AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE

Accreditation Handbook for

Ambulatory Health Care, v43

quality every day
1095 STRONG

OUR MISSION

Improving Health Care Quality Through Accreditation

AAAHC

ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE

Foreword

Thank you for choosing the *Accreditation Handbook for Ambulatory Health Care*, v43 to facilitate your accreditation journey. We welcome ambulatory care organizations seeking AAAHC Accreditation to review and prepare using this valuable resource.

AAAHC began accrediting ambulatory organizations in 1979 with a commitment to improve health care quality. We thank our accredited organizations, partner associations, committees, staff, AAAHC Surveyors, and other subject matter experts for their contributions during the extensive review process. AAAHC leverages this expertise to ensure we maintain relevance and bring value to your practice.

More than 40 years later, we continue our commitment to ambulatory accreditation and certification with enhanced tools and education that support the *1095 Strong, quality every day* philosophy. This edition inaugurates *1095 Engage*, our uniquely designed Accreditation Management System (AMS) which empowers health care organizations to pursue excellence by providing single-source operations solutions. Enjoy the benefits of a full suite of automated guidance and resources to organize and update your required application/profile documentation and keep your organization *1095 Strong*.

AAAHC transitioned to *1095 Engage* with the needs of clients at the forefront. Features include a living profile that drives Standards curation, facilitates organizational change notifications, reinforces ongoing compliance, and accelerates triennial renewal processes. The AMS also provides on-demand access to accreditation documents such as decision letters, survey reports, and certificates. The implementation of *1095 Engage* required Standards revisions and structural changes to enable Standards curation. The new architecture transforms AAAHC Standards from chapters to more cohesive categories and better enables Standards curation so that you can focus on what is most important to your organization.

AAAHC is confident we can work together and unite on the mission of improving health care quality through accreditation and certification, and we will continue to meet evolving challenges and opportunities as they emerge. AAAHC is committed to being a trusted, valuable partner and your resource for updates, education, and guidance on industry issues that affect your organization's business and patient care.

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

Noel M. Adachi, MBA
AAAHC President & CEO

David Shapiro, MD
AAAHC Board Chair

Corrected edition issued January 5, 2024

Acknowledgements

We gratefully acknowledge the efforts of the AAAHC Board of Directors, Standards Development and Expert Content Committees, and the AAAHC staff.

These committees ensure AAAHC measurably drives quality improvement in patient care through Standards that reflect current best practice, are evidence-based and relevant to the intended setting(s), and are understandable, measurable, beneficial, and achievable. The Expert Content Committees are specific to the specialty(ies) and/or practice setting(s) assigned.

These committees are composed of individuals with professional technical, administrative, or clinical expertise in the assigned areas with interest in promoting quality in ambulatory care.

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Note to Readers

Using this Handbook

This Handbook has been developed to communicate AAAHC policies and procedures, to assist organizations in realistically assessing compliance with AAAHC Standards, and to provide resources to help health care organizations improve the quality of services they provide to patients.

AAAHC reserves the right to amend its Standards and Policies and Procedures so long as it provides all accredited organizations with notice of such amendments or includes such amendments in the most recent version of the Handbook.

Supplemental Resources

The AAAHC website offers resources for every step of your *1095 Strong* journey. For more than 40 years, AAAHC has been driving quality improvement in ambulatory patient care by identifying trends and improving AAAHC Standards compliance via meaningful performance measurement, evidence-based resources, and focused educational opportunities.

Refer to the *1095 Engage* portal and the AAAHC website for additional resources to guide your compliance journey.

Maintaining Contact with AAAHC

AAAHC frequently uses email to distribute important information to accredited organizations. We rely on each accredited organization to make sure that these communications reach the relevant individual by designating a Primary Contact. AAAHC encourages organizations to specify *two* contacts within the *1095 Engage* system.

If your organization changes its Primary Contact, it is important that you update your *1095 Engage* profile to be sure your organization continues to receive important and timely accreditation information. To ensure data integrity, accuracy, and ownership, AAAHC will not enter changes on behalf of the organization. It is the organization's responsibility to enter Change Notifications.

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3 Parkway North, Suite 201
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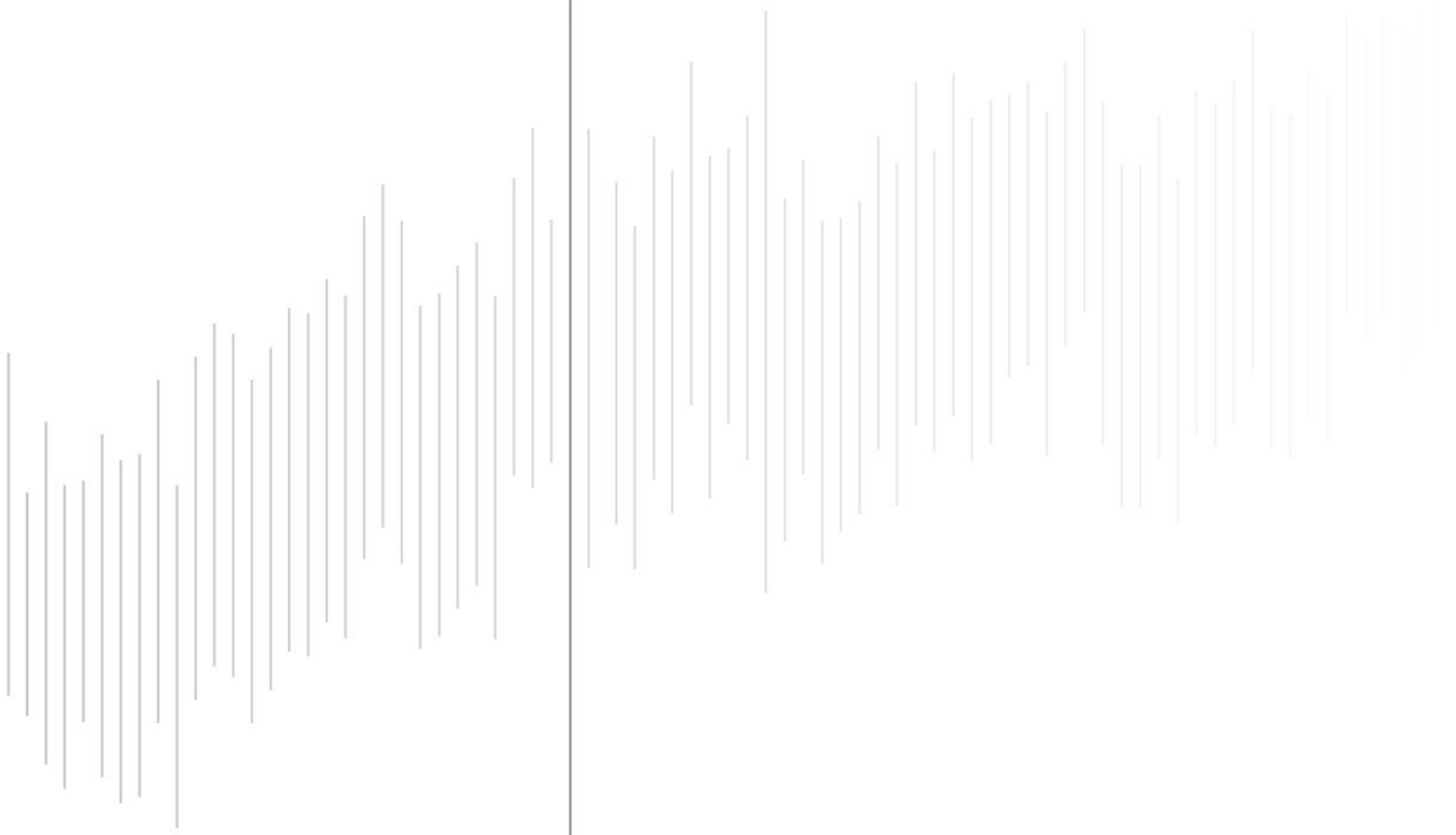

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Introduction

Core to our mission and vision is the *1095 Strong, quality every day* philosophy. *1095 Strong* is a commitment to ongoing education and quality improvement, which demonstrates survey readiness not only on the day of the survey but all 1,095 days of the accreditation term, *1095 Strong* cycle. Through its programs and commitment to this philosophy, AAAHC promotes safe, high-quality patient care and performance measurement in organizations providing health care services in ambulatory settings.

A wide variety of health care organizations use AAAHC Standards and accreditation procedures to improve the quality of care they provide as well as the overall effectiveness and efficiency of their operations. AAAHC accredits ambulatory organizations that fulfill the eligibility criteria outlined in its policies. Setting/practice types include but are not limited to:

- Ambulatory clinics
- Ambulatory surgery centers
- College and university health centers
- Community health centers
- Convenient care clinics
- Correctional health care
- Dental practices
- Diagnostic and other imaging centers
- Endoscopy centers
- Indian health centers
- Lithotripsy practices
- Military ambulatory health care facilities
- Multispecialty group practices
- Non-surgical health care networks
- Occupational health centers
- Office-based anesthesia organizations
- Office-based surgery centers and practices
- Oral and maxillofacial surgery practices
- Pain management centers
- Podiatry practices
- Primary care practices, including those functioning as Medical Homes
- Radiation oncology centers
- Single-specialty group practices
- Urgent or immediate care centers
- Women's health centers
- Worksite health centers

AAAHC offers a range of programs to meet the needs of different settings and practice types. Refer below to *Program Participation Eligibility Criteria* for more information on participation requirements. For additional details, visit the AAAHC website at **www.aaahc.org**.

This AAAHC Handbook is intended for an organization seeking AAAHC accreditation. An ambulatory surgery center (ASC) seeking Medicare Deemed Status Accreditation for purposes of demonstrating compliance to Medicare Conditions for Coverage (CfC) should enroll in the AAAHC *Medicare Deemed Status Accreditation* program. If an organization is unsure about which program is relevant to the organization, contact AAAHC for assistance.

Program Participation Eligibility Criteria

For participation in the *AAAHC Ambulatory Accreditation Program*, an organization must continuously meet the following base eligibility criteria and must also become compliant with AAAHC Accreditation Standards:

1. Is either a formally organized and legally constituted entity that primarily provides health care services, or a subunit that primarily provides such services within a formally organized and legally constituted entity that may or may not be health related and where state law allows such subunit's ownership and organizational structure.
2. Is in compliance with applicable federal, state, and local laws and regulations, or, for an organization operating outside of the United States, all applicable laws and regulations.
3. Is licensed by the state in which it is located, if the state requires licensure for that organization, unless the organization is pursuing AAAHC Accreditation to be used to obtain licensure in a state that recognizes AAAHC Accreditation for this purpose.

4. Provides health care services under the direction of one of the following health care professionals. These individuals or groups of professionals must accept responsibility for the health care provided by the organization and must be licensed in accordance with applicable state laws:

   - Doctor of medicine or osteopathy (MD/DO)
   - Doctor of dental surgery or dental medicine (DDS/DMD)
   - Doctor of podiatric medicine (DPM)
   - Doctor of optometry (OD)
   - Doctor of chiropractic (DC)
   - Advanced practice registered nurse (APRN) practicing in compliance with state law and regulation
   - Licensed clinical behavioral health professional in a behavioral health setting

5. Shares the facilities, equipment, business management, and records involved in patient care among the members of the organization.

6. Operates in compliance with U.S. Equal Employment Opportunity Commission laws.

1095 Engage Accreditation Management System (AMS) Use

Health care organizations are empowered to pursue excellence and relevance for their organization through the AAAHC *1095 Engage* Accreditation Management System portal. This new accreditation and compliance-management portal provides a single-source operations solution for documentation, management of client profile information, communication, and workflow. The AMS transforms the accreditation process through automation and delivers quality and consistency throughout the process, generates curated Standards, and facilitates information consolidation for all organization types and programs. *1095 Engage* delivers workload management dashboards or task lists to monitor activity and elevates client insights throughout the *1095 Strong* journey. The portal enables access to the current Standards, Plan of Correction submission, annual Attestation, and Change Notification processes. The *1095 Engage* portal offers users an entryway to a variety of information, resources, links, and more in an exciting way to remain *1095 Strong every day* throughout the entire accreditation cycle. Visit our website at www.aaahc.org to learn more.

AAAHC Standards

The Standards describe characteristics that AAAHC believes to be indicative of a quality organization. An organization should use this Handbook to understand AAAHC expectations, conduct self-assessments, and identify areas for improvement in preparation for survey, and to monitor compliance throughout the *1095 Strong* cycle. Additionally, Surveyors will utilize this Handbook as a guide in identifying compliance during the onsite survey.

Any organization pursuing and maintaining AAAHC Accreditation is expected to assess its own ongoing compliance with AAAHC Standards and alignment with local, state, federal statutory or regulatory requirements, and its own policies. The organization is also responsible to investigate and implement corrective action to maintain compliance with AAAHC Standards.

Standards Structure

AAAHC Standards are composed of multiple components: Categories, Statements of Requirement(s) (SOR), Elements of Compliance (EOC), and Sub Elements of Compliance (SEOC). Each SOR is also assigned a Level and classified as either Universal or Selective. When applicable, the Handbook also includes guidance and references to provide additional information to assist understanding. Each component is described below.

Categories

Standards are organized by Category. Each Category groups similar concepts to facilitate organization compliance, streamline the onsite survey process, and minimize redundancy during the *1095 Strong* cycle. Prior to applying for AAAHC Accreditation, an organization should purchase, access, and carefully review the Standards and associated policies and procedures. Once accredited, as Standards and policies and procedures are updated and new versions are released, organizations will have access to an updated digital version of the Handbook through the *1095 Engage* portal.

Statements of Requirement (SOR) and Universal and Selective Standards

Each Category is composed of multiple Standards or Statements of Requirement. The SOR states the overarching intent of the Standard. Within each Category, there are two types of SORs: Universal and Selective. Universal SORs apply to all organizations seeking or maintaining accreditation. Selective SORs apply based on program selection and the relevant services or specialty information pertaining to the organization as provided in the organization's application or profile. For example, an organization that provides laboratory services (Category LRD) and Medication Management (Category MED) as indicated in their profile, must be in compliance with the respective Selective SORs. Standards are labeled Universal or Selective at each requirement to assist in determining applicability.

Elements (EOC) and Sub-Elements of Compliance (SEOC)

The Standards are written in general terms followed by Elements and Sub Elements of Compliance, which can be evaluated as Yes, No, or Not Applicable (NA; for EOCs only), and represent the minimum requirements to demonstrate compliance. An organization must demonstrate that all SEOCs are compliant to meet EOC compliance.

