primary source verify items listed in Standards 2.II.B.3.c-f.

At the time of reappointment consideration by the governing body, the entire reappointment application and peer review results and activities, completed in accordance with Chapter 2.III, will be considered.
Ongoing monitoring and documentation of current licensure, certifications, etc.

- At minimum: at expiration, appointment and re-appointment
See sample Application for Privileges in your 2015 Handbook, pp. 115 - 125
Privileging

- Governing body establishes and is responsible for credentialing and reappointment process

- Process for appointment, reappointment, assignment or curtailment of privileges based on professional peer evaluation

- Scope of procedures performed by the org must be periodically reviewed by the governing body and amended as appropriate
Privileging

- Privileges are granted for specific time period
- Health care professional is legally and professionally qualified for privileges granted
- Privileges are granted based on:
  - Applicant’s written request
  - Applicant’s qualifications
  - Recommendations from qualified personnel

Issues with the privileging process were the #1 deficiency in both ASC and primary care for surveys conducted under 2013 Standards
Credentialing and Privileging

**Independent process:**

- Approval of credentials and granting of privileges requires review and approval by governing body

- Credentials may not be approved, nor privileges granted, solely on basis that such were approved by another organization
Credentialing and Privileging

For Allied Health Professionals:

- Governing body provides a process for initial appointment, reappointment and assignment or curtailment of privileges and practice

- Process is consistent with state law and based on evidence of education, training, experience, and current competence
Some items surveyors will observe/review re: Subchapter II

- Credentialing/privileging policies and procedures
- Credentials files
- Policies/procedures for notifying licensing and/or disciplinary bodies
- List of approved procedures that may be performed at the organization
See worksheet used by surveyors in your 2015 *Handbook*

**Accreditation Handbook**, pp. 126-127

**Instruction:**
Mark each box as:
Common problems

- Failure to privilege all who need privileges
- Lack of verification of credentials
- Privileges not granted for specific time period
- Expired credentials – monitoring of license, boards, DEA
- Query of and/or reporting to NPDB
  - For primary care organizations: failure to include info from the NPDB as part of credentialing and privileging process
AAAHC Core Standards

Chapter 2, Subchapter III: Peer Review
Peer review Standards address three topics:

- What elements must the peer review process contain?
- Who must participate?
- What happens to the results?
Elements of the peer review process:

- Ongoing monitoring of important aspects of care is necessary for monitoring individual performance and establishing internal benchmarks
- Development and application of criteria used to evaluate care provided
- Ongoing data collection and periodic evaluation to identify trends affecting patient outcomes
Chapter 2, Subchapter III: Peer Review

Who must participate?

- Health care professionals
- Each physician or dentist receives peer-based review from at least one similarly-licensed peer. (solo practices include outside person)
- Practices led by APN* or licensed clinical behavioral health professionals are peer reviewed by a similarly licensed peer or outside physician or dentist *per state law and regulations
- Participation in development and application of criteria used to evaluate care
- Participation in educational activities, with access to up-to-date information
What happens to the results?

- Integrated into quality management and improvement program
- Reported to the governing body
- Used as part of privileging process
Some items surveyors will observe/review re: peer review

- Medical staff bylaws and/or peer review policies and procedures
- Credential files and records of peer review activities
- Documentation that peer review information is provided to the governing body as part of the quality improvement and credentialing/privileging activities
Chapter 2, Subchapter III: Peer Review

Failure to use peer review as part of the re-privileging process was also a top deficiency for all organization types for surveys conducted under 2013 Standards

More than 80% of the deficiencies with this Standard are due to the fact that although peer review is being conducted, the results of peer review are not consistently being used as part of the process for granting continuation of clinical privileges.
Common problems

- Exclusive reliance on chart review as sole means of peer review
- Is the reviewer a true peer?
- Lack of monitoring of important aspects of care to establish internal benchmarks
- Failure to use results of peer review when granting clinical privileges
AAAHC Core Standards 2015

Chapter 3: Administration
Standards address three major topics:

- Administrative responsibilities for the orderly and efficient management of the organization, including *assessment of patient satisfaction*
- Personnel policies
- Occupational health care for staff
Chapter 3: Administration

Administrative responsibilities

- Enforcement of policies
- Qualified management personnel – employed? contracted?
- Documentation of compliance
- Protection of assets
Administrative responsibilities (cont.):

- Implementing fiscal controls
- Ensuring *internal communication*
- Purchasing and maintaining materials, supplies, equipment, services
- Operating based on established lines of authority
Chapter 3: Administration

Administrative responsibilities (cont.):

- Controlling organization documents
- Ensuring confidentiality and security of data
- *Maintaining health information system*
- Dealing with external inquiries
Chapter 3: Administration

Administrative responsibilities (cont.):

- *Patient satisfaction is assessed*
- Findings are reviewed by the governing body
- Corrective actions are taken when appropriate
Chapter 3: Administration

Some items surveyors will observe/review re: administrative responsibilities

- *Intra-organization communication*
- Policies, policies, policies
- Accounts receivable management
- Management
- *Patient satisfaction results*
Common problems re: administrative responsibilities

✓ “Tie” to governing body directives and actions

✓ Roles, responsibilities, accountabilities

✓ Contractual relationships

✓ **Staff communication / in-service**
Personnel policies are made known at time of employment

- Personnel policies define roles, accountabilities, responsibilities
  - Including compliance with incident reporting system
Personnel policies (cont.)

