AAAHC **AENEID** Report 2014

Standards Compliance Analysis:
Credentialing, Privileging, and Quality Improvement are biggest hurdles

AAAHC
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

Institute for Quality Improvement

A NOTE FROM THE PRESIDENT AND CEO

Welcome to the second edition of the Accreditation Association Electronic National Evaluation and Information Dataset: the *AENEID Report*. This year's report is intended to provide at-a-glance information about compliance with 2013 AAAHC Standards. Those most frequently identified as partially- or non-compliant (PC or NC) by our surveyors are shown in bar graphs. We look first at the aggregate results for all types of ambulatory health care organizations, then, in greater detail, at the results for specific segments: ambulatory surgery centers, office-based surgery settings, and primary care organizations.

Standards referenced throughout this report reflect the 2013 Standards. In instances where the identifiers were changed for 2014, the new Standard ID appears in brackets. Use this document in conjunction with the 2013 or 2014 edition of the *Accreditation Handbook*.

AAAHC staff uses the *AENEID Report* to determine where we should refresh our educational focus and/or create new tools. The committee charged with annual review and revision of Standards uses the *AENEID Report* to identify where greater clarity is needed in the language of the Standards. Our surveyors use it to learn where they can do more to share best practices with the organizations they survey.

You can use this document alongside your most recent survey report to compare how your organization did on the Standards that proved challenging to many recently surveyed organizations as well as how yours compares to peer organizations. Where you find that your results were substantially compliant for Standards that were frequently rated PC or NC for others, I congratulate you. You are helping to raise the bar on quality in ambulatory health care.

If you find that your organization was challenged by the commonly deficient Standards that are reflected in the findings of this report, then please read the full analysis and consider taking advantage of the educational tools and resources that AAAHC continues to develop.

Last year, for example, we learned that emergency drills were an area of concern. An in-depth newsletter article, a webinar on using case-based scenarios for drills, and a Patient Safety Toolkit were among the ways that we responded to this finding.

Each survey returns more than 700 individual data points. I hope you will find this way of analyzing that information useful. As always, I welcome your feedback.

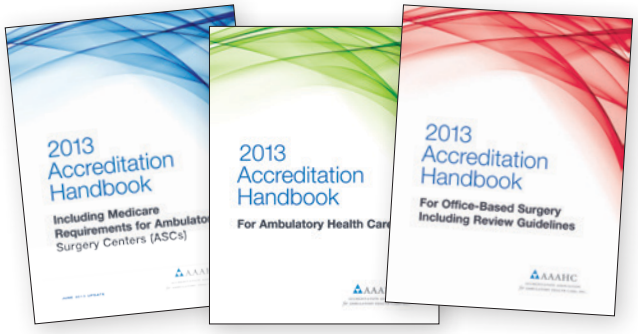
Sincerely,

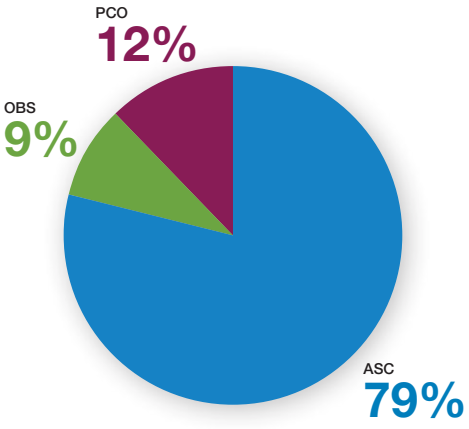
John E. Burke, PhD
AAAHC President and CEO

I. DATA SOURCE

The information in this report comes from AAAHC surveyors' ratings of and comments about compliance with our 2013 Standards. The data were collected during onsite surveys of organizations seeking initial or re-accreditation, including those in the Medicare Deemed Status program.

This report includes data collected from surveys conducted July 2013 through June 2014. It does not include focused surveys—those that did not include all core Standards (Chapters 1-8 of the *Accreditation Handbooks*)—or those that were the result of a random selection to confirm continued compliance or required inter-cycle activity.





