AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

AAAHC Readiness Checklist
AAAHC Accreditation Program
Surgical / Procedural Client Resource

This Checklist is designed to serve as a resource regarding specific COVID-19 considerations for compliance with AAAHC Standards.

The checklist is recommended to clients as a self-assessment tool, to help their organization both prepare for survey and maintain compliance throughout the 1095 accreditation cycle. AAAHC has not changed any Standards at this time, other than as indicated in v41 of the *Accreditation Handbook for Ambulatory Health Care*.

Organizations are expected to make all appropriate policy and procedure revisions to address infectious disease/pandemic considerations, such as changes that may be required during the COVID-19 public health emergency.

For organizations that during 2020/2021, due to COVID-19, were closed or operating at reduced capacity or altered functionality, there may be requirements that could not have been met for that window of time. When Surveyors are on site to conduct a survey, clients should help you understand if this was true for their organization as this will factor into your assessment. Please reference the final page of this resource for more detail and specific Standards implications if this is applicable to an organization (e.g., which Standards may have been waived or deferred as you look back at their compliance throughout their accreditation cycle).

v41 Standard	COVID-19 Considerations for Standards Interpretation	Yes	No	NA
1.A.4	Patients are notified of any time-relevant COVID-19 exposure within the facility in accordance with state and local requirements, if any.	☐	☐	☐
1.C	Patient responsibilities have been updated to include responsibility for adherence to COVID-related policies and procedures.	☐	☐	
2.I.B 2.I.C	If the facility was closed or operating with altered functionality, the governing body developed and approved a plan for resuming normal operations.	☐	☐	☐
2.I.C.5	The organization remained open, reduced services, or closed in accordance with federal, state, tribal, and/or county or city mandates.	☐	☐	
2.I.H	The requirement to notify AAAHC of closures or suspension or addition of services directly related to COVID-19 has been waived until further notice. If changes unrelated to COVID-19 occurred, AAAHC was notified within 15 days.	☐	☐	
2.II.A 2.II.B	Emergency/disaster privileges granted, if any, followed procedures in the organization's credentialing and privileging and/or emergency preparedness policy. If this was not previously addressed in the policies, it has been incorporated in accordance with the organization's process for the approval of policies.	☐	☐	☐
3.C	Personnel policies have been updated to reflect policies for screening and testing of staff for COVID-19, and for any additional policies related to social distancing, use of masks, etc.	☐	☐	
3.D	There is documentation of training of **all** staff in **all** pandemic management policies and procedures.	☐	☐	
4.C	Staff are qualified and sufficient for current services provided.	☐	☐	☐
4.H	If the organization has a transfer agreement with a hospital, it has confirmed that the hospital remains able to accept patients.	☐	☐	☐
5.I.C	Data collection processes remain in place and/or are addressed in the plans for reopening.	☐	☐	
5.I.D 5.I.E	If QI and/or benchmarking activities and studies were suspended, there is a plan for resuming them and/or for beginning new activities/studies.	☐	☐	☐

5250 Old Orchard RD, STE 200
Skokie, Illinois 60077
TEL 847.853.6060
FAX 847.853.9028
www.aaahc.org
info@aaahc.org

v41 Standard	COVID-19 Considerations for Standards Interpretation	Yes	No	NA
5.II.A 5.II.B	Risk management policies have been updated to reflect pandemic considerations, *e.g.,* refusing care, restrictions on observers, persons authorized to perform or assist in procedure areas, reporting of infectious disease events (if required).	☐	☐	
6.F 6.H	Clinical records demonstrate that the organization follows its policies for screening and testing of patients for COVID-19.	☐	☐	
6.I 9.F 10.I.J	Clinical records demonstrate that discussion of the risks of the procedure include any risks specific to COVID-19 if appropriate (e.g., an organization performing upper endoscopy procedures); such risks are also documented as part of the patient's informed consent (if appropriate).	☐	☐	☐
7.I.A 7.I.B	• The organization performed a risk assessment specific to COVID-19 and updated the infection prevention and control program accordingly. • The updated program is based on nationally recognized guidelines for addressing pandemics. • The updated program specifically addresses how compliance with hand hygiene protocols is monitored. Evidence demonstrates that monitoring is occurring, and staff are compliant. • The updated program complies with applicable federal, state, county, city and/or tribal requirements addressing COVID-19. • If the organization did not close, any updates to the program were approved by the governing body. If the organization was closed at any time during the pandemic, approval was obtained before reopening.	☐	☐	
7.I.D	Cleaning, decontamination, high-level disinfection and sterilization processes have been reviewed and updated as needed to address requirements for COVID-19.	☐	☐	
7.I.D.6	If the organization was closed, the sterility and integrity of equipment and instruments was verified prior to reopening.	☐	☐	☐
7.I.G	The infection prevention and control program addresses new or revised needs for space, equipment, supplies, and personnel, and ensures they continue to protect patients and others from infection.	☐	☐	
7.I.H 7.I.I	Cleaning policies have been updated in accordance with nationally recognized guidelines for the current pandemic, and include policies for cleaning *all* areas of the facility (reception areas, office and storage spaces, restrooms, etc.) and *all* medical devices.	☐	☐	
7.II.A	The safety program has been updated if needed to include processes for managing potential and actual disease exposure (such as COVID-19).	☐	☐	
7.II.F 11.L.2-4	Expired products are not used unless the FDA has approved their use. If expired products are used, the organization has documentation of FDA approval for use beyond the original expiration date. **See below information regarding the use of expired products.**	☐	☐	
7.II.G	The system for the management of hazardous waste addresses the storage and cleaning of attire and other laundry that may have been exposed to biologic hazards (such as COVID-19).	☐	☐	
7.II.H	If the organization closed, temperature monitoring may have continued; if so, documentation must be present. If monitoring was suspended, such products were replaced prior to reopening.	☐	☐	☐