- Require hiring/contracting of qualified personnel and regular review of performance and competence

- Comply with laws and regulations

- Written personnel policies define the status of students and postgraduate trainees, when present
Personnel policies (cont.)

Documented orientation and training shall be:

- Completed within 30 days of commencement of employment
- Provided annually thereafter and when there is an identified need
Some items surveyors will observe/review re: personnel policies

- Policies
- Personnel files, employee health records, I-9 forms and visa files
- Orientation and annual training
- Organization chart
Chapter 3: Administration

Common issues re: personnel policies

- Incomplete and/or disorganized personnel files
- Human resource management
- Wage and Hour Law compliance
- Continuing education
See worksheet used by surveyors in your 2015 *Handbook*

Accreditation *Handbook*, pp. 131 - 132

**Personnel Records Worksheet**

**Instructions:**
Mark each box as:
- Adequate – A
- Inadequate – I
- Not Applicable – N/A

File Identifier
Protection from biologic hazards:

- Policies comply with all applicable occ. health/safety regs for health care workers, including the OSHA rules on Occupational Exposure to Bloodborne Pathogens
Chapter 3: Administration

Occupational health care for staff (employee health) – cont.

- Written exposure control plan is reviewed and updated at least annually, including evaluation for availability of safer devices and changes in technology

- Exposure control plan is part of initial orientation and re-training conducted within one year of last training
Chapter 3: Administration

Occupational health care for staff (employee health) – cont.

Programs address:

- Bloodborne pathogens
- Immunization
- A tuberculosis detection and protection plan
- Other relevant biological hazards
- Chemical exposures
- Physical hazards, from ergonomics to terrorism
Records of work injuries and illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately.
Chapter 3: Administration

Some items surveyors will observe/review re: occupational health care for staff

- Policies
- Personal protection
- Workplace injuries
- Work environment
Chapter 3: Administration

Common problems re: occupational health care for staff

✓ TB immunization required
✓ Hepatitis testing / declination
✓ Exposures – patients with known communicable diseases accepted
✓ Policies re: bloodborne pathogens
Let’s take a break… we will resume in 15 minutes
AAAHC Core Standards 2014

Chapter 4: Quality of Care Provided
Critical chapter:

Here, the organization demonstrates that all health care providers, and the organization overall, provide high-quality health care.
Chapter 4: Quality of Care Provided

Critical chapter (cont.)

Integrates many of the core and applicable adjunct Standards:

Ch 1 – *Effective communication* with patients
Ch 2 – Governance, including credentialing and privileging and peer review
Ch 3 – Personnel
Ch 5 – *Quality management and improvement*
Ch 6 – *Clinical records*
Ch 7 – Infection prevention and control and safety
Ch 8 – Facility safety
Chapter 4: Quality of Care Provided

Standards address four major topics:

- Health care professionals
- Demonstrating the provision of high-quality care
- Mechanisms for referrals, consultations, transfers and follow-up
- Cost of care
Chapter 4: Quality of Care Provided

Health care professionals:

- Appropriate training and skills
- Practice in ethical, legal manner
- Appropriately qualified, supervised and available in sufficient numbers for care provided
Demonstrating the provision of high-quality of care:

The organization has a current and comprehensive written quality management and improvement program.
Chapter 4: Quality of Care Provided

Demonstrating the provision of high-quality care (cont.):

- Care provided is consistent with current standard of care
- *Effective communication* with patients
- Appropriate and timely diagnosis
- Medication reconciliation is performed
- Treatment consistent with diagnosis
Demonstrating the provision of high-quality care (cont.):

- **Appropriate and timely consultations and referrals**
- **Continuity of care and follow-up re: significant problems / abnormal findings**
- **Assessing patient satisfaction; taking corrective actions**
- **Use of performance measures to improve outcomes**
Chapter 4: Quality of Care Provided

Demonstrating the provision of high-quality care (cont.):

- Health care provided is consistent with the current standard of care

- *Education of and effective communication with patients concerning diagnosis, treatment, preventive measures and use of health care system*
Demonstrating the provision of high-quality care (cont.):

- Policies and procedures for identifying, storing, and transporting laboratory specimens and biological products

- Include logging and tracking to ensure that results for each specimen are obtained and have been reported to the ordering physician in a timely manner
Chapter 4: Quality of Care Provided

Available health services are accessible and ensure patient safety through:

- Provision for / information about services when the organization is not open
- Adequate, timely transfer of information when patients are transferred
Chapter 4: Quality of Care Provided

When the need arises, the organization assists patients with the transfer of their care

- Adequate specialty consultation available by prior arrangement
- Referrals clearly outlined to the patient and arranged with the accepting provider
ONE of the following is required in case hospitalization is needed:

1. Written transfer agreement with nearby hospital
2. Written policy of credentialing / privileging only physicians/dentists with admitting/similar privileges at nearby hospital
3. Written agreement with physician or provider group with admitting privileges at nearby hospital
4. Detailed written procedural plan for handling medical emergencies
Cost of Care

- Concern for the costs of care is present throughout the organization

- *Absence of clinically unnecessary diagnostic or therapeutic procedures*
Chapter 4: Quality of Care Provided