The AAAHC Institute for Quality Improvement and the AAAHC education department analyzed 1,385 complete surveys. The pie chart shows the distribution of surveys for this period by the most commonly described organizational types: ambulatory surgery center (ASC, n=1085), office-based surgery facility (OBS, n=120), and primary care organizations (PCO, n=160) including military settings (U.S. Air Force and U.S. Coast Guard), community health, Indian health, occupational health, student health, and other primary care settings.

II. OVERALL FINDINGS

Surveyors rate Standards as substantially compliant (SC), partially compliant (PC), or non-compliant (NC). The high compliance findings represent Standards for which the proportion of SC ratings was over 99% across all organization types.

Overall, AAAHC-accredited organizations treat patients with respect, consideration, and dignity (Std.1.A). The organizations are appropriately organized as legal entities (Std. 2.I.A) and readily able to provide patients, staff and others with reliable, up-to-date information about the full range of services they provide (Std. 2.II.H.1 [2.II.I.1]).

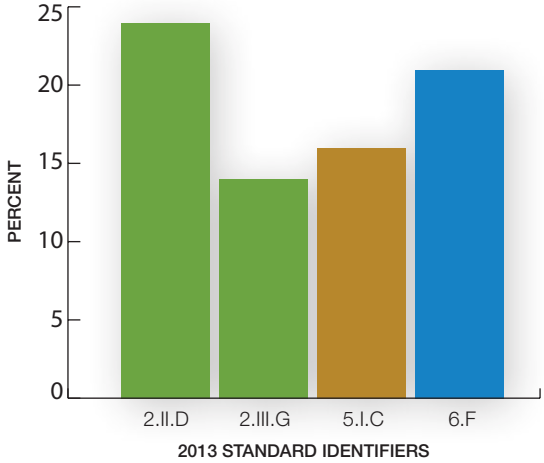
Organizations surveyed under 2013 Standards also maintained excellent fiscal controls (Stds. 3.A.4, 3.A.5.c, 6.C.5)

Most common deficiencies across all organizations

Most organizations seeking AAAHC accreditation are successful in achieving it. The *Accreditation Handbooks* are designed for use as self-assessment tools so that organizations can be fully prepared for the surveyors' review during the on-site survey. In identifying Standards that were most often rated partially- or non-compliant over a specific period of time, we are looking at those for which at least 15% of organizations received a PC or NC rating from AAAHC surveyors.

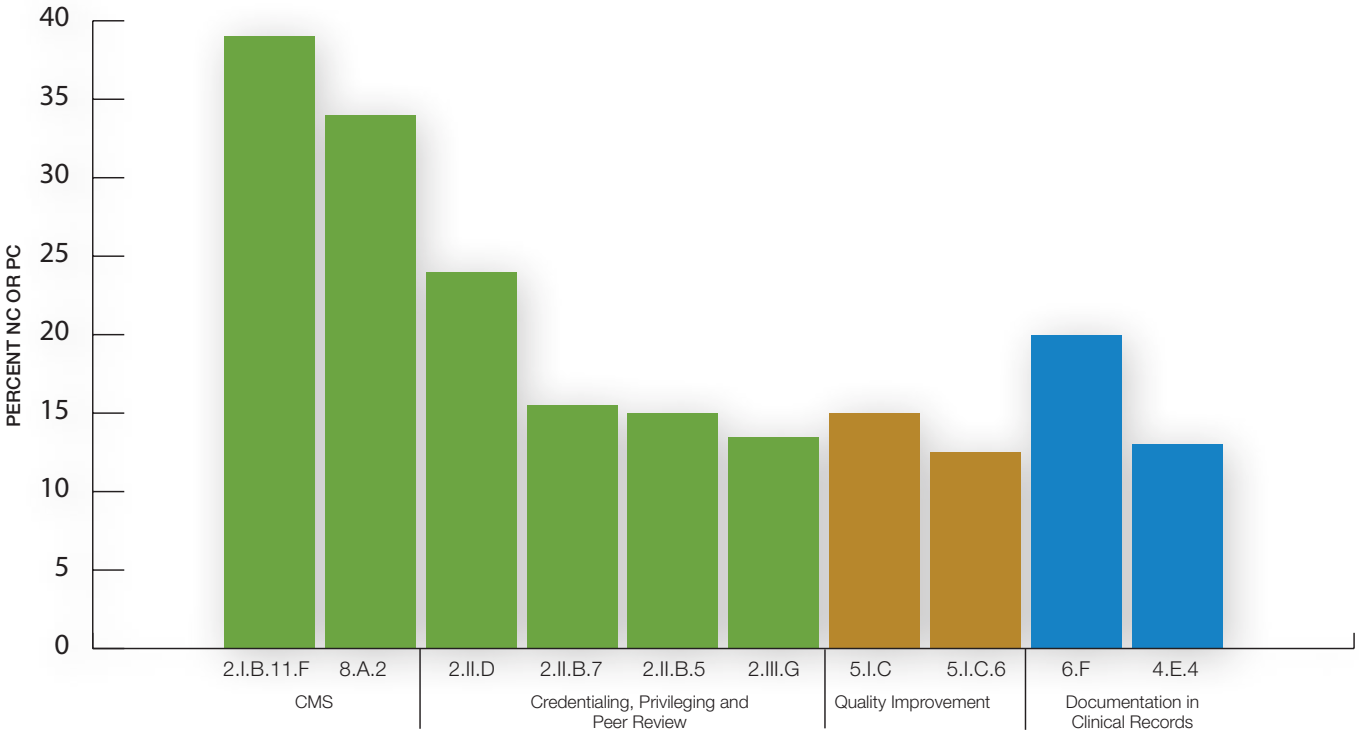
This bar graph illustrates the Standards that meet this threshold across all organizations. They have been color-coded by topic. Specific Standards related to Credentialing and Privileging (Chapter 2), Quality Improvement (Chapter 5), and Clinical Records (Chapter 6) appear in the list of top deficiencies **for all organizations**.