v41 Standard	COVID-19 Considerations for Standards Interpretation	Yes	No	NA
7.II.L	Documentation demonstrates that staff have been trained on new equipment or supplies, to include new PPE or testing equipment or supplies, introduced to the facility.	☐	☐	
7.II.N	Health care workers are protected from COVID-19 exposure, consistent with state, federal and CDC guidelines.	☐	☐	
7.II.Q.2	If a staff member contracts COVID-19, tracing determines whether exposure occurred within the facility, and whether that staff member exposed others within the facility. Policies and processes required by Standards 7.I.B and 7.I.F are followed as necessary.	☐	☐	
8.B.5	If present, the fire suppression system was tested prior to reopening and manufacturer recommendations for inspection, testing and maintenance are up to date.	☐	☐	☐
8.C	Illuminated exit signs are in working order.	☐	☐	
8.D	Safety policies have been reviewed and updated with consideration for appropriate social distancing.	☐	☐	
8.E	Appropriate social distancing measures and requirements for personal protective equipment (PPE) have been implemented in reception areas and restroom facilities.	☐	☐	
8.H	The written emergency and disaster preparedness plan addresses pandemic considerations. If not, the plan was updated.	☐	☐	
8.K	If the organization was closed, emergency equipment was checked and tested prior to reopening; emergency equipment and supplies must be present for reopening.	☐	☐	
10.I.D.1	Criteria for patient selection should be updated to address the inclusion or exclusion of patients related to COVID-19.	☐	☐	☐
10.I	The pre-operative evaluation (H&P) considers whether patients whose surgery was delayed remain appropriate candidates for surgery in an ASC setting.	☐	☐	
10.I.K	Written policies for infection prevention safeguards in the surgical environment have been reviewed and updated with consideration for pandemics, including: • Persons authorized to be in surgical or treatment areas • Additional or revised requirements for PPE for patients and staff (and visitors, if permitted) • Storage and cleaning of attire and other laundry that may have been exposed to biologic hazards • Ensuring that temperature, humidity and air pressure controls have been updated to reflect any changes in nationally recognized guidelines.	☐	☐	
10.I.P	With consideration for COVID-19, the organization has a process in place for an additional time-out, if necessary.	☐	☐	☐

****Survey Procedure: Expired Medications and Other Products**

If the organization is stocking medications with extended expiration dates per the FDA, the written policy and the procedure for handling expired items should have been revised and re-approved to reference the FDA list.

Under v41 Standards, if the organization's written policy allows for continued stocking of medications or other products described specifically by the FDA as having an extended expiration date, per v41 Standard 11.L.3. If the item has an extended expiration date, segregation is not necessary until the new expiration date. If other products with extended expiration dates are used, the policy required by v41 Standard 7.II.F has also been updated accordingly.

This allowance is limited to items approved by the FDA for use beyond the original expiration date. In all other cases, the surveyor must follow normal survey protocol for expired medications and other products.

https://www.fda.gov/drugs/coronavirus-covid-19-drugs/drug-shortages-response-covid-19

Review the following items if the Standard is applicable to the organization:

v41 Standard	COVID-19 Considerations for Standards Interpretation	Yes	No	NA
12.A	If the organization provides testing for COVID-19, it has obtained the CLIA certificate required to perform the particular test. If the organization is only permitted to conduct waived testing but is using a test designated for moderate or high-level complexity testing, documentation demonstrates FDA Emergency Use Authorization for the test when only a CLIA waiver is present.	☐	☐	☐
20.C	The organization has clearly defined the scope and limitations of overnight care during the COVID-19 pandemic (e.g. inclusion and exclusion of patients, temporarily discontinuing services, etc.).	☐	☐	☐
20.D	Policies and procedures address overnight care during the COVID-19 pandemic.	☐	☐	☐