Some items surveyors will observe/review re: Chapter 4

- Credential records, clinical records
- Peer review activities
- Quality improvement activities
- Policies and procedures
- Process for handling medical emergencies / transferring patient to hospital
Chapter 4: Quality of Care Provided

Common problems

✓ Timely review of history and physical
✓ Organization’s responsibility for ensuring a process for lab / radiologic follow-up
✓ Clinical record documentation
✓ Transfer agreement OR providers with admitting or similar privileges
✓ Primary care: medication reconciliation and continuity of care
AAAHC Core Standards 2015

Chapter 6: Clinical Records and Health Information
Standards address five major topics:

- Clinical record policies
- Appropriate and accurate documentation
- Review and authentication
- Informed consents
- Transfer of information when patients are treated elsewhere
There is a system for clinical records that addresses their:

- Collection
- Processing
- Maintenance
- Storage
- Retrieval
- Distribution
Chapter 6: Clinical Records and Health Information

- Designated person in charge of clinical records
- Responsibilities include security of the clinical record, including:
  - Method of tracking who accesses the record, to deter unauthorized access for electronic records
  - Method of identifying designated locations of paper records throughout the organization, to deter unauthorized access
- Patient identification
Chapter 6:
Clinical Records and Health Information

Appropriate and accurate documentation

- Legible and accessible entries
- A summary is used if three or more visits / admissions, OR complex / lengthy records
- Uniform content and format
- H&Ps and lab / radiologic results are reviewed and incorporated as required by the organization’s policies
Chapter 6: Clinical Records and Health Information

Documentation (cont.)

- Presence or absence of allergies and untoward reactions to drugs and materials is recorded in prominent and consistent location in all clinical records.

- Verified at each patient encounter and updated when new allergies or sensitivities are identified.

- Failure to consistently document and or update allergic and untoward reactions created a “top deficiency” for all organization types during 2013 surveys.
Entries in clinical records include at a minimum:

- *Telephone/text/email contact with patients is permanently entered*
- Research
- Date of entry – of reports, H&Ps, etc. – is documented in the record
- Informed consents – necessity, appropriateness, risks
- *Missed and cancelled appointments* (not necessarily in clinical record)
Chapter 6: Clinical Records and Health Information

- **Ensuring continuity of care**

- Transfer of information when patients are treated elsewhere:
  - Obtain from outside provider
  - Send to outside provider

- Failure to obtain and incorporate summaries/records from outside providers resulted in a “top deficiency” for primary care organizations during 2013 surveys.
Confidentiality and security of the clinical record

- Patients are given the opportunity to approve or refuse release of records, except when release is permitted or required by law
Chapter 6: Clinical Records and Health Information

- Clinical information is accessible to authorized personnel
- Written policies address, at a minimum:
  - Retention and retirement
  - Defined accountability for the release and security of information, including accountability for editing, deletion and access of the clinical record content
Some items surveyors will observe/review:

- Policies and procedures
- Interview clinical records personnel
- Clinical records – paper or electronic
- Selected by surveyor (selection cannot be delegated to organization)
- At a minimum, within last 12 months
- Within past 36 months involving deaths, unplanned transfers, litigation, and unplanned outcomes/incidents
See worksheet used by surveyors in your 2013 *Handbook*

**Accreditation Handbook**, p. 128 - 129
Chapter 6: Clinical Records and Health Information

Common problems

✓ Documentation of allergies / untoward reactions
✓ Obtaining records from outside providers
✓ Appropriate patient identification
✓ Timely review of H&Ps, test results, etc.
✓ Use of summary when there are three or more visits / admissions, or record is complex and lengthy
AAAHC Core Standards 2014

Chapter 7: Infection Prevention and Control and Safety
Standards in Subchapter I address two major areas:

- Policies and procedures (administrative)
- Environment and equipment (performance)
Establish a program to:

- ID/prevent infections
- Maintain sanitary environment
- Report results as appropriate or required
Implement nationally-recognized infection prevention and control guidelines:

- Governing body approval
- Integrated with QI program
- Directed by qualified person
- Appropriate to organization; meets applicable state/fed requirements
- Includes plan of action, including direct intervention as needed
Subchapter 7.I:
Infection Prevention and Control

Education and active surveillance to reduce risk of HAI:

- Hand hygiene
- Safe injection practices
- Minimize communicable disease exposure
Subchapter 7.I: Infection Prevention and Control

Sharps injury prevention program:

- Documented orientation and annual education
- Sharps disposal
- Placement, replacement, disposal of sharps containers
Subchapter 7.I: Infection Prevention and Control

- Procedures to minimize sources and transmission of infection, including surveillance techniques
- Policies for isolation/transfer of patients with communicable diseases
- Policy outlines appropriate hand hygiene using products according to product manufacture's guidelines
Subchapter 7.I: Infection Prevention and Control

Performance Standards

- Functional and sanitary environment
- Adherence to all relevant recommendations/guidelines re: cleaning, disinfection, sterilization of instruments, equipment, supplies, implants
Safe and sanitary environment for treating patients:

- Protection from cross-infection through provision of adequate space, equipment, supplies, personnel
Subchapter 7.I: Infection Prevention and Control

- Process for monitoring/ documentation of cleaning, high-level disinfection and sterilization
- Sterile packs within current dates
- Policy re: identification and processing of medical equipment not meeting sterilization parameters
Subchapter 7.1: Infection Prevention and Control

Policy re: cleaning of treatment and care areas addresses at minimum:

- Before use
- Between patients
- Terminal at end of day
Some items surveyors will observe/review re: Subchapter 7.I

- Policies and procedures
- Staff interviews: Awareness of and compliance with infection prevention policies and training
- Adherence to chosen nationally recognized infection control guidelines
- Equipment cleaning/sterilization records

(cont.)
Subchapter 7.I: Infection Prevention and Control

Some items surveyors will observe/review re: Subchapter 7.I (cont.)