The Standards can be used to perform a pre-survey self-assessment and gap analysis, and should be assessed on an ongoing basis during the *1095 Strong* cycle.

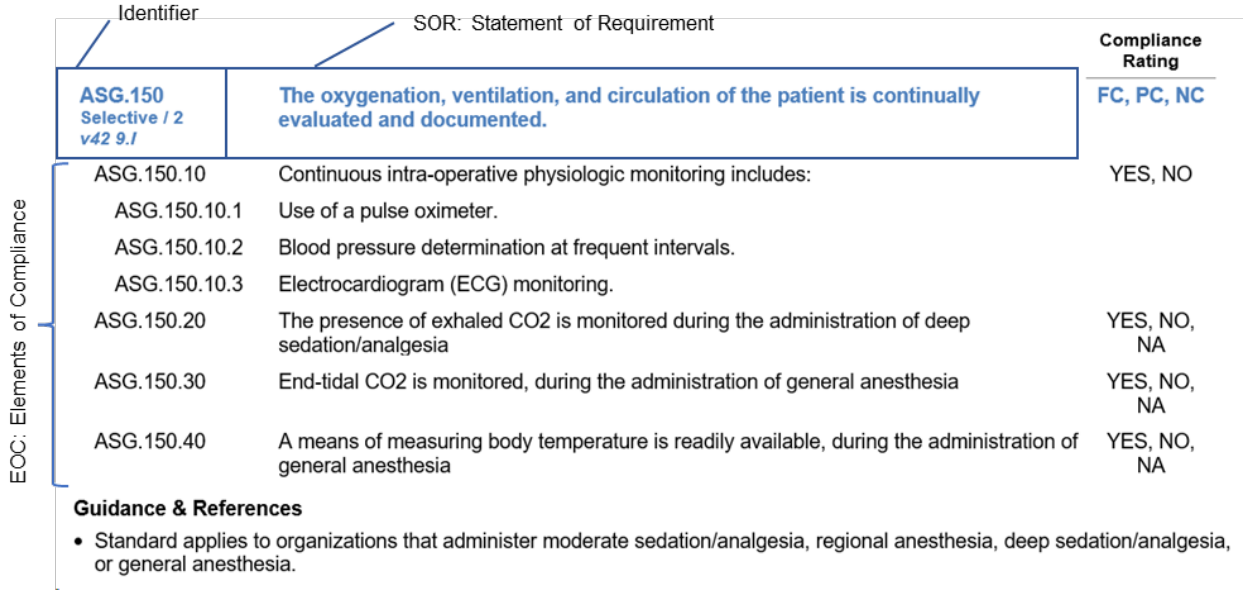
Standards Levels

Standards Levels are denoted at each SOR to distinguish requirements that directly impact patient and staff safety and care. The Standards Level is one of several factors considered in determining accreditation decisions. There are three Standards Levels:

- Level 0: Standards in test mode, or during a grace period for implementation
- Level 1: Standards which specify, or apply to, activities or processes which DO NOT involve the provision or conduct of patient care, OR the assurance of patient or employee safety
- Level 2: Standards which specify, or apply to, activities or processes which involve the provision or conduct of patient care, OR the assurance of patient or employee safety

Guidance and References

When applicable, the Handbook also includes guidance and references to assist understanding. Note that throughout this Handbook, reference is made to specific documents or standards published by other organizations. Subsequent editions of referenced publications become the authoritative reference for AAAHC only after they have been approved by the AAAHC Board of Directors.



To facilitate transition to the new v43 Standards architecture, in this version of the Handbook, where appropriate at each SOR, refer to the v42 Standard identifier (e.g., *v42 10.I.D*). Additionally, where v43 incorporates state-specific requirements previously addressed by onsite worksheets, the v42 crosswalk indicates "*v42 REG*".

Application of the Standards / Curation

Based on organization information provided in the application or updated through the organization's profile, AAAHC creates a set of Standards applicable to each organization that includes Selective and Universal Standards. Clients can access this curated Standards set electronically in the *1095 Engage* portal. This Standards set is also used by the Surveyor during the onsite survey process. As noted previously, Universal Standards apply to all organizations seeking to achieve or maintain accreditation. Selective Standards will apply based on the relevant services or specialty information pertaining to the organization as reflected in the organization's application/profile. For this reason, it is important to ensure accuracy of the organization's initial application and ongoing profile by submitting any changes throughout the *1095 Strong* cycle.

During the survey, if the Surveyor determines that a Standard needs to be added or deleted from the survey due to incorrect or new information necessary to be added to the organization's profile, the organization will need to submit a Change Notification through the *1095 Engage* portal in accordance with the Change Notification policy.

Evaluation of Compliance to Standards

For Standards assigned to the organization, the AAAHC Surveyor will evaluate compliance through documentation review, interview, and observation. To be rated Fully Compliant (FC) with a AAAHC Standard, an organization must:

- Demonstrate compliance with Standards requirements during the onsite survey.
    - Standards without an EOC are rated either Fully Compliant or Non-Compliant.
    - Standards that have EOCs are assessed a compliance rating based on the total number of EOCs verified.
- Throughout the *1095 Strong* cycle, maintain continuous compliance to AAAHC Standards. If the internal Policies and Procedures adopted by the organization exceed AAAHC requirements and the organization is not compliant with its own requirements, a Fully Compliant rating for the Standard may not be awarded, and may result in an adverse accreditation decision.
- Maintain compliance with all local, state, and federal laws and regulations necessary to meet or exceed AAAHC Standards requirements. If the organization does not maintain compliance with local, state, and federal statutory or regulatory requirements, the organization may be subject to an adverse accreditation decision or lose eligibility to be accredited by AAAHC. **If a AAAHC Standard exceeds a statutory or regulatory requirement, AAAHC expects compliance with the AAAHC Standard.**

Except as noted above, AAAHC uses a five-point rating scale to determine degree of compliance with AAAHC Standards. The rating scale varies depending on the number of applicable elements. The example below represents a Standard where five Elements of Compliance are required. Refer to *Evaluation with Compliance of Standards* in the *Resources* section for other sample rating scales.

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
All elements are present	4 of 5 elements are present	3 of 5 elements are present	2 of 5 elements are present	1 or no elements are present

Deficiencies corrected onsite *before* the conclusion of the survey will be reflected in the final survey report as Fully Compliant. For any Non-Compliant, Level 2 Standard, AAAHC requires the organization to submit a structured Plan of Correction (POC) through the *1095 Engage* portal prior to release of an accreditation decision. Refer to *After the Survey: Plan of Correction* section below. All deficiencies not fully resolved during the onsite survey will be rated as less than Fully Compliant on the final survey report.

Applicable Version of the Standards

Periodically, AAAHC releases new versions of the Standards updated for changes in best practice and regulations. New Standards releases have an Effective Date by when accredited organizations are expected to achieve and maintain continuous compliance.

For new clients, the organization will be surveyed against the current version of Standards at the time the organization pays their Application Fee. A survey must be conducted within 180 days of this date, or the application automatically expires. A new application will be required along with the Application Fee to reset the process toward accreditation. Upon application reset, the organization may receive a different version of Standards than those previously received. In some circumstances, federal and state regulators mandate implementation of new requirements with an immediate Effective Date or an Effective Date prior to the release of a new set of AAAHC Standards. In these situations, all applicable requirements will apply to the survey.

Comments and Suggestions Regarding the Standards

Revisions, additions, or deletions to the Standards for inclusion in the next Handbook version may be subject to a 30-calendar day public comment period. Proposed changes are posted at **www.aaahc.org**. AAAHC solicits and invites comments regarding the proposed changes to the Standards from interested parties. AAAHC will consider all public comments.

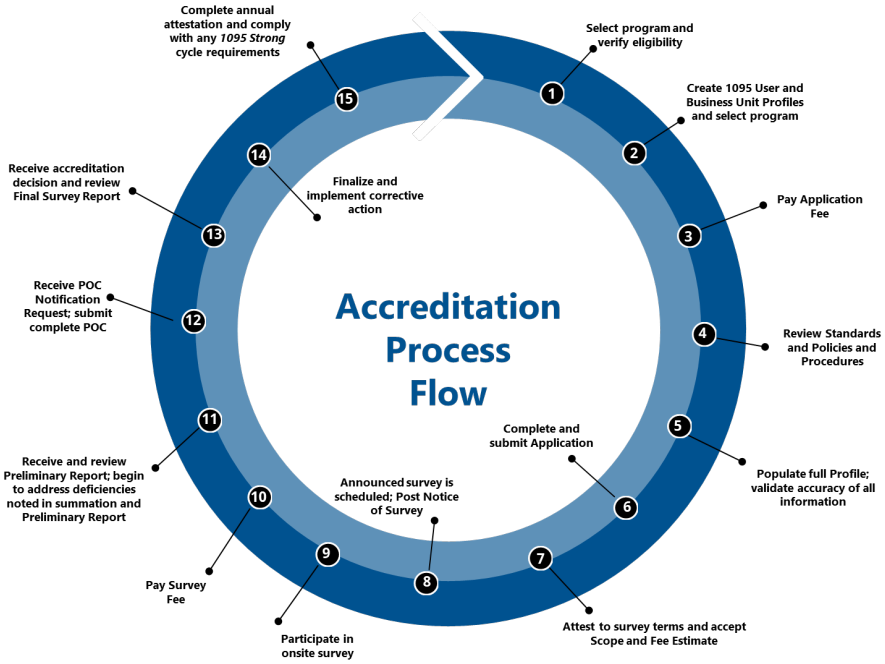
AAAHC also welcomes comments or suggestions about the Standards at any time. Outside the public comment period, send these comments and suggestions to **standards@aaahc.org**.

1095 Engage Accreditation Management Process Flow

The 1095 Engage portal facilitates initial application submission and ongoing organization profile maintenance, ongoing access to program information including Handbooks and focused Standards set applied based on organization profile characteristics, survey reporting, Plan of Correction submission, accreditation decisions, annual attestations, Change Notification submission, and other resources related to ongoing compliance.

An organization seeking accreditation for the first time can access the portal through the AAAHC website at www.aaahc.org.

1095 Engage is designed to align with the accreditation process and engage organizations seeking initial accreditation or maintaining ongoing compliance to AAAHC Standards throughout the *1095 Strong* cycle. The diagram below illustrates the *1095 Strong* cycle highlighting the action required to achieve and maintain accreditation. Refer to the sections that follow this diagram for further explanation and requirements.



Completing the Application and Establishing the Profile

An organization seeking accreditation for the first time can access *1095 Engage* through the AAAHC website. To access the application, the organization must first set up a User Account and provide high level information on the Business Unit (BU) seeking accreditation and its structure.

An organization seeking accreditation enters application information into the AAAHC *1095 Engage* electronic application. The AAAHC uses application information to verify eligibility, assess facility complexity, and scope and schedule a survey.

Good Faith Participation

The accuracy and veracity of information provided by an organization seeking or renewing accreditation is critical to the integrity of the accreditation program. Such information may be derived from documents supplied by the organization, delivered verbally, or obtained through direct observation by AAAHC Surveyors. AAAHC requires that each organization enter into the accreditation relationship and process in good faith.

Failure to participate in good faith during the accreditation process and during any subsequently awarded term of accreditation, including, but not limited to, the submission of falsified, inaccurate, or incomplete documents or information, or failure to pay applicable fees, may be grounds for denial or revocation of an organization's accreditation, for terminating an application or an appeal, or for ceasing to do business with the organization. When an organization fails to act in good faith, it forfeits its right to appeal or reconsideration of any such action by AAAHC. For more information on the appeals process, refer to *Organization's Right of Appeal Following Denial or Revocation of Accreditation*.

In the event that an application or appeal is terminated, AAAHC is entitled to retain any fees paid by the organization. For more information on fees, refer to *Scoping, Fee Estimate, and Survey Scheduling*.

Business Unit Structure

A Business Unit (BU) is the owner of the AAAHC client record and accountable for the accreditation.

- Parent Business Unit (PBU): Owner of the AAAHC client record and accountable for the accreditation and/or certification. Used the same way as BU; a PBU has at least one Child Business Unit (CBU) also referred to as satellite or additional site for which it is accountable.
- Child Business Unit (CBU): Lowest level of a business structure. Physical site or location (e.g., including mobile) that may be surveyed. Sites designated as a CBU must be part of a PBU and cannot be individually awarded accreditation.

Key steps for completing the application include:

1. Set up the User Account for the organization's Primary Contact; the individual within the organization that sets up the BU is initially considered the Primary Contact and System Administrator. The organization can modify Permissions and Users through the portal. AAAHC recommends designation of a second Primary Contact to ensure continuity and system access.
2. Enter information on your BU and structure and select the program for which the organization is pursuing participation.
3. Pay the non-refundable Application Fee to gain access to the curated Standards and the detailed application. Once access is granted, the application is valid and open for up to 180 days or the date on which AAAHC approves the application as complete and acceptable for survey scheduling, whichever is earlier. If the organization does not complete the application within 180 days from initial access, the application will expire and the organization must submit a new application, along with an additional non-refundable Application Fee.
4. Complete all sections of the application including providing supporting documents as required. AAAHC will review submitted applications for completeness and may request clarification or additional information before approval. DO NOT submit any patient health information to AAAHC. Patient health information included in any submission to AAAHC may result in rejection of the submission. Once the application is approved, AAAHC will notify the organization via email, and provide a Scope & Fee Estimate.
5. To finalize the application process and move to survey scheduling, the organization will have 14 calendar days to accept the Scope & Fee Estimate terms through *1095 Engage*.

Organizations seeking renewal of their accreditation follow the same process outlined above with focus on any updates to their application necessary to accurately reflect their organizational hierarchy, scope of services, and overall profile.

By submitting its application, an organization:

1. Attests to the accuracy and veracity of the statements therein, and of other information and documentation provided to AAAHC and to the survey team during the accreditation process.
2. Agrees to comply with all applicable AAAHC Policies and Procedures.
3. Understands that AAAHC may use the information supplied in the application and information collected during the survey for quality improvement purposes. Information will not be identified by organization.

AAAHC reserves the right to reject any application for any reason, including, but not limited to, unpaid invoices, and will inform the organization of the reason for this decision.

System Accreditation

A *System* is composed of a formally organized legally constituted entity (BU) with one or more sites providing patient care referred to as Child Business Units (CBUs), operating under the same policies and governing body, and seeking a single accreditation. In a System, the anesthesia level utilized and scope of services may vary across the BU and its CBUs. All or some sites may be surveyed depending on the anesthesia classification of the physical site and AAAHC sampling rules.