Review the following if the organization has begun to provide telehealth services:

v41 Standard	COVID-19 Considerations for Standards Interpretation	Yes	No	NA
1.A	Patient privacy remains protected in accordance with HIPAA/FERPA.	☐	☐	☐
1.B 1.C	Patients are informed of their rights and responsibilities, and there is a mechanism by which patients acknowledge receipt of such information.	☐	☐	☐
2.I.H 2.I.J.6	If telehealth is a new service, it was approved by the Governing Body and AAAHC was notified.	☐	☐	☐
6.F 6.H	If the organization is using the same clinical record template (paper or electronic) for telehealth as for in-person visits, there may be gaps in the clinical record for items that cannot be accomplished via telehealth.	☐	☐	☐
6.I	Clinical records demonstrate that the patient consents to a telehealth visit, either verbally or in a written format that can be uploaded.	☐	☐	☐
6.K.2	Clinical records contain summaries of telehealth visits.	☐	☐	☐

Normal Operations: Organization was delivering onsite patient care throughout the public health emergency (regardless of volume).

Note: If the organization was open but only performing emergency procedures, they were expected to have been fully compliant with all direct patient care and patient safety-related Standards (i.e., applicable Standards in Chapters 6, 7, 8, 9, 10 and 11).

Waived Standard: A requirement that, during the period in which an organization was closed or operating at reduced capacity or altered functionality (e.g., converted into a hospital), could not be met (e.g., something time bound, such as quarterly drills).

- For these Standards, organizations are not expected to have made up for waived items but are expected to have resumed compliance as they returned to normal operations.
- Example: the organization did not conduct a drill in Q2 because it was closed. While it is not necessary for the organization to have conducted two drills in Q3, the organization must have created and carried out a plan to complete the required drill in Q3. However, if the organization was not compliant with this Standard *before* it closed, for some portion of their term of accreditation, a deficiency should be cited.

Deferred Standard: A gap in the application of policies during the period in which an organization was not seeing patients onsite or conducting normal operations.

- For these Standards, organizations must have caught up, but will not be deficient for the gap incurred while not conducting normal operations
- **Deferred Standard – Safety: Must have been addressed and brought back into compliance before the resumption of onsite patient care.** Example: doing the full review, re-stocking, and testing equipment on the crash cart according to organization policies. It is acceptable that there was a gap in these checks while the organization was closed, as long as these procedures were completed prior to resuming onsite patient care.
- **Deferred – Administrative: Must have been caught up within 30 days of resuming onsite patient care**. Example: resuming data collection activities that drive an organization's quality improvement activities and studies. If the organization was not compliant with this Standard before it closed, for some portion of their term of accreditation, a deficiency will be cited.

Review the following items if your organization closed or experienced reduced or alternate capacity:

v41 Standard	W: Waived DA: Deferred-Admin DS: Deferred-Safety	These requirements may be waived or deferred depending on whether the organization maintained normal operations versus was closed or operated in a reduced or alternate capacity	Yes	No	NA
2.I.G	DA	Governing body meetings as required by timelines specified in organization's bylaws or policies	☐	☐	
2.I.J	DA	Governing body annual review of accreditation requirements (if scheduled meeting was missed due to COVID-19)	☐	☐	
2.II.E 2.II.I 2.II.L	DA	Approval of applications for reappointment, and of privileges that may have expired	☐	☐	
2.II.J	DA	Ensuring date-sensitive information such as licensure, DEA registrations and Board certifications are current	☐	☐	
2.II.K	DA	Reappointment, including peer review, of solo providers	☐	☐	☐
2.II.M	DA	Reappointment of allied health care professionals	☐	☐	☐
2.III.A 2.III.B 2.III.C.5	DA	Annual peer review (or more frequent if required by the organization's policies)	☐	☐	
2.III.D	DA	Ongoing data collection for peer review	☐	☐	

v41 Standard	W: Waived DA: Deferred-Admin DS: Deferred-Safety	These requirements may be waived or deferred depending on whether the organization maintained normal operations versus was closed or operated in a reduced or alternate capacity	Yes	No	NA
3.E	DA	Timelines for orientation and annual training	☐	☐	
5.I.C	DA	Ongoing data collection processes for quality improvement	☐	☐	
5.I.D 5.I.E	DA	If QI and/or benchmarking activities and studies were suspended, there is a plan for resuming them and/or for beginning new activities/studies.	☐	☐	
7.II.D 9.N 9.T	DA	Current certifications (BLS, ACLS, PALS) [*Note:* Certifications may have expired but COVID-19 related extensions associated with renewal dates have concluded.]	☐	☐	
8.B.1 8.B.2	DS	Monthly inspections of fire extinguishers, and documentation of annual inspection	☐	☐	
8.I	W	Quarterly emergency drills	☐	☐	
8.J	DS	Maintenance of medical equipment according to manufacturer instructions	☐	☐	
9.D	W	Supervision of CRNAs if required by the state – requirement suspended by CMS.	☐	☐	