- Hand hygiene practices
- Safe injection practices including use of multi-dose vials
- OSHA regulations/bloodborne pathogens
- Environmental cleaning practices
- Care, maintenance, storage and appropriate use of medical equipment
Common problems

✓ Lack of evidence of training/competence of appointed leader of infection control program
✓ Failure to select and adopt nationally-recognized guidelines for safe injection practices or hand hygiene
✓ Insufficient (or no) monitoring and documentation of cleaning, HLD and sterilization
✓ Lack of written policies re: cleaning of treatment and care areas – or lack of adherence to them
Chapter 7: Infection Prevention and Control and Safety

Two subchapters:

I: Infection Prevention and Control

II: Safety
Standards in Subchapter 7.II address four major topics:

- Overall safety program
- Patient-specific safety requirements
- Fire and other hazards
- Equipment/device safety
Subchapter II: Safety

Overall Safety Program

- There is a written program
- Someone is responsible for it
- Everyone receives safety program education and training and complies with the requirements
Subchapter 7.II: Safety

A written safety program meets or exceeds local/state/federal safety requirements.

Elements include, at a minimum:

- Processes for managing safety concerns
- Reporting of known adverse events when required by law
- Reduction/avoidance of medication errors

(cont.)
Subchapter 7.II: Safety

Elements of the written safety program include, at a minimum (cont.):

- Addressing recalled meds, equipment/devices, food products
- Preventing falls, other injuries. As required by regulation or contract, the reporting of falls or physical injuries is accurate and timely.
Overall safety program (cont.)

- Personnel trained in basic life support (BLS) and the uses of cardiac and all other emergency equipment and supplies are present in the facility when patients are present.
Patient-specific safety requirements

- Consistent use of unique patient identifiers
- Patient education/verification of competence re: prescribed medical devices
Subchapter 7.II: Safety

Fire and other hazards

- Comprehensive emergency/disaster preparedness plan to address internal and external emergencies
- **Written** plan must include provision for safe evacuation during an emergency, especially of individuals at greater risk

(cont.)
Subchapter 7.II: Safety

Fire and other hazards (cont.)

- Education re: fire prevention, fire hazard reduction
- Fire safety, drills part of surveillance activities
Fire and other hazards (cont.)

- Environmental hazards are identified and safe practices are implemented
- Measures to prevent skin/tissue injuries
- Evidence of compliance with local/state/federal requirements re: patient food/drink prep, service, storage, disposal
Subchapter 7.II: Safety

Equipment/device safety

- **Written** policies must clearly require documentation of the pre-cleaning, transport and handling of medical devices intended for external vendor processing, inspection or repair.

- Reprocessing of single-use devices must comply with FDA guidelines and devices must be cleared under the FDA 510(k) process.
Subchapter 7.II: Safety

Equipment/device safety (cont.)

- **Written** policy/process addressing the recall of drugs, devices, etc.

- At minimum, the policy addresses documentation of:
  - Sources of recall information
  - Methods for notifying staff
  - Methods to determine if recalled product is present, and/or has been given to patients
  - Response to recalled products
  - Disposition or return of recalled items
  - Patient notification, as appropriate
Subchapter 7.II: Safety

Equipment/device safety (cont.)

- Monitoring expiration dates; policy for disposal of expired items
- Prior to use, appropriate education provided to operators of newly-acquired devices or products
- Designated person responsible for ensuring education prior to use of newly acquired devices for patient care – not solely vendor reps
Subchapter 7.II: Safety

Some items surveyors will observe/review re: Subchapter 7.II

- Policies and procedures
- Recall process - in place proactively?
- Staff orientation records and ongoing training records
- Use of patient identifier(s) at each appropriate contact point
- Monitoring of products carrying expiration dates
- Expired meds disposed of according to local, state, federal guidelines
Subchapter 7.II: Safety

Common challenges

✓ Appropriate storage of cleaning solutions
✓ Correct cleaning solution for task at hand
✓ Active ongoing surveillance re: hazards
✓ Awareness of local/state food regulations
✓ Ensuring intended-user training on devices or products used in patient care
AAAHC Core Standards 2015

Chapter 8: Facilities and Environment
Components of “safe and appropriate environment”

- **OPERATIONAL**: Activities, care processes, protocols
  - Policies and procedures
    - Universal – constant
    - Context driven

- **PHYSICAL**: Design and construction
  - Building codes and standards – constants
  - Accepted standards of care – context driven
Facility regulations

Facilities must conform to local, state and federal regulations, building codes, and fire prevention requirements including "periodic" inspections by fire control agency.