Through *System Accreditation,* the System submits one application and receives one survey report with a single accreditation decision. If accreditation is awarded, the BU and each CBU within the defined hierarchy receives an accreditation certificate. The System is subject to all AAAHC Policies and Procedures and Standards compliance requirements described in this Handbook.

The BU must provide its organizational structure of patient care settings and provide a complete list of all sites. The BU must self-identify CBUs proposed for inclusion in the *System Accreditation*. Each CBU must be distinctly identifiable from a patient perspective. If accreditation is awarded, the excluded sites will not receive a certificate or be listed on the AAAHC website, and the organization may not market, or allow these sites to be marketed, as part of the *System Accreditation*. For additional requirements regarding accurate representation of accreditation refer to *Public Recognition of AAAHC Accreditation*.

AAAHC reserves the right to review eligibility on a case-by-case basis. In addition to the characteristics described above, to be eligible for participation, the BU applying for *System Accreditation* must demonstrate oversight through centralized administration at each CBU location under its auspices and for which it is seeking accreditation. The BU has the authority to initiate organizational changes for all locations. Additionally, this oversight means that consistent processes are applied and governed by the System and accessible at each location, to include all of the following:

- Credentialing and Privileging
- Human Resource function
- Contract management
- Quality Improvement program exists across the System with entity having authority to direct performance initiatives
- Policies and Procedures are consistent across the System controlled by the governing body and accessible across all sites

All or some of the System sites may be surveyed depending on the scope of services and anesthesia classification of the CBU physical site and sampling plan through which AAAHC determines, at its sole discretion, the sites to be surveyed.

As part of its accreditation, the System may undergo a single survey event involving multiple sites, or a survey tour. Each survey event is scoped separately. A survey tour is an aggregation of discrete survey events, all of which contribute to a single accreditation decision.

If the System achieves accreditation, each CBU in the system is subject to the terms of the accreditation decision, including System Anniversary Date requirements. At the System's annual Anniversary Date, one or more Compliance surveys may be triggered. Refer to *Survey Types*.

At any time that the System adds sites or changes their scope of services, the organization must submit a Change Notification to AAAHC through the *1095 Engage* portal. Site additions or scope of service changes may result in a survey. Refer to *Continuation of accreditation following a significant change*.

Request to Accredit Subunits of an Organization

Although in general, AAAHC surveys and accredits a single legal entity, it will review a subunit of an eligible legal entity, if requested, when the subunit exhibits autonomous characteristics and demonstrates the capability to meet AAAHC Standards on its own. In such cases, the survey will be limited to a review of the autonomous subunit.

When the applicant organization is a subunit of a legal entity and does not exhibit autonomous characteristics, the survey will include a comprehensive review of all aspects of the organizational legal entity. When the applicant organization is a separately organized legal entity but does not exhibit autonomous characteristics from another legally related entity, the survey will include a comprehensive review of all aspects of the related legal entity.

Any accreditation decision conferred will apply solely to the applicant seeking accreditation even though other entities were included in the survey review process.

Refer to the table below for a summary of requirements when submitting a request for subunit accreditation.

Subunit Type	Independence	Review Requirement
Non Legal Entity	Autonomous	Survey the subunit alone
Non Legal Entity	Non autonomous	Survey all aspects of the related legal entity
Separate Legal Entity	Non autonomous	Survey all aspects of the related legal entity

Business Associate Agreement (BAA)

AAAHC does not maintain, retain, store, or transmit any Protected Health Information (PHI). During the AAAHC survey process, any documents containing PHI are reviewed by our onsite survey team only to determine compliance with applicable Standards. An organization should not submit any Protected Health Information to AAAHC.

The Business Associate Agreement (BAA) is available in the AAAHC *1095 Engage* portal under the Application Supporting Documents section. The application is not considered complete until all supporting documentation is uploaded and approved including the AAAHC BAA or documentation from an organization describing inapplicability of this requirement.

A Note About Confidentiality

AAAHC will maintain as confidential all information provided with respect to any organization that is seeking or has obtained accreditation; will use such information solely for purposes of reaching a certification decision; and will not disclose such information to any third party except: 1) on prior written authorization from the organization; 2) as otherwise provided in these Policies and Procedures; 3) as otherwise required by law or agreement with a state or federal regulatory authority; 4) or when disclosure of outstanding account or invoice information is necessary to recover unpaid invoices.

In submitting its application, the organization either provides or authorizes AAAHC to obtain official records and reports of public or publicly recognized licensing, examining, reviewing, or planning bodies.

If AAAHC determines that an organization has supplied false, misleading, or incomplete information, AAAHC reserves the right to disclose information about the organization to obtain accurate or complete information.

Survey Types

AAAHC determines survey type based on the information an organization provides in its application and other factors. AAAHC will determine the scope of the survey and assess a survey fee for each survey, unless otherwise noted. Refer to *Scoping, Fee Estimate, and Survey Scheduling*. Following the survey, AAAHC will provide the organization a survey report and decision letter. The organization may be subject to an Intracycle survey to maintain the three-year term. Refer to *Intracycle Surveys* for additional information.

Early Option Survey (EOS)

An organization may request this type of survey if it is not accredited by AAAHC, meets accreditation eligibility criteria, and has been providing services for fewer than six months before the onsite survey. Such an organization is: 1) newly existing, operational, and requires accreditation for third party reimbursement, and a six-month wait for a survey would entail financial hardship; or 2) requires accreditation to meet laws or regulations before the facility can legally begin operations.

The organization must also meet the following requirements before a survey can be scheduled:

1. The building in which patient care services will be provided is built and ready to support such care, as evidenced by reports of any inspections conducted by local or state fire marshals, local or state health departments, or other code enforcement agencies.
2. All governance and administrative structures are in place, including bylaws, policies, and procedures.
3. Key executives are employed, and medical staff have been credentialed and privileged by the governing body.
4. All necessary equipment is in place and appropriately tested and/or calibrated with up-to-date maintenance logs in place.
5. The date to begin operations has been identified.
6. Licensure or provisional licensure has been obtained from the state licensing authority, unless the organization is applying for accreditation to obtain licensure in a state that recognizes accreditation for this purpose. If the state requires a licensure survey but will not conduct it until immediately prior to opening, AAAHC Surveyors must verify the license or licensure survey at the time of the EOS. If not subject to facility licensure law, the organization should provide a statement from the appropriate authority attesting to this fact.

An organization that does not have sufficient case volume for adequate review may be subject to an Interim survey.

Initial Survey

This survey is for an organization that is not currently accredited by AAAHC and has been providing services for at least six months before the onsite survey. An organization that does not have sufficient case volume for adequate review may be subject to an Interim survey.

Renewal Survey

This survey is for a currently AAAHC-Accredited Organization seeking continuation of its AAAHC Accreditation.

Intracycle Surveys

In addition to the survey types described above, AAAHC may conduct one or more Intracycle surveys that occur within the *1095 Strong* cycle as described below.

NOTE: AAAHC will determine the survey focus based on previous deficiencies and other Standards deemed appropriate for review at the time of survey, and may include a full review of all applicable Standards.

Following the Intracycle survey, the organization's three-year term of accreditation may be maintained or revoked, or it may be determined that another Interim survey is necessary if the organization is not in substantial compliance with AAAHC Standards. An organization is not eligible for a new Anniversary Date as a result of an Intracycle survey. AAAHC will provide the organization a decision letter and survey report. The organization may be assessed a fee for any survey.

Interim Survey

An Interim survey is conducted for an organization that is currently AAAHC accredited and for which AAAHC has determined that oversight is required to assess ongoing compliance with the AAAHC Standards. AAAHC will notify an organization of an Interim survey requirement in its decision letter.

Random Survey

To support ongoing quality improvement initiatives, AAAHC may select an accredited organization for a Random survey to occur at any time within the *1095 Strong* cycle. Random surveys are unannounced and are a means by which AAAHC can evaluate the consistency and quality of its programs, while also demonstrating to the public and regulators that accredited organizations remain committed to AAAHC Standards throughout the *1095 Strong* cycle. An organization is not charged any fees when selected for a Random survey.

Discretionary and Special Surveys

A Discretionary survey is conducted when concerns about the organization have been raised from any source or AAAHC deems it necessary to verify an accredited organization's continued compliance with the Standards. An accredited organization may undergo a Discretionary survey at any time, without advance notice, and at the discretion of AAAHC. If triggered by a significant change, AAAHC may refer to a Discretionary survey as a *Special survey. Refer to Continuation of accreditation following a significant change*.

If an allegation is substantiated, but the organization subsequently implemented effective corrective action and the survey reveals no current non-compliant practices, then the organization is in current compliance and is not cited for a deficiency based on the past non-compliance.

If, as a result of a Discretionary survey, an allegation is substantiated, but there is no evidence that the organization subsequently implemented effective corrective action, then the organization will be cited for a deficiency based on the current non-compliance.

An organization may be assessed a survey fee in the event of a Discretionary survey.

Compliance Survey

A Compliance survey may be conducted for a System Accreditation as a quality check of the system's ability to maintain compliance with AAAHC Standards throughout the *1095* cycle and across all sites.

At the System's annual anniversary, a Compliance survey may be triggered. The minimum number of Compliance surveys, as well as the nature of these surveys are determined during the application process and AAAHC sampling plan development. AAAHC may change the number of Compliance surveys to be conducted during a term of accreditation based on System changes.

When a System adds more sites or changes its scope of services, a Change Notification is required. Refer to *Continuation of accreditation following a significant change*. These changes necessitate a determination whether an organization's size or scope may have changed sufficiently to warrant additional Compliance surveys or a Special survey.

A survey fee is assessed for a Compliance survey.

Scoping, Fee Estimate, and Survey Scheduling

Scoping and Fee Estimate

Each survey is tailored to the type, size, and range of services offered by the organization seeking accreditation. The length of the onsite visit and the number of Surveyors AAAHC schedules are based on review of the information in the organization's application and previous deficiencies. These factors determine the Fee Estimate.

AAAHC will share the Scope and Fee Estimate with the organization's Primary Contact upon acceptance of the application.

Except where prohibited by law, accreditation or survey fees are invoiced on the last day of survey and must be paid within 15 calendar days of the invoice date, and AAAHC reserves the right, through its own action or through the action of a third-party agent, to pursue any avenues available to collect all monies owed. At this time, acceptable payment methods are ACH/wire transfer, credit card or via check. In addition, AAAHC reserves the right to apply credit card surcharge fees.

For questions about the invoice, contact the AAAHC Finance Department at ar@aaahc.org or 847-853-6060, and select option 1.

NOTE: *The survey report and decision letter may not be released until the fees are paid in full. Failure to pay applicable fees, may be grounds for denial or revocation of an organization's accreditation.*

Administrative Fees

AAAHC reserves the right to assess administrative fees when an organization or its affiliate requires that AAAHC complete administrative tasks in order to do business. Administrative tasks that may result in additional fees include, but are not limited to, tasks related to information technology assessments, AAAHC registration in fee-based purchasing systems, and fees for certificates of insurance. When an administrative task requires AAAHC payment of fees to do business with the organization, the organization will receive an invoice for reimbursement to AAAHC of the amount paid by AAAHC.

Scheduling

For most survey types, AAAHC schedules an organization's survey date(s) with consideration for the organization's blackout dates. An organization is allowed up to five blackout dates to be avoided in survey scheduling. AAAHC will also consider days on which the organization typically schedules surgeries and procedures (if applicable). AAAHC will only conduct surveys when the organization is open for business and providing patient services. Blackout dates may be limited or not offered if an organization submits an application less than 60 days prior to accreditation anniversary.

Once AAAHC has scheduled the survey, the organization can access *1095 Engage* to receive and review confirmation details and access related resources to assist in survey preparation and readiness.

NOTE: *Surveyor(s) are responsible for their own travel including hotel arrangements; it is not necessary for the organization to coordinate travel on their behalf.*

Survey Postponement Policies

To request postponement of a scheduled survey, an organization must call AAAHC and send their request via email to info@aaahc.org. The following policies apply to all postponement requests.

- Application Fees are non-refundable.
- AAAHC policy requires that all surveys be scheduled within 90 days of AAAHC's approval of the organization's application. A postponement request that results in rescheduling greater than 90 days from the application approval date may require the organization to reapply for accreditation and pay a new Application Fee.
- For each postponement request, AAAHC will immediately assess and invoice postponement fees. Postponement fees must be paid prior to the rescheduled survey start date.

Postponement Request	Application Fee	Accreditation or Survey Fees
Postponements requested prior to survey	No refund	All travel expenses incurred by AAAHC as of the date the postponement request is received, plus an administrative fee
Survey postponed onsite	No refund	Organization responsible for full Fee Estimate; the organization may be required to reapply for accreditation and be subject to new fees

Survey Cancelation Policies

To request cancelation of a confirmed survey, an organization must call AAAHC and send their request via email to info@aaahc.org. The following policies apply to all cancelation requests.

- Application Fees are non-refundable. In addition, AAAHC reserves the right to apply credit card surcharge fees.
- For a cancelation request, AAAHC will immediately assess and invoice Cancelation Fees.

Cancelation Request	Application Fee	Cancelation Fee
Cancelations requested within 48 hours of survey confirmation receipt	No refund	All travel expenses incurred by AAAHC as of the date the cancelation request is received, plus an administrative fee
Cancelations requested more than 48 hours after survey confirmation receipt	No refund	Organization responsible for full Fee Estimate

An organization's request to cancel a survey may be grounds for denial or revocation of accreditation.

Prepare for the Onsite Survey

Responsibilities and Surveyor Preparation

After the assigned Surveyor(s) has reviewed the organization's application materials, and typically within two weeks prior to the survey start date, the Surveyor will contact the organization's designated Primary Contact. During this contact, the Surveyor will provide an overview of the upcoming survey. Based on the Surveyor's review of the application materials, they may request that the organization provide additional explanation or documentation at the time of survey. Questions regarding Surveyor responsibilities should be directed to the AAAHC office prior to the survey.

Public Posting of the *Notice of Survey*

Prior to the survey, the applicant organization's Primary Contact(s) can access information via the *1095 Engage* portal about the upcoming site visit including a general outline of the survey agenda, a list of documents Surveyors may request for review, and a copy of the *Notice of Accreditation Survey* for public posting.

For all survey types except Random and Discretionary surveys, this *Notice* must be posted prominently throughout *all* organization sites for at least 30 calendar days prior to the scheduled survey start date. If the organization receives confirmation of the scheduled survey fewer than 30 calendar days prior to the start date, the *Notice* must remain posted for a total of 30 calendar days.