Although Standard 2.II.D ranked highest in the frequency with which it is cited across all organizations and it received a surveyor rating of NC or PC in more than 15% of aggregated surveys, it was not necessarily the most frequently deficient Standard for any one type of organization. Pages 4, 5, and 6 place these most common deficiencies in context by illustrating the frequency of the top deficiencies specific to ambulatory surgery centers (ASC), primary care organizations (PCO), and office-based surgery facilities (OBS).



III. ANALYSIS OF FINDINGS BY SETTING

Most common deficiencies, Ambulatory Surgery Centers



Note: There is a strong correlation between 2.II.G, and 2.II.B.5. When one of these is deficient, it is highly likely that both will be.

The two most frequently deficient Standards for ASCs (2.I.B.11.F and 8.A.2), are Medicare Conditions for Coverage requiring that the governing body ensure compliance with CMS requirements including NFPA Life Safety Code regulations. These Standards are applicable to any organization participating in the Medicare/Medicaid program.

For Deemed Status organizations, the chart below shows the five Medicare Conditions for Coverage and Life Safety Code requirements most frequently cited as deficient. Refer to your *Handbook* for specifics.

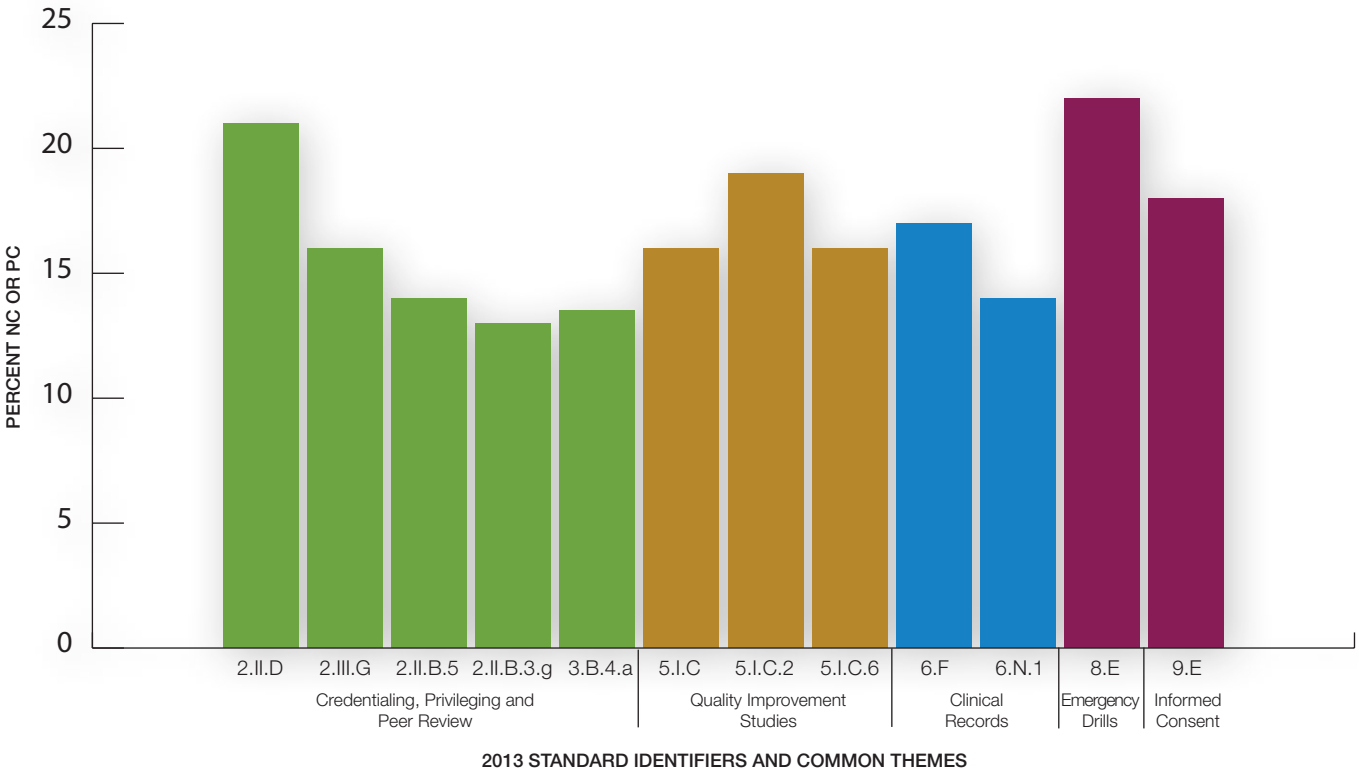
CMS Conditions for Coverage	Life Safety Code identifiers as used in the AAAHC Physical Environment Checklist (PEC)
416.44(b)	1.1o
416.44(b)(1)	2.1o
416.44(4)	3.1o
416.47(b)(5)	8.2o
416.49(B)(2)	10.1o