Existing facilities should already be in conformance with applicable codes, as demonstrated by a current occupancy permit.
Facility regulations (cont.):

The organization provides evidence of compliance with applicable state and local fire prevention regulations.
Chapter 8: Facilities and Environment

Facility regulations

- Appropriate number of portable fire extinguishers [i.e., 1 unit of “A” (#A#BC) for each 1,500 SF of facility area]
- Illuminated emergency exit signs
- Emergency exit pathway lighting
- Fire-protected stairwell exits
Rules

- No smoking
- Identify and address hazards
- Accommodate disabled individuals
Emergy preparedness:

- Facility use encourages safety and security, with written policy(ies) addressing safety and security practices
  - Clinical processes and risks
  - External threats
  - Internal processes and control
- Adequate staff, equipment, and procedures to address emergency situations
Emergency preparedness (cont.):

- Documented, periodic staff education/training
- Conduct at least one emergency / disaster preparedness drill per quarter, with written evaluations of each
  - One must be cardiopulmonary resuscitation technique drill, as appropriate to the organization
  - Others should relate to reasonably likely and/or possible adverse events or conditions
Chapter 8: Facilities and Environment

- Conduct at least one scenario-based drill each calendar quarter of the internal emergency and disaster plan.
- One drill must be a documented CPR technique drill, as appropriate to the organization.
- Complete a written evaluation of each drill, promptly implementing any needed corrections.

✓ Failure to comply with one or more of these requirements resulted in a “top deficiency” for all organization types during 2013 surveys.
Chapter 8: Facilities and Environment

Policies / Systems

- Protect patients, staff and environment from hazardous materials and waste

- P&P for medical equipment include its standardized use, and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer’s specifications
Policies / Systems

- Testing of fire alarm / inspection of fire suppression systems performed and documented
Chapter 8: Facilities and Environment

Policies / Systems

- Proactive, ongoing risk assessment re: environmental hazards when there is demolition, construction or renovation
  - Safety measures are implemented as indicated
Policies / Systems

- Ongoing temperature monitoring for frozen, refrigerated and/or heated products
  - Per manufacturer recommendations
  - Stated temp ranges available to staff
Chapter 8: Facilities and Environment

Overall standards of care

*Reception areas, restrooms, telephones adequate for patient/visitor volume*
Chapter 8: Facilities and Environment

Overall standards of care

*Design and use protects patient privacy*
Chapter 8: Facilities and Environment

Overall standards of care

- Adequate light and ventilation
- Clean and well maintained
- Space allocated is for function/service
Specific standards of care

- Emergency equipment for patient care: accessible and maintained
Some items surveyors will observe/review re: facilities and environment

- Facility tour: clean, orderly, free of hazards?
- Licenses, inspection reports
- Records of emergency drills conducted
- Current “tags” on fire extinguishers
- Exit sign locations and types
Chapter 8: Facilities and Environment

Common problems re: Facilities and Environment

✓ One documented emergency drill per quarter – total of four spread over 12 months; not just fire

✓ Clean / soiled separation

✓ Testing / inspection of fire alarm and fire suppression system – and documentation thereof

✓ Construction for privacy
Questions?
Let’s break for lunch

Frank started to get a funny feeling that his doctor was a quack.
Test your knowledge!
IPC Question #1

TRUE or FALSE:

Except in Medicare certified ASCs, the AAAHC Standards do not require the infection preventionist to be a licensed professional. It could be acceptable to have a medical assistant or dental assistant as the infection preventionist as long as this person has proper training and demonstrates current competence in infection prevention and control.
IPC Question #2

TRUE OR FALSE:

All reusable fingerstick devices resembling a pen, with the means to remove and replace the lancet after each use, are intended to be used for one person only and not multi-person use.
IPC Question #3

TRUE OR FALSE:

When cleaning exam rooms between patient visits, cleaning of “high touch” surfaces and equipment that came in contact with the previous patient is required.
TRUE OR FALSE:

If a staff member's clothes or scrubs are contaminated by blood or other potentially infectious materials, the employer is responsible for laundering the soiled clothes on-site or off-site through a contracted laundry service.
TRUE OR FALSE:

It is acceptable for a doctor to wear a lab coat when seeing patients during an exam in a primary care facility as long as the coat is clean and not contaminated with blood and other infectious material during the patient visit.
IPC Question #6

TRUE OR FALSE:

When using an autoclave for sterilization, the chemical indicator should be placed inside the package so when the nurse or technician opens the package for use, the indicator is immediately seen.
THE SELECTION OF STERILIZATION PACKAGING MATERIALS IS UP TO THE ORGANIZATION; HOWEVER, THE PACKAGING MATERIAL MUST BE APPROPRIATE FOR THE SPECIFIC STERILIZATION CYCLE, TO PERMIT THE PENETRATION OF THE STERILANT, PROVIDE PROTECTION AGAINST CONTAMINATION DURING HANDLING, AND MAINTAIN STERILITY DURING STORAGE.
IPC Question #8

TRUE OR FALSE:

During the cool-down cycle of the sterilization process, visible evidence of moisture within the wrapped pack is normal.
Other Resources
AAAHC Core Standards

Chapter 5:  
Quality Management and Improvement
In striving to improve the quality of care and to promote more effective and efficient utilization of facilities and services, an accreditable organization maintains an active, integrated, peer-based program of quality management and improvement that links peer review, quality improvement activities and risk management in an organized, systematic way.
Note:
The intent of this chapter is that administrative and clinical personnel are involved in the quality management and improvement activities of the organization.
Two subchapters:

- I – Quality Improvement Program
- II – Risk Management
Chapter 5, Subchapter I: Quality Improvement Program

An accreditable organization maintains an active, integrated, organized, and peer-based quality improvement (QI) program.
Subchapter I describes components of the quality improvement (QI) program that addresses:

- Clinical, administrative and cost-of-care performance issues
- Actual patient outcomes, i.e., results of care, including safety of patients
Chapter 5, Subchapter I: Quality Improvement Program

The written QI program must:

1. *Address the full scope of services*
2. Identify responsibility – who?
3. Involve at least one (1) physician
4. Have purposes and objectives
5. Specify data collection processes used to ensure ongoing quality and identify quality-related problems or concerns (cont.)
Chapter 5, Subchapter I: Quality Improvement Program

The **written** QI program must (cont.):

6. Implement activities to improve performance
7. Describe how QI activities, peer review and risk management are integrated
8. Be evaluated annually for effectiveness
9. Describe processes used to ensure that findings are reported to governing body and throughout organization as appropriate
Chapter 5, Subchapter I: Quality Improvement Program

Implementation of data collection processes to ensure ongoing quality and identify quality-related problems or concerns. Processes include but are not limited to:

1. Analysis of results of peer review
2. Periodic audits of critical processes
3. Ongoing monitoring of important processes and outcomes of care
4. Comparison of performance to internal and external benchmarks
5. Methods to systematically collect info from other sources, e.g., patient sats, outcomes data
6. Evaluation of the info/data to identify areas for improvement
The "10 elements" of QI activities:

Written reports of QI activities include:

1. Purpose, including description of process or situation being reviewed, or of known or suspected problem

2. Measurable performance goal

3. Description of data to be collected (methodology)

4. Evidence of data collection

5. Data analysis – frequency, severity, sources of problem(s)
Chapter 5, Subchapter I: Quality Improvement Program

The "10 elements" (cont.)

Written reports of QI activities include:
6. Comparison of current performance to goal
7. Corrective action(s) / intervention(s)
8. Re-measurement
9. Additional corrective actions and re-measurement, if needed
10. Communication/reporting of findings
External benchmarking activities include but are not limited to:

- Use of selected performance measures
- Collection and analysis of performance data
- Using recognized benchmarks
- Measuring changes in performance
- Demonstrating improvement over time
- Reporting of findings
Chapter 5, Subchapter I: Quality Improvement Program

Some items surveyors will observe/review re: QI program:

- Written description of program and annual evaluation
- Linkage to peer review and risk management
- Review/critique most recent projects/studies, provide coaching
- Review Committee, Med. Exec., governing body meeting minutes
Chapter 5, Subchapter I: Quality Improvement Program

Common problems

- Exclusive or excessive reliance on quality management/monitoring vs. quality improvement (BOTH are needed)
- Failure to set a measurable performance goal (elements 2 and 6)
- Improvement topics unrelated to real events in the organization (e.g., incident reports, near misses)
- Poor documentation of data collection and analysis
- Lack of benchmarking
- No staff education and/or reporting of findings
- Lack of active physician participation
An accreditable organization develops and maintains a program of risk management, appropriate to the organization, designed to protect the life and welfare of an organization’s patients and employees.
Chapter 5, Subchapter II: Risk Management

Subchapter addresses five major topics:

1. Documented education for all staff
2. Requirements for the risk management program, which is implemented consistently throughout the organization
3. Required elements of "adverse event"
4. Additional required policies
5. Governing body responsibilities
Chapter 5, Subchapter II: Risk Management

Governing body responsibilities

- Provides oversight of risk management program
- Designates person/committee responsible for risk management
Documented education is provided to all staff within 30 days of beginning employment, annually thereafter, and when there is an identified need

Education re:

- Risk management activities, and safety policies and processes
- Infection control policies and processes
Risk management processes are implemented consistently throughout organization, including but not limited to:

1. Definition of adverse incident (see 5.II.F)
2. Identification, reporting and analysis of all adverse incidents
3. Encouraging the reporting of near-misses
4. Communication of reportable events, as required by law/regulation
Chapter 5, Subchapter II: Risk Management

Risk management processes (cont.)

5. Periodic review of all litigation

6. *Ongoing review of patient complaints/grievances*

7. Documentation of timely notification to liability carrier when adverse/reportable events occur

8. Periodic review of clinical records and clinical record policies

9. Other state or federal risk management requirements
Chapter 5, Subchapter II: Risk Management

Definition of adverse incident includes at minimum:

1. Unexpected occurrence during health care encounter, not related to the natural course of patient’s illness or underlying condition
2. Any process variation of which recurrence could result in serious adverse outcome
3. Events resulting in an outcome not associated with standard of care or acceptable risks
4. All events involving reactions to drugs, materials
5. Near-miss events
Chapter 5, Subchapter II: Risk Management

Additional risk management policies address:

1. Written methods for dismissing patient or refusing care
2. Process for managing situation in which health care professional becomes incapacitated during a procedure
3. Process for communicating concerns re: an impaired health care professional
4. Responsibility for and documentation of after-hours coverage
Chapter 5, Subchapter II: Risk Management

Additional risk management policies (cont.):

5. Policies restricting observers in patient care areas, and addressing persons authorized by GB to perform/assist in the procedure area

6. Requirement for evidence of patient consent for non-authorized staff in patient care areas
Some items surveyors will observe/review re: risk management

- Written risk management plan and/or policies and procedures
- Risk management activities and all adverse events (e.g., deaths, hospital transfers, litigation)
- Update/sign General Information Form
- Complaints
Let’s take a break…
we will resume in 15 minutes
Developing Meaningful Quality Improvement Studies
Part I: Collecting Data

Are you collecting data?  