The organization may post multiple copies of the *Notice* to achieve significant visibility.

The goal of the *Notice* is to provide an opportunity during the onsite survey for patients, staff, and members of the general public to present to AAAHC Surveyor(s) relevant information about the organization's provision of care or its compliance with AAAHC Standards. Alternatively, individuals may present such information in writing directly to AAAHC. AAAHC will consider all information received from individuals for relevance and accuracy during the accreditation process. AAAHC may include the findings in the survey report if applicable.

AAAHC will manage the schedule for public presentation of information during the survey. Any such requests received by the organization should be referred to AAAHC.

The Surveyor usually schedules the opportunity for individuals to present information in person the morning of the first survey day; typically, these sessions do not exceed one hour. The time and length of the session should be agreeable to all parties concerned, but final authority for such matters rests with the AAAHC Surveyor. The surveyed organization will provide reasonable accommodations for the session, which is chaired by the AAAHC Surveyor. The organization may be asked to inform the requesting individual of the date, time, and place for the presentation to the Surveyor(s).

If the *Notice* is not posted, the survey will take place, but the accreditation decision may be held until it has been posted for 30 calendar days. If the *Notice* is not posted and subsequent to the survey, AAAHC receives a request to present relevant information, a Surveyor may be sent, at the surveyed organization's expense, to receive the information.

During the Onsite Survey

AAAHC Survey Team

Although an accreditation survey is evaluative, AAAHC emphasizes the educational benefits of accreditation. AAAHC Surveyors are physicians, dentists, podiatrists, pharmacists, registered nurses, ambulatory health care facility administrators, and other health care professionals who are in active practice and/or have substantial experience in ambulatory health care. These dedicated individuals offer their time to train and work as Surveyors and use their practical knowledge in the consistent application of the Standards.

Survey team members are selected, to the extent possible, on the basis of their knowledge of and experience with the range of services provided by the organization. In the interest of objectivity, AAAHC cannot honor requests for specific Surveyors.

Surveyor Conduct During the Survey

Surveyors are representatives of AAAHC. Their priorities are to be ambassadors of AAAHC, objective fact finders, and educators.

Surveyors may not participate in surveys of organizations that may be in direct competition with their business interests, or that bear any significant beneficial interest to the Surveyors or their immediate family.

Additionally, while serving as representatives of AAAHC, Surveyors may not solicit personal business or take part in any activities that appear to be in furtherance of their personal, entrepreneurial endeavors.

In support of these policies, the surveyed organization should refrain from offering consultative or other types of business to its AAAHC Surveyor(s), and/or to members of the Surveyors' immediate families. Immediately report a survey team conduct concern or question to AAAHC.

Additions to the Survey Team

An organization that applies for a survey accepts possible additions to the survey team as determined by AAAHC, as follows:

- **Observers:** AAAHC staff and individuals approved by AAAHC may observe a survey as part of staff development, training, and ongoing quality improvement of the accreditation process. Observers do not participate in the onsite survey process in any manner.
- **Additional Surveyors:** AAAHC reserves the right to assign additional Surveyors as part of ongoing Surveyor education procedures.

The presence of observers or extra Surveyor(s) does not result in any additional charge to the organization. It may not serve as grounds for any challenge to the accreditation outcome.

AAAHC Onsite Process

When arriving at the survey site, the Surveyor(s) will provide identification, introduce themselves, and conduct a brief orientation conference for the organization. The Surveyor(s) will provide an overview of the agenda, request needed documents, and ask the organization to identify key personnel who will provide information and the access necessary to complete the survey. During this initial onsite briefing, AAAHC encourages the organization to ask questions about the anticipated survey activities.

Prior to the onsite survey, the organization will receive a list of specific documentation and other information that should be available for Surveyor review. Having this documentation ready allows Surveyors to gather and review information with minimal disruption to the daily activities of the organization. Surveyors may ask to see additional documents or may request additional information. Surveyors must also review clinical records and observe a surgery or procedure. An organization's failure to provide information requested by AAAHC or its Surveyors or to ensure that Surveyors observe a surgery or procedure may be grounds for termination of the survey or accreditation denial or revocation.

Organizations are asked to make a workspace available for Surveyor use. This private or semi-private area should be sufficient to review policies, conduct interviews, and hold survey team meetings to discuss findings.

Organization consultant participation in the AAAHC Accreditation survey is limited to attendance at the survey opening conference and/or the summation conference. The AAAHC Surveyor has the right to limit or exclude the participation of any individual(s) in any or all parts of onsite survey activities.

Concluding the Survey Experience

At the end of the onsite survey, the Surveyor(s) conduct a summation conference at which they present the findings to representatives of the organization for discussion and clarification. AAAHC Surveyors are "fact finders" and do not render the final decision. For this reason, decision information is not provided during the summation conference. Members of the organization's governing body, medical staff, and administration are encouraged to take this opportunity to comment on or rebut the findings, as well as to express their perceptions of the survey.

Accreditation Process: After the Survey

Following the onsite survey, additional action is required as outlined below.

Preliminary Report

Within 24-48 hours of survey completion, organizations can access their Preliminary Report via *1095 Engage*. Access to the Preliminary Report provides the organization an opportunity to review the preliminary Surveyor findings and consider an action plan. *This document may not include all current survey findings. Survey findings listed in the Preliminary Report are subject to change prior to release of the Final Report.*

Following completion of the survey, AAAHC will issue a Final Report. Once the Final Report is issued, the Preliminary Report will be replaced with the Final Report and will no longer be available in *1095 Engage*.

Plan of Correction (POC)

AAAHC requires an organization to correct deficiencies for all Standards rated less than Fully Compliant (FC) and Elements of Compliance rated No.

For each Level 2 Standard rated as Non-Compliant (NC), the organization will be required to electronically submit an acceptable Plan of Correction to AAAHC through the *1095 Engage* portal within 30 calendar days of receiving the POC Request Notification and instructions from AAAHC. Using the *1095 Engage* portal, the organization must provide all information indicated below for an effective POC:

- Explanation of the corrective actions including all steps taken to bring the organization into compliance
- Title of the party responsible for POC implementation
- Implementation timeline and completion date
- Monitoring activities to ensure that the POC is effective, and that the specific deficiency cited remains corrected and/or in compliance with the Standard requirements
- Supporting documentation / evidence of correction

NOTE: The POC is the only opportunity for an organization to contest findings. In addition, some State regulatory requirements / agreements are more stringent than the requirements outlined above. Refer to state regulatory rules (e.g., CA AB595 rules).

The organization's corrective actions should be documented, and this documentation made available upon request by AAAHC and during subsequent surveys. The next survey team will have information on any deficiencies cited and will verify that corrective actions were addressed in the timeframe documented by the organization.

The AAAHC Ambulatory Accreditation Program provides a 30-calendar day timeframe from the date of the POC request for the organization to make corrections.

If an organization fails to submit an acceptable POC within the required timeframe, accreditation may be denied.

Accreditation Decision and Notification

A three-year term of accreditation is awarded when AAAHC concludes that an organization is in substantial compliance with the Standards, adheres to AAAHC accreditation Policies and Procedures, and there are no reservations about the organization's continuing commitment to provide high-quality patient care and services consistent with the Standards.

Accreditation decisions are made by the AAAHC Accreditation Committee after review of the information gathered during the survey and documented in the survey report, any other applicable supporting documents, and recommendations of the Surveyor(s) and staff. All documents reflecting the opinions or deliberations of any AAAHC Surveyor, staff member, committee member, officer or director constitute peer review materials and will not be disclosed to the organization seeking accreditation or to any third party. A Surveyor, staff member, or member of the AAAHC Governance who is in any way affiliated with an organization, or whose participation represents a conflict of interest, will not participate in deliberations or voting relative to the accreditation status of that organization.

The organization will receive access to the accreditation decision in the *1095 Engage* portal and will receive a detailed report of the survey findings.

In the event that AAAHC decides to deny or revoke accreditation, the organization usually has an opportunity to provide additional information before a final denial or revocation decision is rendered, and the final denial decision is subject to the organization's right of appeal. When the accreditation decision is based on findings from a survey, the decision is based on the organization's compliance with the AAAHC Standards in effect *at the time of the survey*.

In the event that a decision is made to revoke accreditation, AAAHC will notify the organization of the revocation of accreditation, including the effective date. Refer to *Denial or Revocation of Accreditation*.

NOTE: Organizations that are owned by a solo health provider and either 1) the organization or the provider is the subject of a governmental investigation or criminal indictment (other than a traffic violation); or 2) the health care provider's practice license is on probationary status, will be required to undergo an Interim survey each year of the term or until the physician's license is no longer on probationary status. A survey fee will be assessed for each survey event. Refer to *Interim Survey*.

Your Feedback is Appreciated

Following decision release, organizations are encouraged to provide feedback about the entire survey process, Surveyor(s), and post-survey process through *1095 Engage*. An organization's feedback will have no bearing on the accreditation decision but provides valuable information to AAAHC for continuous improvement.

Term of Accreditation

Accredited organizations are expected to maintain compliance at all times with the current AAAHC Standards. Following an accreditation survey, an organization may be awarded a three-year term of accreditation, or it may be denied accreditation/have its accreditation revoked. Refer to *Denial or Revocation of Accreditation*.

An organization may receive a three-year term with required intracycle activity referred to as an Interim survey for continued assessment of ongoing compliance with the Standards. Refer to *Interim Survey*.

AAAHC staff are available throughout an organization's term of accreditation to provide assistance and guidance.

Anniversary Dates

The Anniversary Date is determined based on the last day of the Initial or EOS survey.

An organization that is in substantial compliance with AAAHC Standards is accredited for an initial three-year term and must renew its accreditation every three years. An organization that has completed its onsite renewal surveys prior to its Anniversary Date will be considered accredited until a final decision is made regarding its renewal. The organization's Anniversary Date will not change between *1095 Strong* cycles.

If an organization changes AAAHC accreditation programs, switches between an accreditation and certification program, or achieves accreditation after revocation or a lapse in accreditation, AAAHC will establish a new Anniversary Date.

Public Recognition of AAAHC Accreditation

The AAAHC Certificate of Accreditation is recognized as a symbol of quality by third-party payers, medical organizations, insurance companies, state and federal agencies, and the public. AAAHC displays a searchable list of currently accredited organizations at **www.aaahc.org**.

An AAAHC-accredited organization is encouraged to publicly display its certificate. It is the responsibility of each organization to comply with any state regulations which may specify posting requirements. The AAAHC Certificate will reflect the legal name of the organization, as well as one additional name, if appropriate (i.e., "doing business as").

Representation of accreditation to the public must accurately reflect the AAAHC accredited entity. Only locations accredited by AAAHC may obtain and/or display the Certificate of Accreditation or represent AAAHC Accreditation.

If the organization loses its accreditation for any reason, all certificates remain the property of AAAHC and must be destroyed. The organization must remove all representations of AAAHC Accreditation from its written and electronic marketing media including its social media and websites.

An organization must ensure continuous compliance with the authorized directives for representing its AAAHC Accreditation status and AAAHC branding as required in the AAAHC Marketing Kit available on the AAAHC *1095 Engage* portal.

To submit feedback about an accredited facility, the public may be referred to **www.aaahc.org**.

Denial or Revocation of Accreditation

AAAHC denies accreditation to or revokes the accreditation of an organization when it concludes that the organization is not in substantial compliance with AAAHC Standards and/or Policies and Procedures.

AAAHC reserves the right to revoke or deny the accreditation of any organization at any time without prior notice. Revocation or denial of accreditation may occur if AAAHC determines that an organization:

1. No longer satisfies AAAHC program participation eligibility criteria.
2. Is no longer in compliance with AAAHC Policies and Procedures, or Standards.
3. Has significantly compromised or jeopardized patient care.
4. Fails to act in good faith in providing data and other information to AAAHC.
5. Fails to notify AAAHC within 15 calendar days of any significant change. For a list of what may constitute a significant change, refer to *Continuation of accreditation following a significant change*.
6. Fails to notify AAAHC within 15 calendar days of an imposed sanction, change in license or qualification status, governmental investigation, criminal indictment, guilty plea, or verdict in a criminal proceeding (other than a traffic violation), or any violation of state or federal law with respect to the organization, its owners, or its health care professionals.
7. Fails to allow a Surveyor timely access to the organization to conduct a survey.

In addition, AAAHC may revoke the term of accreditation of an organization when it determines that there is a material change in the organizational structure, financial viability, operations, ownership, or control of the organization, or in its ability to perform services such that a new survey is required to determine compliance with AAAHC program participation eligibility criteria or Standards. Revocation may be retroactive to the date of the material change, the imposition of sanctions, or the violation of law.

Appeal of Accreditation Decision

Generally, a decision to deny or revoke accreditation may be appealed. The appeal of any decision is governed by AAAHC appeal procedures in effect at the time of the appeal. Refer to *Organization's Right of Appeal Following Denial or Revocation of Accreditation*.

In the unlikely event that an applicant organization exercises its right to appeal and, receiving the decision of the AAAHC Board of Directors, seeks further appeal, the applicant shall have the right to submit its request for settlement by arbitration administered by the American Arbitration Association in Chicago, IL in accordance with its Commercial Arbitration Rules. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

An organization that is denied accreditation, or that has its accreditation revoked based solely on failure to comply with AAAHC Policies and Procedures and/or Standards, may re-apply for accreditation at any time following the decision, as long as it has not exercised its right to appeal.

Limitations on Other Rights

The applicant waives all other rights to sue or to resolution of any such claims against AAAHC, its officers, directors, employees, agents, Surveyors, and members of its committees in a court of law. The applicant recognizes and agrees that it shall not be entitled to monetary damages, whether compensatory, consequential, collateral, punitive, or otherwise, from AAAHC, its officers, directors, employees, agents, Surveyors, and members of its committees as a result of any controversy or claim with AAAHC arising out of any procedures or decision with respect to accreditation.

Continuation of Accreditation

An accredited organization acts as an advocate for its patients and the community through the provision of quality patient care. Therefore, an accredited organization is required to maintain its operations in compliance with the most current AAAHC Standards and Policies and Procedures throughout its accreditation term. This involves correcting any deficiencies cited during a survey in a timely manner, submitting a Plan of Correction (POC) to AAAHC as necessary, and implementing continuous quality improvements to maintain ongoing compliance. AAAHC reserves the right to amend its Standards and Policies and Procedures so long as it provides all accredited organizations with notice of such amendments, or includes such amendments in the most recent version of the Handbook. Refer to *Applicable Version of the Standards*.