The operational requirements of the Life Safety Code mandate routine inspection, testing, and maintenance for structural components building systems and for each piece of equipment. Manufacturers and/or the National Fire Protection Association have outlined what, how, and when to inspect and test parts or the whole. If repairs are needed during these scheduled inspection and testing intervals, surveyors will look for documentation of repairs and subsequent testing or routine inspections that provide evidence that the repair was successful.

Standards 2.II.B.5 and 7 refer to the requirement that medical staff submit an application for re-appointment and that peer review is a factor in this review. For solo medical/dental practices, an outside peer must provide review of the re-appointment application and credentials.

An additional deficiency frequently cited in ASC settings but not seen in other types of organizations is a failure to perform medication reconciliation (Standard 4.E.4). Organizations that have been rated PC or NC for this Standard may use this information for a meaningful quality improvement study.

Most common deficiencies, Primary Care Organizations



The Standard most frequently rated PC or NC for PCOs is 8.E, the requirement for four quarterly emergency drills, one of which must be (or include) a CPR drill. Each drill must be documented with corrective actions noted and implemented as needed. In 2014, the AAAHC Institute and the AAAHC Education Department developed and published a tool to help organizations implement and document scenario-based emergency drills. This tool can be downloaded electronically, or purchased as a hard copy on our website.

Standard 9.E relates to documentation of informed consent for procedures, including those where only local or topical anesthesia or minimal sedation is administered.