**HINT**  
Refer to your QI program, risk assessment, actual problems, other programs requiring surveillance, state requirements for mandatory reporting, physician scorecards/dashboards, and required quality metrics for ideas.

Is your data quantitative?  

**HINT**  
Use numeric values such as “10%,” “20 out of 50,” “within 1 degree.” Avoid vague terminology.

Based on the data collected, can you identify your current performance level?  

**HINT**  
Check frequency and consistency of collection. Identify specific intervals at which you will analyze the results and determine your performance.

Don’t stop here. Put your data to work for you; go to Part II.
Part II: Compare Performance

1. Have you identified a performance goal?
   - HINT: Setting a goal helps determine if current performance is acceptable.

2. Did you use a benchmark to determine your goal?
   - HINT: Benchmarking compares your current performance measure to a specific metric. **External benchmarks** can come from nationally-recognized guidelines, federal quality measurements, a professional association for your medical specialty, the AAAH-C Institute, a literature review, or other sources. **Internal benchmarks** compare current performance to an internal metric, e.g. the same measure from last month or year, the result from another department or physician. Most goals can be benchmarked.

3. Is your goal SMART?
   - HINT: Specific means it can be translated into action. Measurable means quantitative; it has a numeric value. Achievable means realistic. Benchmarking may help establish a realistic goal. Relevant means the goal is related to your organization and matters. Time-bound means you’ve established a date for completion.

   - Y

---

**Don’t stop here. Put your data to work for you; go to Part III.**
Part III: Solve the Quality Equation

- **QA**
  - Current Performance $\geq$ Performance Goal
  - **Then** Continue monitoring; it's a QUALITY ACTIVITY

- **QI**
  - Current Performance $<$ Performance Goal
  - **Consider developing a QUALITY IMPROVEMENT Study using the 10 elements.**

**Did you meet your goal?**

- **Y**
  - Congratulations! Your monitoring is a quality activity and can remain part of your quality improvement program. *IT IS NOT ELIGIBLE TO BE USED AS A QI STUDY BECAUSE THERE IS NO GAP REQUIRING IMPROVEMENT TO MEET YOUR GOAL. Report your findings to the governing body and others. Celebrate your success!*

- **N**
  - Your monitoring activity indicates potential for improvement. Corrective action and re-measurement are the next steps. Continue to Part IV.
Let’s look at some sample QI studies
Adjunct Standards Most Often Applied in Primary Care Settings
Adjunct Chapters

9. Anesthesia Care Services
10. Surgical & Related Services
11. Pharmaceutical Services
12. Pathology & Medical Laboratory Services
13. Diagnostic & Other Imaging Services
14. Dental Services/Dental Home
15. Other Professional & Technical Services
16. Health Education & Health Promotion
Adjunct Chapters

17. Behavioral Health
18. Teaching & Publication Activities
19. Research Activities
20. Overnight Care and Services
21. Occupational Health Services
22. Immediate/Urgent Care Services
23. Emergency Services
24. Radiation Oncology Treatment Services
25. Medical Home
Overview of AAAHC

HRSA Accreditation Initiative (PAL 2009-12)
Funding Sources

HRSA: The Accreditation Initiative

AAAHC: On-site Certification

HRSA: PCMH recognition

Supplemental Funding
Perks for Participating

- Application and survey fee covered
- Nationally recognized accreditation
- Marketing boost (clinic listed on AAAHC website); provider recruitment
- Education, mentoring and resources provided
Participation In HRSA’s Accreditation Initiative

- Complete a Notice of Intent (NOI)
- Reviewed and processed by HRSA
- Notification to AAAHC from HRSA to begin the survey preparation and process
- AAAHC project manager will contact organization to begin the process
- AAAHC *Handbook* and resource materials sent
Steps to the Accreditation Survey
Steps to Accreditation

- Timeline of Events
- AAAHC *Handbook*
- Pre-Survey Assessment
- Application/Scheduling
- Mock Survey (if part of task order)
- On-site Survey
Timeline of Events

- Conduct Pre-survey Assessment
- Conference call to discuss findings
  - Summary of call sent to organization
- Submit application
- Survey scheduled
- On-site survey
- Follow-up
  - Decision letter
Pre-assessment Survey

- Select the time period during which the Pre-survey Assessment will be conducted
- Identify the staff member(s) involved in the Pre-survey Assessment
- Utilize the selected Chapters checklist in the AAAHC Handbook as your guide
- Refer to the Chapter “Tip Sheets” on the HRSA website
- Use the Pre-survey Assessment Tip Sheet to complete the assessment
Review Current Handbook

Core Chapters
- Chapters 1-8
- Applicable to all

Adjunct Chapters
- Chapters 9-24
- May apply depending on services provided

Medical Home
- Chapter 25
2. Governance

An accreditable organization has a governing body that sets policy and is responsible for the organization. Such an organization has the following characteristics.