Continuation of Accreditation Following a Three-year Term

A currently accredited organization must undergo a Renewal survey at least once every three years. The organization must complete and submit an application, supporting documentation, and the non-refundable Application Fee at least 150 days prior to the Anniversary Date.

Submission of an application, even if complete, fewer than 60 calendar days before the Anniversary Date may result in a lapse of accreditation or assessment of an expedited fee to ensure there is no lapse. Late submission of an application may result in an Initial survey for the organization.

Annual Attestation

The Annual Attestation supports each organization's commitment to *1095 Strong*. An organization must submit an electronically signed attestation via *1095 Engage* no later than the organization's annual Anniversary Date. Through the Attestation, the organization verifies the accuracy of its profile in *1095 Engage*, acknowledges receipt of the latest version of AAAHC Standards, and attests to completion of a Self-Assessment of the applicable Standards.

The Attestation must be electronically signed through the *1095 Engage* portal by the Chief Medical Officer listed in the organization's profile and designated with this responsibility.

Failure to comply with these requirements may impact an organization's accreditation status up to and including revocation.

Continuation of Accreditation Following a Significant Change

An organization must notify AAAHC in writing within 15 calendar days of significant organizational, ownership, operational, or quality of care events, including interruption in delivery of health care, criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) directly or indirectly involving the organization or any of its officers, administrators, physicians/health care professionals, or staff within their role in the organization. Any such change/event that negatively affects public perception of the accredited organization or AAAHC, as the accrediting body, must also be reported. An organization's duty to provide this information begins with submission of an application and continues during the entire accreditation term. If no reportable events occur, an organization is expected to demonstrate knowledge of these reporting requirements during the onsite survey in order to comply with AAAHC Standards.

Notice is made by completing and submitting the required and relevant documents within the Change Notification section of the *1095 Engage* portal. Refer to the portal for instructions for relevant documentation to include for specific changes.

Depending on the change submitted, AAAHC will determine whether a survey is warranted.

If the organization is exercising its right of appeal, the organization must notify AAAHC in writing immediately of any such changes. Failure to do so may result in an immediate revocation of accreditation, or termination of the right to appeal.

Accreditation is not automatically maintained when an accredited organization undergoes significant changes as described above. AAAHC will determine whether the current accreditation term will be maintained and will establish any such conditions.

End of Accreditation

When an organization's accreditation term has ended and the organization is not seeking renewal, or it is choosing to withdraw from the accreditation process prior to the Anniversary Date of its accreditation, the organization must:

- Notify AAAHC using the Change Notification process with the *1095 Engage* profile.
- Remove and destroy all AAAHC Accreditation Certificates.
- Review all internal and public-facing information, documents, correspondence, and internal recorded phone messages, to ensure that anything bearing the AAAHC name and/or logo has been removed or destroyed.
- Review marketing materials: website, print, radio, or television ads, and all other public-facing materials to ensure the removal of references to the AAAHC name, logo, and accreditation status.
- Cease all other activity that would create a public perception of AAAHC accreditation.

Organization's Right of Appeal Following Denial or Revocation of Accreditation

Opportunity to Submit Additional Material

A proposed recommendation for denial or revocation of accreditation by AAAHC is reported to the chief medical executive and the administrative head of the organization. Such notice will include an explicit statement of the reasons for the decision and generally provide the organization with an opportunity to submit additional material to AAAHC within 14 calendar days of receipt of the notice. Unless otherwise indicated by AAAHC, the information provided should be limited to that available at the time of the survey and relative to the Standards identified by AAAHC as less than fully compliant and should not be duplicates of the information submitted to AAAHC when contesting findings during the POC process. The information that is provided will be considered by AAAHC in determining whether to change its accreditation decision.

Final Decision Subject to Right to Appeal

Any decision to deny or revoke accreditation by AAAHC will be accompanied by an explanation of the reasons for the decision and of the organization's right to a hearing before an Appeals Hearing Panel. Unless otherwise specified by AAAHC, the panel will be composed of three individuals designated by the President and CEO of AAAHC. The panel will not include: 1) any person who participated in the accreditation decision on behalf of AAAHC; 2) any person who is or ever has been a Surveyor of the organization; 3) more than one director from the AAAHC Board of Directors; or 4) any person who is in direct economic competition with or has a bias with respect to the organization seeking accreditation.

The organization's written request for a hearing to appeal a decision to deny or revoke accreditation must be received within 10 calendar days of the date of the notification, along with a one-time nonrefundable payment of $3,500 to defray administrative costs incurred in planning and convening the appeals hearing. If the organization fails to request such a hearing on a timely basis, or fails to include payment of $3,500 at the time of the request, the decision becomes final. The appeal of any decision is governed by AAAHC's appeal procedures that are in effect at the time of the appeal.

Hearing Before the Appeals Hearing Panel

A hearing before the Appeals Hearing Panel that is requested by an organization is ordinarily held within 60 calendar days following receipt by AAAHC of its written request and the administrative payment of $3,500.

In the event that the organization is not available for an appeals hearing within 60 calendar days the organization will be deemed to have waived its right to an appeal unless AAAHC, in its sole discretion, agrees to extend the period for the appeal.

Approximately 14 calendar days before the hearing, the organization is provided notice of the time and place of the hearing, and the name, professional credentials, and location of the panel members. When the decision is based on findings from an onsite survey, the organization will be provided the factual findings included in the survey report. The hearing will be held at the AAAHC office, unless otherwise agreed by the organization and the AAAHC. Panel members may be convened by conference call, and the hearing may proceed with only two of the panel members participating.

At the hearing before the Appeals Hearing Panel, the organization may be accompanied by counsel, make oral presentations, offer testimony, and interview any available Surveyor(s) who participated in the survey. At least 14 calendar days before any such hearing, the organization may request, in writing, the presence at the hearing of any such Surveyor(s) it wishes to interview. Surveyors who are requested to participate in the hearing may be convened by conference call. If the organization makes any written submission to the Appeals Hearing Panel, the documents should be provided to AAAHC prior to the hearing.

The Appeals Hearing Panel will consider all materials submitted to it on a timely basis. When the accreditation decision is based on findings from a survey, the recommendation of the Appeals Hearing Panel will be based on the organization's compliance with the AAAHC Standards effective at the time of the survey.

Following the hearing before the Appeals Hearing Panel, the organization will be notified promptly of the panel's recommendation. If the panel's recommendation is to uphold the original decision to deny or revoke accreditation, the organization has the right to appeal directly to the AAAHC Board of Directors.

The organization's written request for appeal to the Board must be received within ten calendar days of the date of notification of the Appeals Hearing Panel's recommendation.

If the Appeals Hearing Panel recommends granting accreditation, the organization will be notified of the recommendation, and the Accreditation Committee will be afforded the opportunity to consider the recommendation of the Appeals Hearing Panel at their next regularly scheduled meeting. Following this meeting, the organization will be notified promptly of the accreditation decision. If the decision to deny or revoke accreditation is not modified or reversed by the Accreditation Committee, the organization has ten calendar days from the date of such notice to appeal directly to the AAAHC Board of Directors.

Appeal to the AAAHC Board of Directors

The Board of Directors will consider any appeal at its first regular meeting that is scheduled at least 30 calendar days after receipt of the request for appeal. Members of the Accreditation Committee will not participate in the discussion or the vote by the Board of Directors relative to the accreditation of the organization. Similarly, any AAAHC director who has an interest in the organization, who is a direct economic competitor of the organization, who was a Surveyor of the organization, or who was a member of the Appeals Hearing Panel will not participate in the discussion or the vote by the Board of Directors.

The organization may submit, at least 20 calendar days prior to the Board meeting, a written response or comments for review by the Board. The Board will review any such written response and comments submitted, the survey report, and any other materials considered by the Appeals Hearing Panel, and make an accreditation decision that will be final. When the accreditation decision is based on findings from a survey, the Board's decision will be based on the organization's compliance with the AAAHC Standards in effect at the time of the survey.

Exceptions with Respect to the Above Appeal Procedures

AAAHC reserves the right to immediately revoke or deny accreditation before providing notice and an opportunity to submit additional materials or appeal the accreditation decision when, among other things, the organization's failure to satisfy the AAAHC Standards may result in imminent danger to the health of any individual or individuals. Under such circumstances, AAAHC shall provide subsequent notice and the opportunity to appeal.

AAAHC also reserves the right to deny an organization the right to an appeal if:

1. The organization no longer satisfies the Program Participation Eligibility Criteria.

   The organization fails to notify AAAHC of a significant change. For a complete list of what constitutes significant changes, refer to *Continuation of accreditation following a significant change*.

2. Any imposition of sanctions, changes in license or qualification status, governmental investigation or proceedings, or violation of state or federal law with respect to the organization, its officers, administrators, physicians/ practitioners, or staff occurs.

Conditions with Respect to the Appeal Process

An appeal of an accreditation decision generally does not extend or otherwise affect the term of accreditation. If accreditation is revoked, the organization is not accredited during the appeals process. If an accredited organization seeking renewal of accreditation is revoked, the organization generally remains accredited until the original term of the accreditation expires, which could occur during the appeals process.

Any appeal conducted pursuant to these procedures requires all parties to act in good faith. An organization's failure to participate in the appeal process in good faith, including, but not limited to, the submission of falsified, incomplete, or inaccurate documents or information for any use during the appeal of an accreditation decision may result, at the discretion of the AAAHC Board of Directors, in termination of the organization's right to appeal the decision and immediate termination of the appeal.

Any organization that exercises its right to an appeal is obligated to notify AAAHC immediately of any significant change as outlined in *Continuation of accreditation following a significant change*.

No organization may exercise its right to an appeal at the same time that it applies for AAAHC Accreditation. Organizations that apply for accreditation should be aware that information about the basis for the previous denial or revocation will be provided to the Surveyor.

Compliance with Omnibus Reconciliation Act of 1980

For any health care organization that pays AAAHC $10,000 or more in any 12-month period to comply with Section 952, PL 96-499, the Omnibus Reconciliation Act of 1980, AAAHC hereby stipulates that only those AAAHC records, contracts, documents, or books that are necessary to verify the extent and nature of AAAHC costs will be available for four years after the survey, consultation, or contracted services are completed to the Secretary of the Department of Health and Human Services (DHHS), the Comptroller General of the United States, or any of their duly authorized representatives. This stipulation is provided as a matter of policy by AAAHC in lieu of providing separate contracts for each affected organization. These same conditions will apply to any subcontracts AAAHC has with related organizations if such payments amount to $10,000 or more in any 12-month period. This policy applies to all contracts, surveys, and AAAHC records as of December 5, 1980, and so long as these regulations remain in force.

California, Florida, and New York State Requirements

The following information is for states that require formal reporting by accrediting organizations: California, Florida, and New York. Check with the respective State and/or Medical Board for ongoing regulatory updates.

California State Requirements

The following information is for California, a state that requires formal reporting by accrediting organizations. Check with the State and/or Medical Board for ongoing regulatory updates.

California Outpatient Organizations

The following regulatory requirements are applicable to outpatient surgery settings that meet the definitions below. During the onsite survey, AAAHC Surveyors will determine compliance with the requirements that follow. This overview of applicable laws is not intended to be a complete listing of all laws relevant to California Outpatient Settings.

Definitions

Health and Safety Code 1248(b)(1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

1248(b)(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

1248(b)(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

1248(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

State Mandated Outpatient Setting Accreditation California Business and Professions Code, Section 2216

On or after July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Section 1248.1 of the Health and Safety Codes. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes."

In accordance with the law, the Medical Board of California adopted standards for approval of accreditation agencies to perform the accreditation of outpatient settings. AAAHC has received approval from the Medical Board of California as a recognized accrediting organization.

According to *Health and Safety Code, Section 1248.3.(a)*, certificates of accreditation issued to outpatient settings by an accreditation organization shall be valid for not more than three years.

Accredited organizations reported for compliance with Section 1248 of the Health and Safety Codes may not have an accreditation term that exceeds 36 months. Therefore, such organizations are required to submit their application for reaccreditation at least six months prior to their accreditation expiration date.

California Health and Safety Code, Section 1248, was amended effective January 1, 2012 and includes, among other requirements, the following:

- Outpatient settings that have multiple service locations shall have all sites inspected.
- The accrediting organization shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest, to determine whether any adverse accreditation decisions have been rendered against them.
- If the accrediting organization determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may require correction of any identified deficiencies within a set timeframe. Failure to comply shall result in the accrediting agency revoking the outpatient setting's accreditation.

- Any outpatient setting that has been denied accreditation shall disclose the accreditation report to any other accrediting organization to which it submits an application. The new accrediting organization shall ensure that all deficiencies have been corrected.
- During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting organization shall send a list of deficiencies and the corrective action to be taken to the Medical Board of California.
- All final survey records, which include the survey report, list of deficiencies, plans of correction or plan for improvements and correction, and corrective action completed, shall be public records open to public inspection.
- The Medical Board must obtain and maintain the list for all accredited outpatient settings and must notify the public by placing the information on its website, http://mbc.ca.gov, whether the setting is accredited, or the setting's accreditation has been revoked, suspended, or placed on probation by the accreditation organization.

Adverse Event Reporting

Business and Professions Code 2216.3: As of January 1, 2014, an accredited outpatient surgery setting is required to report adverse events, as defined in HSC Section 1279.1, to the Medical Board of California no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected.

For the adverse event reporting form, refer to:

https://www.mbc.ca.gov/Download/Forms/oss-adverse-event.pdf

Patient Death or Transfer Reporting

Pursuant to Business and Professions Code §2240: A physician or surgeon who performs or supervises a medical procedure outside of a general acute care hospital that results in a death must file a report. The physician must complete the patient death reporting form and send it to the Medical Board of California.

For the patient death reporting form, refer to:

https://www.mbc.ca.gov/Download/Forms/oss-patient-death.pdf

Also, under the Code, when a physician or surgeon performs a scheduled medical procedure (as defined in subdivision (a) of Section 1250 of the Health and Safety Code) outside of a general acute care hospital, that results in a transfer, it must be reported within 15 days after the occurrence.

For the patient transfer reporting form, refer to:

https://www.mbc.ca.gov/Download/Forms/enf-2240b.pdf

Patient Transfer Plan

Health and Safety Code 1248.15(a)(2)(D): As of January 1, 2012, in addition to the requirements imposed at 1248.15(a)(2)(C), an outpatient setting must submit its detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergent and urgent care situations to AAAHC for approval.