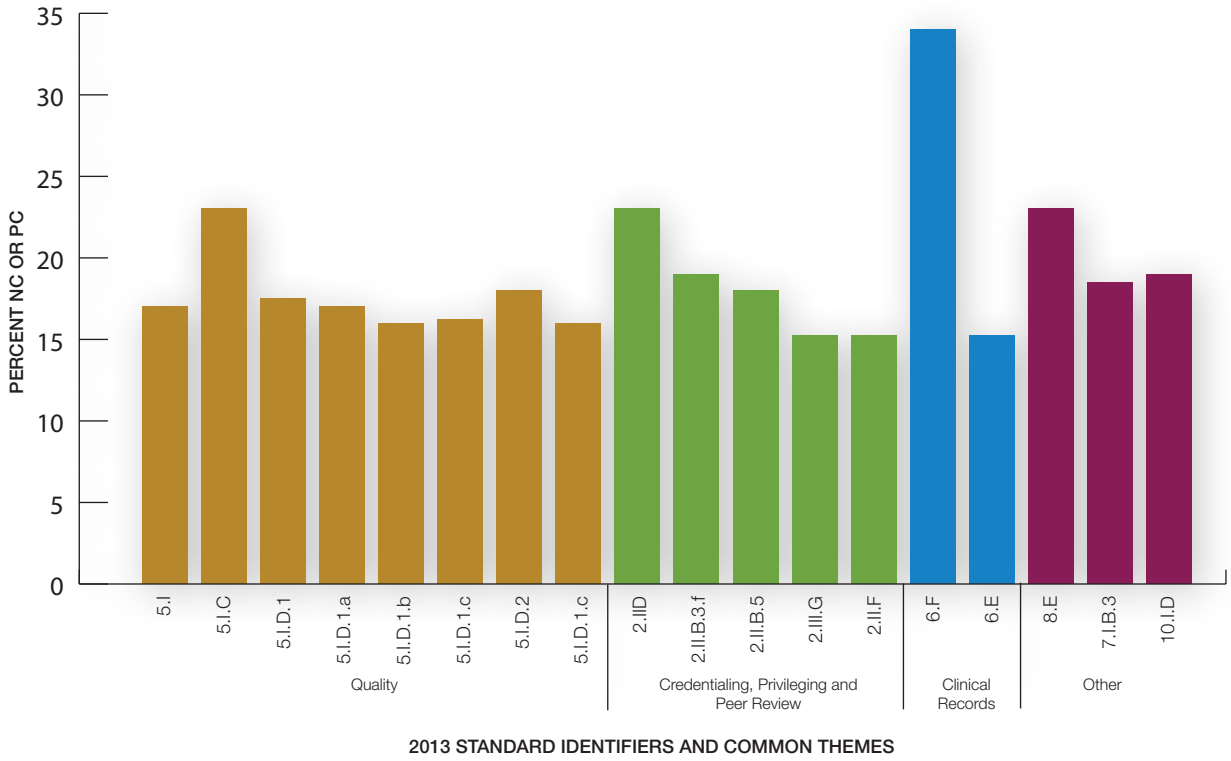
The remaining Standards frequently rated PC or NC fall within the categories of Credentialing, Privileging, and Peer Review, QI studies, and documentation and management of clinical records. See pages 7 and 8 for additional information.

Sixty-nine of the PCOs surveyed under 2013 Standards sought accreditation as a Medical Home. The table below lists the Medical Home Standards most frequently rated PC or NC.

Medical Home (Chapter 25) Deficiencies >15%	
Relationship	25.A, 25.A.1.12-16
Accessibility	25.B, 25.B.1, 25.B.2
Comprehensiveness of Care	25.C.2.b, c, and f
Continuity of Care	25.D.11
Quality	25.E.5, and 6.a-e

Most deficiencies for Medical Home organizations are relationship Standards. Many of these, plus additional Standards relating to accessibility, have to do with communications between providers and patients, specifically whether/how aspects of the medical home practice model are shared with patients. Organizations are finding additional challenges with proactive communications about wellness and life/care transitions. For further information on deficiencies in the category of Quality, see page 8.

Most common deficiencies, Office-Based Surgery Organizations



A higher proportion of Standards were rated PC or NC for office-based surgery organizations than for other types of ambulatory health care settings. OBS facilities may need to pay special attention to committing policies and processes to paper and to on-going internal review of these protocols.

More than 15% of the OBS organizations surveyed under 2013 Standards were rated PC or NC for Chapter 5, subchapter I (Quality Improvement Program), as a whole. Within that subchapter, seven Standards, elements of Standards, or sub-elements of Standards contributed to this overall chapter deficiency. See pages 8 and 9 for more information on 5.I.C and for information on benchmarking resources.