Subchapter I — General Requirements: This subchapter describes general requirements for an organization and its governing body.

A. The organization is a legally constituted entity, or an organized sub-unit of a legally constituted entity, or is a sole proprietorship in the state(s) in which it is located and provides services.
   1. The legally constituted entity is documented by at least one of the following: articles of organization, articles of incorporation, partnership agreement, operating agreement, legislative or executive act, or bylaws, unless the organization is a sole proprietorship.

B. The names and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies, or subdivisions of other bodies, such as public agencies or religious, fraternal, or other philanthropic organizations) are available upon request and furnished to AAAHC.

C. The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to:
   1. Determining the mission, goals, and objectives of the organization.
   2. Ensuring that facilities and personnel are adequate and appropriate to carry out the mission.
   3. Establishing an organizational structure and specifying functional relationships among the various components of the organization.
Standard Rating

For each Standard:

- Assign a rating (see definitions on next slide)
  - (SC): Substantially Compliant
  - (PC): Partially Compliant
  - (NC): Non-Compliant
  - (NA): Not Applicable

- Brief comment
  - “No policy written”
  - “Reappointment of privileges not documented in the governing body minutes”

- Location of content within the organization
Standard Rating

(SC) Substantially Compliant
Current operations are acceptable; meet Standard

(PC) Partially Compliant
Portion of the Standard is met, but area(s) need to be addressed

(NC) Non-Compliant
Current operations do not meet Standard

(NA) Not Applicable (in Core Chapters)
Does not apply to the organization
## Next Step to Improvement

<table>
<thead>
<tr>
<th>Standard Rating</th>
<th>Rationale for Deficiency</th>
<th>Plan for Improvement (PFI) for each Standard Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deficiency</td>
<td></td>
<td></td>
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</tbody>
</table>

- Create a list of Standards receiving a PC or NC
- Identify missing policies/procedures, processes and documentations
- Identify corrective action(s)
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Chapter Champion/Co-Champion</th>
<th>Target Date</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient Rights and Responsibilities</td>
<td>Administrator</td>
<td>4/4/15</td>
</tr>
<tr>
<td>2.I</td>
<td>Governance</td>
<td>Administrator</td>
<td>4/4/15</td>
</tr>
<tr>
<td>2.II</td>
<td>Privileging</td>
<td>Medical Director</td>
<td>4/4/15</td>
</tr>
<tr>
<td>2.III</td>
<td>Peer Review</td>
<td>Medical Director</td>
<td>4/4/15</td>
</tr>
<tr>
<td>3</td>
<td>Administration</td>
<td>Administrator</td>
<td>4/4/15</td>
</tr>
<tr>
<td>4</td>
<td>Quality of Care</td>
<td>Staff Nurse</td>
<td>4/4/15</td>
</tr>
<tr>
<td>5.I</td>
<td>Quality Management and Improvement</td>
<td>Quality Manager</td>
<td>4/4/15</td>
</tr>
<tr>
<td>5.II</td>
<td>Risk Manager</td>
<td>Risk Manager</td>
<td>4/4/15</td>
</tr>
</tbody>
</table>
Pre-survey Assessment Call

- Organization’s goals and concerns
- Overall impression of pre-survey assessment by organization and surveyor
- Review of ratings and comments by surveyor
- Identify specific Chapter/Standard concerns
- Review surveyor summary and recommendations
- Review plan for improvement
- Surveyor answers additional questions
Application for Survey Process

- Application Coordinator: Eliana Teran
  eteran@aaahc.org
- Access the Application for Survey at
  www.aaahc.org
- Application should be submitted 3 months prior to anticipated survey date
- Submit supporting documents along with the application
Scheduling the Survey

Scheduler: Jodie Ducatenzeller

- Organization is contacted for available dates for survey
- Surveyor team is assigned
  - Re-accreditation survey: Dates must be prior to accreditation expiration date
  - Ensure key people are available
- Confirmation email is sent to the organization’s contact person
On-Site Survey

- Scheduled for 2.5 days
- Two peer surveyors will be assigned
- Report with term of accreditation within 30 days
  - 3 years, no plan for improvement; or
  - 3 years, with plan for improvement; or
  - 3 years, with plan for improvement; or
  - interim survey
- Denial of accreditation
Surveyor expectations

- Survey chair will call contact person 2 weeks prior to the survey
- Surveyors are the “eyes and ears” of AAAHC and collect facts only; do not make or provide the accreditation decision
- Survey process:
  - Opening comments
  - Tentative schedule for next 2.5 days
  - Schedule satellite visits
  - Summation conference
Examples of materials reviewed:

- Board and committee meeting minutes
- All policies: personnel, credentialing and privileging, QI, clinical records, infection prevention and control
- Contracts / agreements
- Recent audit/balance sheets
- Patient satisfaction scores
- State and local fire marshals or health department
- Staff training records
Accreditation Certificates

CERTIFICATE OF ACCREDITATION

In recognition of its commitment to high quality of care and substantial compliance with the Accreditation Association for Ambulatory Health Care standards for ambulatory health care organizations.

CERTIFICATE OF MEDICAL HOME ACCREDITATION

In recognition of its commitment to high quality of care and substantial compliance with the Accreditation Association for Ambulatory Health Care standards for medical home organizations.
Questions?
AAAHC

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