The plan shall include the following minimum provisions in cases where a patient is being transferred to a local accredited or licensed acute care hospital:

i. Notify the individual designated by the patient to be notified in case of an emergency.

ii. Ensure that the mode of transfer is consistent with the patient's medical condition.

iii. Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.

iv. Continue to provide appropriate care to the patient until the transfer is effectuated.

Liability Coverage

Pursuant to California Business and Professions Code §2216.2: Physicians must maintain adequate security by liability insurance or by participation in an interindemnity trust, for claims by patients arising from surgical procedures performed outside of a general acute care hospital.

Under this law, the Medical Board of California determines the appropriate amount of required insurance. For purposes of Section 2216.2 of the code, "adequate security" means that a physician has coverage of the type described in Section 2216.2 of the code. Section 1304 of Title 16 of the California Code of Regulations defines "adequate security" as an amount of not less than $1 million per incident and not less than $3 million per year. Section 1304 states that the division shall reevaluate the requirements in the regulation at least every three years.

Posting the AAAHC Accreditation Certificate

Health and Safety Code 1248.15(a)(8) and (9): Outpatient surgery settings must post the certificate of accreditation in a location readily visible to patients and staff and post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff. California organizations affected by the law are instructed to post the following:

(Name of Organization) is accredited by the Accreditation Association for Ambulatory Health Care, Inc. Any complaints regarding services provided at (Name of Organization) can be directed in writing to:

AAAHC
3 Parkway North, Suite 201, Deerfield, IL 60015
Or by phone: 847.853.6060; Or by fax: 847.853.9028

Written Discharge Criteria

Health and Safety Code 1248.15(a)(10): Outpatient settings must have written discharge criteria.

Advanced Cardiac Life Support (ACLS)

Health and Safety Code 1248.15(b): Outpatient settings must have a minimum of two staff persons on the premises, one of whom is either a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present in the facility and has not been discharged from supervised care.

Inform Patients of Physician License

Business and Professions Code 138: Physicians in California are required to inform their patients that they are licensed by the Medical Board of California and include the board's contact information. As of January 1, 2023, the notice shall include a quick response (QR) code that leads to the board's *Notice to Consumer* webpage at:

https://www.mbc.ca.gov/licensing/Notice-to-Consumers.aspx

A *Notice to Consumers* is available at: https://www.mbc.ca.gov/Download/Documents/notices.pdf

Sample *Notices* in various languages are available at: https://www.mbc.ca.gov/licensing/Notice-to-Consumers.aspx.

Florida Physician Office Surgery Organizations (Allopathic and Osteopathic) Requirements

The Florida Board of Medicine and the Florida Board of Osteopathic Medicine recognize AAAHC as an accrediting organization for allopathic and osteopathic physicians performing surgery in an office setting.

Florida Office Surgery organizations accredited by AAAHC are required to be in compliance with the Florida Standards for office-based surgery under Florida Statutes Chapters 456 and 458 and the rules promulgated thereunder at Chapters 64B8-9 (allopathic) and 64B15-14 (osteopathic) of the Florida Administrative Code.

All offices in which a physician performs a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is removed, a Level II office surgery center, or a Level III office surgery center must register with the Department of Health and either be accredited by an approved accrediting organization or be inspected by the Department.

For additional information on Florida's office surgery requirements, please visit:

https://www.floridahealth.gov/licensing-and-regulation/office-surgery-registration/index.html

State of New York Office-Based Surgery Organization Accreditation Requirements

The intent of the New York State office-based surgery requirements is to ensure delivery of safe care in a safe environment. Accreditation does not create an entitlement to enhanced revenue, but accredited office-based surgery practices are not precluded from negotiating enhanced rates or fees with its insurers. In addition to the AAAHC Standards found in this Accreditation Handbook, outpatient organizations in New York must also be in compliance with the following laws:

- In July 2007, New York enacted State Public Health Law Sec. 230-d mandating that all office-based surgery practices that perform surgical or invasive procedures using moderate, deep, or general anesthesia, and any liposuction procedure, obtain and maintain full accredited status with a nationally-recognized accrediting agency, as determined by the New York State Commissioner of Health.

Public Health Law Sec. 230-d(h): "Office-based surgery" means any surgical or other invasive procedure, requiring general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure, where such surgical or other invasive procedure or liposuction is performed by a licensee in a location other than a hospital, as such term is defined in article twenty-eight of this chapter, excluding minor procedures and procedures requiring minimal sedation.

In 2012, the definition of "licensees" in the OBS law was expanded at Public Health Law Sec. 230-d(1)(i) to include podiatrists that are licensed under the education law and privileged by the State Education Department to perform ankle surgery.

- After July 14, 2009, surgery in a non-accredited office-based practice subject to this law became prohibited, and constitutes professional misconduct by the physician under Education Law § 6530. For more information about this law, use the following link: **https://www.health.ny.gov/professionals/office-based_surgery**
- Effective April 13, 2016, the deadline for submission of OBS adverse event reports has been extended from 24 hours to 72 hours. NY CLS Pub Health § 230-d(4)(a). Also, effective April 13, 2016, office-based surgery practitioners must report two additional types of adverse events: (1) unplanned emergency department visits within 72 hours of office-based surgery; and (2) unscheduled assignment to observation services within a hospital within seventy-two hours of the office-based surgery. NY CLS Pub Health § 230-d(1)(b).

  These new types of OBS adverse events are in addition to the following previously mandated types of adverse events: unplanned transfer to a hospital or emergency department from an OBS practice; unscheduled admission to the hospital for longer than 24 hours within seventy-two hours of office-based surgery; patient death within thirty days; suspected transmission of blood-borne pathogens from staff to patients or between patients; and any other serious or life-threatening event (defined primarily as the National Quality Forum's serious reportable events). NY CLS Pub Health § 230-d(1)(b).
- Effective February 17, 2014, NY CLS Pub Health § 230-d(1)(i) requires podiatrists privileged to perform ankle surgery by the State Education Department and seeking to perform such surgeries in office(s) of a private podiatry practice utilizing more than minimal sedation or local anesthesia must file adverse event reports with the Department of Health and must be OBS accredited.

According to the New York State Department of Health, each designated accrediting agency is also required to collect adverse event data from its accredited office-based surgery practices. If the organization is accredited by AAAHC, the following procedure applies: At the time a reportable adverse event, as defined by New York law, is reported to the New York State Department of Health, the AAAHC-Accredited Organization must also report certain information to AAAHC. Notice is made by completing and submitting the required and relevant requirements with the *Change Notification Form.* The form and instructions for patient care related adverse events can be found at **www.aaahc.org**

For additional information on adverse event reporting requirements in New York State, visit:

https://www.health.ny.gov/professionals/office-based_surgery/

Accredited office-based surgery practices in New York State must post a notice, adjacent to, at the same height and with the same size and typeface, as its accreditation certificate stating that any patient wishing to make a complaint to the accrediting agency regarding treatment he or she has received at the OBS practice may submit such complaints in writing to:

AAAHC
3 Parkway North, Suite 201, Deerfield, IL 60015
Or by phone: 847.853.6060; Or by fax: 847.853.9028

A private practice may only use "office-based surgery" in its name if it is accredited to perform office-based surgery. An office-based surgery practice should not use the words "facility", "center", or "clinic" in its name. Direct questions about naming of a private medical or podiatric practice to the New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Professional Corporations Unit.

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Standards by Category

Standards by Category

AAAHC
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE

ADM Administration

ASG Anesthesia and Surgery

BEH Behavioral Health

CMC Care Management and Coordination

CPV Credentialing and Privileging

CRD Clinical Records

EMG Emergency Management

FAC Facilities and Equipment

GOV Governance

IPC Infection Prevention and Control

LRD Laboratory and Radiology

MED Medication Management

MHM Medical Home

DHM Dental Home

OCS Other Clinical Services

QUA Quality

PRR Patient Rights, Responsibilities and Protections

SAF Safety

VAL Validation

Standards by Category

ADM Administration

This Category outlines the expectations of administrative functions that are essential to the direction and operation of the organization. This includes the day-to-day operations of an organization that influence the client experience and organizational objectives, and ensuring that systems are in place to facilitate effective leadership and individual development. Operational effectiveness ensures organizations run efficiently while delivering high-quality, safe care and all providers and personnel providing care are appropriately qualified and supervised and available in sufficient numbers for the care that is provided.

The Standards address administration, contracts, financial, and personnel management.

		Compliance Rating
ADM.100 **Universal / 2** ***v42 2.I.H***	**Within 15 calendar days of significant organizational, ownership, operational, or quality of care events, the organization notifies AAAHC of the event in writing.**	**FC, NC**

Guidance & References

- See the AAAHC Policies and Procedures for additional information regarding events that must be reported to AAAHC.

		Compliance Rating
ADM.110 **Universal / 2** ***v42 2.I.I***	**Representation of accreditation to the public accurately reflects the AAAHC-accredited entity.**	**FC, NC**

		Compliance Rating
ADM.120 **Universal / 1** ***v42 3.A***	**Administrative policies, procedures, and controls adopted by the governing body are implemented to ensure the orderly and efficient management of the organization.**	**FC, SC, PC, MC, NC**
ADM.120.10	All policies adopted by the governing body are appropriate for the organization given the services provided and the patients served.	YES, NO
ADM.120.20	As evidenced by the personnel files, all staff employed possess at least the minimum qualifications, experience, competencies, and licensure and/or certification required for their positions.	YES, NO
ADM.120.30	Written job descriptions define and delineate functional responsibilities, authority and qualifications including licensure and/or certification.	YES, NO
ADM.120.40	Written policies and procedures, as well as other documentation such as (but not limited to) meeting minutes and educational materials, indicate that all reasonable steps are taken to comply with applicable laws and regulations.	YES, NO
ADM.120.50	Evidence is present that official organizational documents such as governing body meeting minutes, corporate organizational documents, bylaws and other similar records are properly filed, secured and safeguarded.	YES, NO

		Compliance Rating
ADM.130 **Universal / 1** ***v42 3.B***	**Fiscal controls are in place to protect the assets of the organization.**	**FC, SC, PC, MC, NC**
ADM.130.10	Appropriate and adequate policies and procedures are in place to provide accounting controls over assets, liabilities, revenues and expenses.	YES, NO
ADM.130.20	Written policies and procedures are in place for controlling accounts receivable and accounts payable.	YES, NO
ADM.130.30	Written policies and procedures are in place to control cash payments and credit arrangements.	YES, NO
ADM.130.40	Written policies and procedures are in place to manage unpaid accounts and accounts being considered for transfer to a collection agency.	YES, NO, NA
ADM.130.50	Written policies and procedures are in place to manage the purchase, receipt, distribution, maintenance, and security of supplies, equipment, and facilities.	YES, NO

		Compliance Rating
ADM.140 **Universal / 1** ***v42 3.C***	**Written personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization.**	**FC, SC, PC, MC, NC**
ADM.140.10	Written policies are made known to employees at the time of employment.	YES, NO
ADM.140.20	Written policies describe incentives such as rewards or wellness programs, if any exist.	YES, NO, NA
ADM.140.30	Written policies specify privileges and responsibilities of employment, including compliance with an incident and adverse event reporting system.	YES, NO
ADM.140.40	Written policies specify the organization's procedures for handling of workplace violence and aggression.	YES, NO
ADM.140.50	Written policies require periodic appraisal of each person's job performance, including current competence.	YES, NO
ADM.140.60	Written policies comply with prevailing laws and regulations regarding verification of eligibility for employment (I-9 form), and visas as required.	YES, NO
ADM.140.70	Written policies define the status of students and postgraduate trainees, if present in the organization.	YES, NO, NA

Guidance & References

- File contains employment-related items as required by the organization's personnel policies (e.g., job application, resume, job description, verification of references, results of background check and employee benefit forms).
- File contains evidence that personnel policies were made known to the employee at the time of employment.
- Refer to the risk management program Standards and state requirements for defining incidents and adverse events.
- Organization may choose to keep I-9 forms separate from personnel files.

		Compliance Rating
ADM.150 **Universal / 2** ***v42 3.D***	**Orientation and training address safety and privacy.**	**FC, SC, PC, MC, NC**
ADM.150.10	Orientation and training address the organization's statement of Patient Rights and Responsibilities and associated policies and procedures.	YES, NO
ADM.150.20	Orientation and training address the organization's procedures for handling of workplace violence and aggression.	YES, NO
ADM.150.30	Orientation and training address the organization's safety program.	YES, NO
ADM.150.30.1	The orientation and training address the safety program, including exposure control training and sharps injury prevention.	
ADM.150.30.2	The orientation and training includes applicable fire safety prevention practices.	
ADM.150.40	Orientation and training address the emergency and disaster preparedness plan, including the use of emergency equipment and supplies.	YES, NO
ADM.150.50	Orientation and training address the infection prevention and control program, including bloodborne pathogen and other training required by OSHA.	YES, NO
ADM.150.60	Orientation and training address the risk management program, including training in the reporting of incidents and adverse events.	YES, NO
ADM.150.70	Orientation and training address confidentiality and privacy (e.g., HIPAA, FERPA).	YES, NO

Guidance & References

- If the organization provides telehealth/telemedicine services, this standard applies. Consider including information about privacy, confidentiality, and emergency management in the telehealth/telemedicine setting.
- If telehealth and telemedicine services are offered, the governing body should ensure that they fulfill all applicable obligations under prevailing laws and regulations concerning medical privacy at both the clinician's location and the patient's/client's location (the originating site and the distance site).

		Compliance Rating
ADM.160 **Universal / 2** ***v42 3.E***	**Orientation and training according to position description are provided to all staff.**	**FC, PC, NC**
ADM.160.10	Documented orientation and training are completed within 30 days of employment.	YES, NO
ADM.160.20	The training is provided annually thereafter.	YES, NO
ADM.160.30	The training is provided when there is an identified need.	YES, NO
ADM.160.40	The delivery of all training is documented.	YES, NO

Guidance & References

- If the ASC is in the Medicare Deemed Status program and training is not provided to appropriate staff upon hire/granting of privileges, with some refresher training thereafter, or, if training is completely absent, then consideration should be given to condition-level deficiency at §416.51 Condition for Coverage—Infection control (CfC) particularly when the ASC's practices fail to comply with infection control standards of practice.
- Training provided annually and when there is an identified need should be documented and include safety and privacy orientation and training Standard requirements.