For office-based surgery facilities, the most frequently deficient Standard is 6.F with almost 30% failing to achieve a rating of Substantially Compliant. See page 8 for more information on this Standard.

Standard 8.E, the requirement for four quarterly emergency drills, one of which must be (or include) a CPR drill is another “problem” Standard for OBS organizations. At least one drill is required each calendar quarter. Each drill must be documented with corrective actions noted and implemented as needed. In 2014, the AAAHC Institute developed and published a tool to help organizations implement and document scenario-based emergency drills. This tool can be downloaded electronically, or purchased as a hard copy on our website.

Standard 7.I.B.3 is the requirement that the infection prevention and control program be under the direction of an designated individual with training and current competence in infection control. This is a safety issue for both patients and employees and, as such, important for the organization. AAAHC does not define the required training for this role; it is up to the organization to determine this. Once established, however, our surveyors will be looking for evidence that the organization is meeting its own policy requirements.

Standard 10.I.D requires a current health history (within 30 days) of any procedure.

The remaining high-deficiency Standards relate primarily to peer review, another critical element of ensuring high quality care (see page 7).

IV. ANALYSIS OF OVERALL FINDINGS

Chapter 2: Governance, subchapter II – Credentialing and Privileging

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

Intent of the Standard

The purpose of this Standard is to ensure that all services offered by the organization are provided by health care professionals identified by the governing body as qualified to provide them. Provider privileges are granted for a specific period of time so that there are opportunities for the governing body to reassess services provided, as well as the qualifications required for providing those services, and to determine if the continuation of an individual's privileges is appropriate.

Physicians, dentists, and others are credentialed and privileged according to medical staff bylaws, rules/regulations and policies established by the governing body.

Surveyor findings

Comments provided when this Standard is rated PC or NC usually cite:

- Individuals administering anesthesia and/or those supervising others who administer anesthesia have not been granted privileges to do so.
- Individuals have not been granted privileges for specific technologies, procedures, or activities, such as lasers, ultrasound, admitting patients to overnight care, and the interpretation of diagnostic images.
- Core privileges have been granted without identifying what these privileges include.
- Inappropriate privileging is taking place, e.g., the defined process is bypassed by signing off on one's own privileges or granting privileges based on those approved at another health care facility.
- There has been a failure to re-privilege at re-appointment.
- Privileges were granted without governing body review/approval.

Hints for meeting 2.II.D

- An organization may not rely on another organization to grant privileges to its medical and dental staff.
- An organization can only privilege its physicians and dentists for procedures approved by the governing body and that the facility is equipped to safely perform.
- Documentation of initial privileging and reappointment must include a specific time period for which the privileges are granted.
- Ensure the documentation of specific privileges e.g., anesthesia, fluoroscopy, laser, and supervision.
- When services are added, or when services are no longer provided, review and edit your privileging forms to reflect these changes.

Chapter 2: Governance, subchapter III – Peer Review

Std. 2.III.G [2.III.H] *The results of peer review are used as part of the process for granting continuation of clinical privileges as described in Chapter 2.II.*

Intent of the Standard

The purpose of this Standard is to ensure that the results of peer review are considered by the governing body when the health care professional applies for the continuation of clinical privileges. Peer review information would not have been available when the individual was new to the organization and first applied for privileges, but at the time of reappointment, it should be available and included in the consideration of whether to grant continuation of privileges.

Surveyor findings

Most (over 80%) of comments provided when this Standard is rated PC or NC indicate that peer review is conducted, but that the results are not integrated into the re-privileging/re-appointment process.

Additional comments include:

- Peer review for CRNAs is not conducted and; therefore not used for re-privileging/reappointment.
- Physician Assistants (PA) are not being required to apply for privileges, and therefore do not apply for re-privileging/reappointment.
- There is inconsistency in the application of the organization's peer review policy, especially with regard to timing of re-privileging/re-appointment.

Hints for meeting 2.III.G [2.III.H]

- This Standard is closely related to Standards 2.II.F and 2.III.B, which serve as prerequisites to an SC rating for 2.III.G [2.III.H]. Standards 2.II.F requires a formal process for the appointment, reappointment and privileging of health care professionals; Standard 2.III.B requires that each physician or dentist receives peer review.
- The peer review process should not be limited to review of clinical records, but should also incorporate other items such as infection rates, patient satisfaction survey results and compliance with medical staff rules and regulations.
- Providers should participate in determining the criteria for peer review.
- The results of peer review must be communicated to the governing body.

Chapter 5: Quality Management and Improvement, subchapter I – Quality Improvement Program

Std. 5.I.C *The organization demonstrates that ongoing improvement is occurring by conducting quality improvement studies when the data collection processes described in Standard 5.I.B indicate that improvement is or may be warranted. Written descriptions of QI studies document that each study complies with each of the [ten] elements as applicable.*

Intent of the Standard

Organizations are usually engaged in the collection of data about various aspects of their performance (as required by Standard 5.I.B) but all too often, the data is not reviewed or analyzed to identify what it is actually saying about that performance. The purpose of this Standard is to ensure that the data is reviewed and that, when opportunities for improvement are identified, the organization takes steps to demonstrate the implementation and success of corrective actions.

Hints for meeting 5.I.C

- Ensure that performance-related data is carefully reviewed on a regular basis, to identify trends or specific incidents that present opportunities for improvement.
- Use the templates provided in the Worksheets and Forms section of the *Accreditation Handbook* to ensure that each of the 10 elements of a QI study is addressed.
- Assess QI studies (especially goals) against SMART criteria: Specific, Measureable, Achievable, Relevant, Time-bound.

Chapter 6: Clinical Records and Health Information

Std. 6.F *The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistently defined location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.*

Intent of the Standard

In an accreditable organization, clinical records are complete, comprehensive, legible, accurate and provide easy access to information to support high-quality care for each patient. Up-to-date, accurate information about patient allergies and untoward reactions is critical to providing high-quality care. The purpose of this Standard is to ensure that the clinical records contain this important information.

Surveyor Findings

Frequent comments provided when this Standard is rated PC or NC include:

- Allergies have not been verified/updated on each visit.
- Documentation regarding allergies is inconsistently located in clinical records.
- "Allergies" are listed, but the reactions are not.
- There is reliance on "NKDA" (No Known Drug Allergies) without reference to other types of allergies/sensitivities.

Hints for meeting 6.F

- As one consumer company says, "Just do it." Random chart audits are a good way to assess whether allergies/sensitivities are being consistently recorded.
- Be sure to include reactions to materials; enter "unknown" as a response if the patient can't describe the reaction. At least you (and your surveyor) will know that it has been assessed.

V. FOCUS FOR IMPROVEMENT 2015

Organizations should initiate a self assessment using the data in this report. Refer to your most recent survey report for the relevant Standards and the comments your survey team may have provided to explain PC or NC ratings.

AAAHC will continue to implement targeted interventions to help organizations improve their understanding of and compliance with Credentialing, Privileging, and Quality Improvement Standards.

Look for:

- Clarification to existing Standards regarding credentialing and privileging.
- "Illuminating Quality Improvement," launching at *Achieving Accreditation* in December 2014.
- Increased emphasis on these topics in newsletters, webinars, and conference presentations.
- Ongoing development of new tools to assist organizations in improving their compliance with AAAHC Standards.
- Additional consultative support from surveyors while on-site.

AAAHC Institute Resources

The resources identified here are available (many of them free of charge) at www.aaahc.org/institute.

The Bernard A. Kershner Innovations in Quality Improvement Award is presented each December for excellence in QI studies. One award is given to the best study by a surgical/procedural organization; another is given for the outstanding work by a primary care organization. The awards are made at the *Achieving Accreditation* seminar with winners presenting their work through poster presentations for attendees.

Previous winning studies are published in the annually updated *Innovations in Quality Improvement Compendium*, available for purchase at www.aaahc.org/institute > Publications.

Quality Improvement Insights is a collection of white papers on specific topics in the area of QI including benchmarking.

Using Benchmarking Measurement to Improve Performance Over Time is a white paper illustrating the use of benchmarking within a QI study. This resource is available free of charge on our website.

New workbooks for QI novices and advanced practitioners are planned for release in 2015.

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