		Compliance Rating
ADM.170 **Universal / 2** ***v42 4.C***	**All personnel assisting in the provision of health care services are appropriately qualified and supervised and are available in sufficient numbers for the care provided.**	**FC, PC, NC**
ADM.170.10	Evidence of the following is present:	YES, NO
ADM.170.10.1	Such personnel are appropriately qualified.	
ADM.170.10.2	Such personnel are appropriately supervised.	
ADM.170.20	Interviews and observation confirm that such personnel are available in sufficient numbers for the care provided.	YES, NO

		Compliance Rating
ADM.180 **Selective / 2** ***v42 10.III.B***	**Allied health care personnel assisting in the provision of lithotripsy services are appropriately qualified and trained.**	**FC, NC**
ADM.180.10	If the allied health care personnel are organization staff members:	YES, NO, NA
ADM.180.10.1	All such personnel meet state and federal licensure requirements for the operation of radiation equipment.	
ADM.180.10.2	Documentation of staff education, including orientation to equipment, is present.	
ADM.180.20	If outside providers of lithotripsy services are used, the vendor provides the accredited organization with documentation of the following for its personnel providing services:	YES, NO, NA
ADM.180.20.1	Appropriate training and licensure.	
ADM.180.20.2	Ongoing education.	
ADM.180.20.3	Annual competency evaluation.	

		Compliance Rating
ADM.190 **Universal / 2** ***v42 4.D***	**The organization has policies and procedures for identifying, storing, and transporting laboratory specimens and biological products.**	**FC, PC, NC**
ADM.190.10	Logging and tracking procedures ensure that results for each specimen are obtained.	YES, NO
ADM.190.20	Results for each specimen are reported to the ordering health care professional in a timely manner.	YES, NO
ADM.190.30	Biological products are handled, stored and transported in accordance with manufacturer's instructions and/or regulatory requirements, as applicable.	YES, NO

Guidance & References

- For a definition of biological products, see https://www.fda.gov/files/drugs/published/Biological-Product-Definitions.pdf.

		Compliance Rating
ADM.200 **Universal / 2** ***v42 11.A***	**Pharmaceutical services are directed by a qualified licensed provider.**	**FC, NC**

Guidance & References

- Pharmaceutical standards apply to any organization that uses drugs or pharmaceutical medical supplies and samples, regardless of the presence or absence of an onsite pharmacy.

		Compliance Rating
ADM.210 **Selective / 2** ***v42 11.B***	**If the organization owns or operates a pharmacy, it is supervised by a licensed pharmacist.**	**FC, NC**

		Compliance Rating
ADM.220 **Selective / 1** ***v42 12.D***	**Provider-performed microscopy, moderate complexity testing and high complexity testing are provided under the direction of a pathologist, other physician or other qualified individual as specified by the state for the level of testing performed.**	**FC, NC**

Guidance & References

- Standard applies if State licensure program is or is not exempt from CLIA program requirements.

		Compliance Rating
ADM.240 **Selective / 2** ***v42 18.A***	**A current, fully executed written agreement with each training institution is present.**	**FC, SC, PC, MC, NC**
ADM.240.10	Each agreement includes a description of the types of students and/or postgraduate trainees eligible for the teaching experience.	YES, NO
ADM.240.20	Each agreement describes the extent to which students and postgraduate trainees are involved in patient care activities.	YES, NO
ADM.240.30	Each agreement includes expectations of students and postgraduate trainees regarding adherence to organizational policies and other regulations.	YES, NO
ADM.240.40	Each agreement indicates whether liability coverage is required and, if so, minimum amounts required.	YES, NO
ADM.240.50	Each agreement describes responsibilities of each party for:	YES, NO
ADM.240.50.1	HIPAA/FERPA training.	
ADM.240.50.2	OSHA training related to bloodborne pathogens.	
ADM.240.60	Each agreement includes a requirement that each student or postgraduate trainee signs an addendum to the teaching agreement accepting its terms and conditions.	YES, NO

Guidance & References

- Depending on the level of involvement in patient care, credentialing of residents and fellows as described in the AAAHC Standards for credentialing (CPV) may be appropriate.
- If students and postgraduate trainees participate in telehealth/telemedicine activities, this participation is referenced in the written agreement.

		Compliance Rating
ADM.250 **Selective / 2** ***v42 18.B***	**Written policies concerning teaching activities have been adopted.**	**FC, PC, NC**
ADM.250.10	Written policies address how the identity of the person arriving for training is confirmed.	YES, NO
ADM.250.20	Written policies address requirements for orientation and other training.	YES, NO
ADM.250.30	Written policies addressing the provision of health care by personnel with student or postgraduate trainee status include a definition of “close and adequate supervision” of these individuals.	YES, NO
ADM.250.40	Written policies addressing the provision of health care by personnel with student or postgraduate trainee status include the process for obtaining patient consent for student/trainee participation in or observation of the patient's care.	YES, NO

Guidance & References

- If students and postgraduate trainees participate in telehealth/telemedicine activities, it is referenced in their orientation and other training.

		Compliance Rating
ADM.260 **Selective / 1** ***v42 18.C***	**If staff is involved in publishing, a written policy specifies approvals needed, if any, of publications attributed to or resulting from care provided by the organization.**	**FC, NC**

		Compliance Rating
ADM.270 **Selective / 1** ***v42 19.B***	**Research is conducted in accordance with established written protocols.**	**FC, PC, NC**
ADM.270.10	Written protocols for conducting research are present.	YES, NO
ADM.270.20	The written protocols for conducting research were approved by the governing body or its designee after medical (or dental) and legal review.	YES, NO
ADM.270.30	There is evidence that professionals involved in research activities are aware of and follow the organization's research protocols.	YES, NO

		Compliance Rating
ADM.280 **Selective / 2** ***v42 20.B***	**Overnight care and services are provided by qualified personnel.**	**FC, SC, PC, MC, NC**
ADM.280.10	The governing body has appointed one or more qualified physicians to supervise overnight care and services.	YES, NO
ADM.280.20	A patient is admitted or discharged only upon the order of a physician who is responsible for the medical care of that patient.	YES, NO
ADM.280.30	Providers may admit patients to this program if they:	YES, NO
ADM.280.30.1	Are licensed to treat patients or supervise care and services in this setting.	
ADM.280.30.2	Have been granted such privileges by the governing body of the organization, in accordance with AAAHC Standards for credentialing and privileging.	
ADM.280.40	There is documented evidence that registered nurses and other health care professionals are appropriately trained.	YES, NO
ADM.280.50	At least one physician is present or immediately available by telephone whenever patients are present.	YES, NO
ADM.280.60	At least one registered nurse is on duty whenever patients are present.	YES, NO

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
ADM.290 **Selective / 2** ***v42 21.B***	**Personnel providing occupational health services have the appropriate skills, knowledge and resources to provide appropriate care.**	**FC, SC, PC, MC, NC**
ADM.290.10	As demonstrated by information in credentials and/or personnel files, personnel have appropriate training and/or certification in occupational health.	YES, NO
ADM.290.20	Occupational health personnel have documented competency, as appropriate for their roles, in workplace demands and hazards for each employee/patient served.	YES, NO
ADM.290.30	Occupational health personnel have documented competency, as appropriate for their roles, in pertinent occupational regulatory requirements.	YES, NO
ADM.290.40	Consultative services associated with evaluating workplace hazards are available.	YES, NO
ADM.290.50	Ready access to appropriate reference materials in occupational health is provided.	YES, NO

Guidance & References

- Examples of pertinent regulatory requirements include ADA, OSHA, FMSCA.
- Examples of consultative services include industrial hygiene, ergonomics, toxicology, occupational health nursing, epidemiology, and physicians with training in occupational medicine.

		Compliance Rating
ADM.300 **Selective / 2** ***v42 22.A***	**Immediate/urgent care services are provided by qualified health care professionals.**	**FC, PC, NC**
ADM.300.10	All health care professionals are appropriately licensed.	YES, NO
ADM.300.20	Each provider has been granted privileges by the governing body to provide immediate/urgent care services, or has been designated to provide these services via job description.	YES, NO

		Compliance Rating
ADM.310 **Selective / 2** ***v42 23.C***	**Emergency services are provided by qualified health care professionals.**	**FC, PC, NC**
ADM.310.10	All health care professionals are appropriately licensed.	YES, NO
ADM.310.20	Each provider has been granted privileges by the governing body to provide emergency services or has been designated to provide these services via job description.	YES, NO

		Compliance Rating
ADM.320 **Selective / 2** ***v42 24.B***	**The radiation oncology treatment service employs trained and qualified health care professionals to supervise and perform the services provided.**	**FC, SC, PC, MC, NC**
ADM.320.10	Staff includes a radiation technologist certified by the American Registry of Radiologic Technologists (ARRT) or a state-licensed technologist.	YES, NO
ADM.320.20	Staff includes a dosimetrist.	YES, NO
ADM.320.30	Staff includes a qualified radiation physicist.	YES, NO
ADM.320.40	Staff includes other appropriately trained health care professionals as may be in keeping with local practice and legal requirements, such as oncology nurses, nutritionists, and medical social workers.	YES, NO
ADM.320.50	Observation and interviews confirm that the number of staff is sufficient for the services provided.	YES, NO

		Compliance Rating
ADM.330 **Selective / 2** ***v42 REG***	**The Accreditation Certificate and the Notice for Complaint are posted in the organization in a readily visible location.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Health and Safety §1248.15(a)(8 and 9): Outpatient surgery settings must post the certificate of accreditation in a location readily visible to patients and staff, and post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff. California organizations affected by the law have been instructed to post the following information:

  (Name of Organization) is accredited by the Accreditation Association for Ambulatory Health Care, Inc. Any complaints regarding services provided at (Name of Organization) can be directed in writing to the AAAHC at 3 Parkway North, Suite 201, Deerfield, IL 60015, by phone at 847.853.6060, or by fax at 847.853.9028.

ASG Anesthesia and Surgery

The Anesthesia and Surgery Category outlines the expectations for the provision of safe and high-quality anesthesia, procedural and surgical care. This Category emphasizes the importance of evaluation, communication and adherence to best practices designed to reduce errors and facilitate surgical team collaboration.

In this Category and throughout this Handbook, the terms "surgery," "procedure," and "operation" are used interchangeably. The use of any of these terms is to reference any such skill, method, or technique that involves cutting, abrading, suturing, lasering, or otherwise physically entering or changing body tissues and organs, including invasive pain management procedures.

Applicable ASG Standards are curated in *1095 Engage* based on organization profile and selected level of anesthesia.

Definitions

Local or topical anesthesia is the application of local anesthetic agents, in appropriate doses adjusted for weight.

Minimal sedation (anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Inhaled nitrous oxide in low concentrations that would not reasonably be expected to result in loss of the patient's life-preserving protective reflexes would be considered minimal sedation.

Moderate sedation/analgesia (conscious sedation) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. (Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.) No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Regional anesthesia is the application of anesthetic medication around the nerve or nerves in a major region of the body, which supply the area that is targeted for the abolition of painful neural impulses. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep sedation/analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. (Note that reflex withdrawal from a painful stimulus is NOT considered a purposeful response.) The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Individuals administering minimal or moderate sedation/ analgesia or regional anesthesia should be able to support the respiratory and cardiovascular system of patients who enter a state of deep sedation / analgesia, while those administering deep sedation/analgesia should be able to support the respiratory and cardiovascular system of patients who enter a state of general anesthesia.

The Standards address anesthesia, surgical safety measures, and recovery, and apply to organizations that perform any invasive procedures, such as pain management, endoscopy procedures, cardiac catheterization, lithotripsy, and invitro fertilization, as well as surgery.

		Compliance Rating
ASG.100 **Selective / 2** ***v42 9.E***	**Written policies and procedures for anesthesia services are present.**	**FC, PC, NC**
ASG.100.10	Written policies and procedures address education, training, and supervision of personnel.	YES, NO
ASG.100.20	Written policies and procedures address responsibilities of non-physician anesthetists.	YES, NO, NA
ASG.100.30	Written policies and procedures address responsibilities of supervising physicians and dentists.	YES, NO, NA

Guidance & References

- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.

		Compliance Rating
ASG.110 **Selective / 1** ***v42 10.I.E***	**The organization has written policies regarding the procedures and treatments offered to patients.**	**FC, PC, NC**
ASG.110.10	The written policies address the criteria for patient selection.	YES, NO
ASG.110.20	The written policies address the need for anesthesia support.	YES, NO
ASG.110.30	The written policies address post-procedural care.	YES, NO
ASG.110.40	The written policies address staffing requirements to ensure that registered nurse(s) or other health care professionals assisting in the provision of surgical services are available in sufficient numbers for the surgical care provided.	YES, NO

		Compliance Rating
ASG.120 **Selective / 1** ***v42 10.I.D***	**The organization must develop and maintain a policy regarding the requirement for medical history and physical examination prior to surgery.**	**FC, PC, NC**
ASG.120.10	The written policy must include the requirement and timeframe for completion of a medical history and physical examination prior to surgery.	YES, NO
ASG.120.20	The policy must address, but is not limited to, the following factors: patient age, diagnosis, the type and number of procedures scheduled to be performed on the same surgery date, known comorbidities, and the planned anesthesia level.	YES, NO
ASG.120.30	The policy must be based on any applicable nationally recognized standards of practice and guidelines, and any applicable state and local health and safety laws.	YES, NO

Guidance & References

- Standard maintains applicability if all or part of the pre-surgical assessment occurs via telehealth and telemedicine services.

		Compliance Rating
ASG.130 **Selective / 2** ***v42 9.H***	**Immediately before surgery, a physician or anesthetist (as defined at §410.69(b)) on the surgical team must examine the patient to evaluate the risk of anesthesia.**	**FC, NC**

Guidance & References

- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.

		Compliance Rating
ASG.140 **Selective / 2** ***v42 10.I.K***	**Immediately before surgery, a physician on the surgical team must examine the patient to evaluate the risk of the procedure to be performed.**	**FC, NC**

		Compliance Rating
ASG.150 **Selective / 2** ***v42 9.I***	**The oxygenation, ventilation, and circulation of the patient is continually evaluated and documented.**	**FC, PC, NC**
ASG.150.10	Continuous intra-operative physiologic monitoring includes:	YES, NO
ASG.150.10.1	Use of a pulse oximeter.	
ASG.150.10.2	Blood pressure determination at frequent intervals.	
ASG.150.10.3	Electrocardiogram (ECG) monitoring.	
ASG.150.20	The presence of exhaled CO2 is monitored during the administration of deep sedation/analgesia	YES, NO, NA
ASG.150.30	End-tidal CO2 is monitored, during the administration of general anesthesia	YES, NO, NA
ASG.150.40	A means of measuring body temperature is readily available, during the administration of general anesthesia	YES, NO, NA

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
ASG.160 **Selective / 2** ***v42 9.L***	**Patients are observed and monitored in a post-anesthesia care unit, or in an area that provides equivalent care, by methods appropriate to each patient's medical condition and sedation/analgesia or anesthesia.**	**FC, PC, NC**
ASG.160.10	Patients are observed and monitored in a post-anesthesia care unit or in an area that provides equivalent care.	YES, NO
ASG.160.20	Observation methods are appropriate for each patient's medical condition and sedation/analgesia or anesthesia.	YES, NO
ASG.160.30	Appropriate monitoring equipment is present for the level(s) of anesthesia provided.	YES, NO

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
ASG.170 **Selective / 2** ***v42 9.M***	**A written policy requires the presence of a physician, dentist, or other delegated, qualified health care professional supervised by a physician or dentist until the medical discharge of the patient following clinical recovery from the surgery/procedure and anesthesia.**	**FC, NC**

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
ASG.190 **Selective / 2** ***v42 9.R***	**If anesthesia is provided by other than an anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an anesthesiologist assistant within his/her scope of practice, the governing body has granted such personnel privileges to administer sedative, hypnotic, or analgesic drugs that do not have an antagonist medication (for example, propofol), if these drugs are used.**	**FC, NC**

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
ASG.200 **Selective / 2** ***v42 9.S***	**If anesthesia is provided by other than an anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an anesthesiologist assistant within his/her scope of practice, a written protocol defines how the organization will respond in the event that a deeper-than-intended level of sedation occurs.**	**FC, NC**

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
ASG.210 **Selective / 2** ***v42 9.Q***	**A written policy prohibits the administration of moderate or deep sedation or general anesthesia unless a physician, dentist, or other qualified individual supervised by a physician or dentist, in addition to the one performing the surgery, is present to monitor the patient.**	**FC, PC, NC**
ASG.210.10	A written policy is present.	YES, NO
ASG.210.20	Clinical records demonstrate that the policy is followed.	YES, NO

Guidance & References

- Not all states require physician supervision of CRNAs. The operating physician or dentist may be the supervising physician or dentist. During moderate sedation, the additional individual may assist with minor, interruptible tasks. Refer to state guidelines for applicable supervision requirements.
- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
ASG.220 **Selective / 2** ***v42 10.I.G***	**If applicable, protocols for the handling, maintenance, and storage of blood or blood products for transfusion, and/or human cells or tissues for transplantation, are present.**	**FC, PC, NC, NA**
ASG.220.10	Written protocols for handling, maintaining and storing blood or blood products for transfusion are present.	YES, NO, NA
ASG.220.20	Written protocols for handling, maintaining and storing human cells for transplantation are present.	YES, NO, NA
ASG.220.30	The written protocols are consistent with those of a nationally recognized authority, such as the American Association of Tissue Banks (AATB) or the U.S. Food and Drug Administration (FDA).	YES, NO, NA

Guidance & References

- NA may be applied depending on services provided by the organization.

		Compliance Rating
ASG.230 **Selective / 2** ***v42 10.I.F***	**If procedures performed pose the risk that blood loss may require blood replacement, the organization has written policies and procedures to address this situation.**	**FC, NC, NA**

Guidance & References

- NA may be applied depending on services provided by the organization.

		Compliance Rating
ASG.240 **Selective / 2** ***v42 10.I.H***	**A written policy is in place for assessing the risk of, and implementing practices to prevent, deep vein thrombosis when appropriate for the patient.**	**FC, NC, NA**

Guidance & References

- NA may be applied depending on services provided by the organization.

		Compliance Rating
ASG.250 **Selective / 2** ***v42 10.I.I***	**If pediatric patients are served, written policies define appropriate care.**	**FC, PC, NC, NA**
ASG.250.10	Policies address criteria for treatment as a pediatric patient.	YES, NO, NA
ASG.250.20	Policies address requirements for the appropriate pediatric:	YES, NO, NA
ASG.250.20.1	Equipment.	
ASG.250.20.2	Supplies.	
ASG.250.20.3	Medications.	

		Compliance Rating
ASG.260 **Selective / 2** ***v42 10.I.N***	**If procedures requiring counts of sponges, sharps, and instruments are performed, a written policy, based on nationally recognized guidelines for conducting counts, is present.**	**FC, SC, PC, MC, NC**
ASG.260.10	The policy addresses the types of procedures requiring counts of sponges, sharps, and instruments.	YES, NO
ASG.260.20	The policy requires a count before the start of the procedure and before skin closure.	YES, NO
ASG.260.30	The policy addresses how start and end counts are reported to the surgeon.	YES, NO
ASG.260.40	The policy requires documentation of the counts in the patient's record.	YES, NO
ASG.260.50	The policy includes actions to be taken if the count is not correct.	YES, NO
ASG.260.60	Observation and interviews confirm that the policy is followed.	YES, NO

Guidance & References

- An example of nationally recognized guidelines includes the World Health Organization (WHO) Surgical Safety Checklist. See https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources.

		Compliance Rating
ASG.270 **Selective / 2** ***v42 10.I.O***	**Prior to the surgery or procedure, the intended procedure is verified.**	**FC, PC, NC**
ASG.270.10	A written verification policy based on nationally recognized guidelines is present.	YES, NO
ASG.270.20	The patient or their authorized representative is involved in the verification process.	YES, NO
ASG.270.30	Clinical records contain documentation of procedure verification.	YES, NO

Guidance & References

- An example of nationally recognized guidelines includes the World Health Organization (WHO) Surgical Safety Checklist. See https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources.

		Compliance Rating
ASG.280 **Selective / 2** ***v42 10.I.P***	**Prior to a surgery or procedure involving level or laterality, the site is marked.**	**FC, SC, PC, MC, NC, NA**
ASG.280.10	A written site marking policy is present.	YES, NO, NA
ASG.280.20	The policy includes the organization’s definition of “surgical team”.	YES, NO, NA
ASG.280.30	The patient or their authorized representative is involved in the site marking process prior to the administration of anesthesia.	YES, NO, NA
ASG.280.40	The site is marked by the person performing the procedure, or by their designated member of the surgical team who will be present during the time-out.	YES, NO, NA
ASG.280.50	Clinical records contain documentation of site marking.	YES, NO, NA

Guidance & References

- NA may be applied if no procedures involving level or laterality are performed.

		Compliance Rating
ASG.290 **Selective / 2** ***v42 10.I.Q***	**A time-out is conducted immediately prior to beginning a procedure.**	**FC, PC, NC**
ASG.290.10	The provider performing the procedure assumes responsibility for the time-out.	YES, NO
ASG.290.20	The entire team is engaged in the time-out.	YES, NO
ASG.290.30	During the time-out, the following items are verified:	YES, NO
ASG.290.30.1	Patient identification.	
ASG.290.30.2	Intended procedure.	
ASG.290.30.3	Correct surgical/procedural site.	
ASG.290.30.4	All equipment necessary for performing the scheduled procedure is immediately available and functional in the operating/procedure room.	
ASG.290.30.5	Any implantable devices intended for use during the procedure were prepared before the procedure and are available.	

		Compliance Rating
ASG.300 **Selective / 2** ***v42 10.III.D***	**Written policies for the provision of lithotripsy services are present.**	**FC, SC, PC, MC, NC**
ASG.300.10	Policies include a recognized methodology for diagnosis and treatment, including pre-procedure evaluation (lab work, x-rays, etc.).	YES, NO
ASG.300.20	Policies include the requirement that a provider shall perform the treatment and be present during treatment.	YES, NO
ASG.300.30	Policies include criteria for patient selection.	YES, NO
ASG.300.40	Policies include the administration of anesthesia/medication.	YES, NO
ASG.300.50	Policies address the correction of medication-related and other medical conditions contributing to coagulopathy and the relationship to lithotripsy.	YES, NO
ASG.300.60	Policies address pre- and post-procedure teaching.	YES, NO

Guidance & References

- A wide choice of anesthetic methods is available and appropriate. Successful lithotripsy requires the appropriate administration of anesthesia/medication for patient comfort and compliance. A patient's health, habits, and history must be such that they can safely undergo anesthesia/analgesia for lithotripsy.

		Compliance Rating
ASG.330 **Selective / 2** ***v42 REG***	**If the organization utilizes capnography, the following measures are in place: (NYS PHL 230-d(1)(a))** • **Continual monitoring occurs.** • **The end tidal CO2 alarm is audible to the clinical staff responsible for monitoring the patient.** • **Capnography is documented at frequent intervals in the physiologic monitoring record.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.

		Compliance Rating
ASG.340 **Selective / 2** ***v42 REG***	**The organization maintains written discharge criteria.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Health and Safety Code §1248.15(a)(10): Outpatient settings must have written discharge criteria.

		Compliance Rating
ASG.350 **Selective / 2** ***v42 REG***	**The organization maintains two staff persons on the premises, one of whom is either a licensed physician and surgeon, or a licensed health care professional with current certification in ACLS, as long as a patient is present in the facility and has not been discharged from supervised care.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Health and Safety Code §1248.15(b): Outpatient settings must have a minimum of two staff persons on the premises, one of whom is either a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present in the facility and has not been discharged from supervised care.

		Compliance Rating
ASG.360 **Selective / 2** ***v42 REG***	**For the New York OBS performing liposuction: the governing body has defined specific criteria for initial appointment, reappointment and privileging that includes that the proceduralist is a New York State licensed physician (MD or DO) with appropriate training, experience and competence to perform these procedures and practice in compliance with New York State Education Law Article 131-A § 6530.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.370 **Selective / 2** ***v42 REG***	**For the New York OBS performing liposuction: the governing body has defined specific criteria for initial appointment, reappointment and privileging that includes the physician planning to perform procedures of liposuction with removal of greater than 500 ccs with or without fat grafting in the OBS setting have privileges in their specialty for the same procedure at a licensed Article 28 acute care hospital and/or ambulatory surgery center with appropriate training, experience and competence to perform these procedures and practice in compliance with New York State Education Law Article 131-A § 6530.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.380 **Selective / 2** ***v42 REG***	**For the New York OBS performing liposuction: The patient is under the care of a licensed practitioner (physician performing procedure and/or patient's primary care provider), who evaluated the condition of the patient, including specific comorbidities that may complicate performance of the procedure and/or anesthetic management, and identified and discussed with the patient the potential risks associated with the treatment option.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.390 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: Patients with pre-existing medical or other conditions, at undue risk for complications, are referred to an appropriate specialist for a preoperative consultation, and to another treatment setting/facility for performance of the surgery and administration of the anesthesia as deemed necessary by the evaluation.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.400 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: Immediately before surgery, the proceduralist performs a preprocedural evaluation, including the review of findings and documents the decision whether to proceed and perform procedure.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.410 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: Immediately before surgery, the proceduralist performs a preprocedural evaluation, including the review of findings and documents the decision whether to proceed and perform procedure.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.420 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: Documentation in the clinical record verifies that:** • **Pertinent preprocedural testing based upon findings of the preprocedural evaluation was performed, as applicable.** • **Available laboratory test results are reviewed and additional laboratory tests are ordered, guided by the patient's medical condition, physical examination, and the potential that results will affect the management of moderate sedation/analgesia.** • **Review of preprocedural testing is documented in the medical record.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.430 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: In accordance with the organization's policy for assessing the risk of and implementing practices to prevent, deep vein thrombosis when appropriate for the patient:** • **There is documentation in the clinical record that patients are evaluated for history of, or potential for, venous thromboembolism (VT) and a risk stratification was performed as part of the preprocedural evaluation.** • **-here is documentation in the clinical record that a venous thromboembolism risk assessment tool (VTRA) (e.g., Modified Caprine Scale) was utilized** • **There is documentation in the clinical record that risks of hormone therapy were discussed and discontinuation was considered.** • **There is documentation in the clinical record when hormonal therapy is discontinued, the ordering physician is consulted prior to discontinuing.** • **There is documentation in the clinical record that intermittent pneumatic compression devices for mechanical prophylaxis, early mobilization, chemical prophylaxis based on venous thromboembolism risk assessment findings/score are used.** • **Operating Room times are limited to 2-3 hours for each patient procedure and do not exceed 6 hours.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.440 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: The findings and techniques of the procedure are accurately and completely documented immediately after the procedure:** • **Large volume liposuction (greater than 5,000 ccs total aspirate) and/or large volume liposuction combined with other procedures are performed in an Article 28 facility (i.e., acute-care hospital or an Ambulatory Surgery Center).** • **No more than 5,000 ccs of aspirate are removed while performing liposuction unless the patient is monitored overnight in an appropriate Article 28 facility with minimum of a registered nurse (RN) with ACLS certification in attendance.** • **When performing gluteal fat grafting procedures, fat is injected into the subcutaneous space only and never crosses the gluteal fascia (intramuscular or submuscular fat injections are contraindicated).** • **When the aesthetic goal requires a greater amount of fat than can be placed in the subcutaneous layer, the surgeon stages the procedure instead of injecting below the subcutaneous layer.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.450 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: The written policies for post procedural care include:** • **Identifying length of required patient monitoring/recovery time in facility post procedure (number of hours) or if overnight monitoring is needed, arranging transport and stay in an Article 28 facility.** • **Assessment of fluid and electrolyte requirements and planning for administration of replacement fluids to assure fluid and electrolyte balance.** • **For longer procedures, 4 to 6 hours in length, the patient is not discharged after less than a 1-2 hour monitored observation in a Post Anesthesia Care Unit (PACU).**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.460 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: Patients are provided with written instructions for self care that include post-discharge early ambulation and chemical prophylaxis based on the patient venous thromboembolism risk assessment.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

		Compliance Rating
ASG.470 **Selective / 2** ***v42 REG***	**For the New York OBS performing Liposuction: In accordance with the organization's written procedures for managing medical emergencies, unplanned outcomes and procedures that exceed recommended operating room time:** • **When the Operating Room time is expected to exceed the maximum of 6 hours, is the patient referred to an alternative facility (i.e., Article 28 acute-care hospital or an Ambulatory Surgery Center) for performance of the surgery and administration of the anesthesia.** • **When the intended procedure which, under usual circumstances would not exceed the maximum 6 hours in the Operating Room, exceeds 6 hours the following processes in place prior to the start of the case:** **i) A written emergency transfer procedural plan for transferring patients to a hospital, and** **ii) A transfer agreement with a local acute-care hospital within thirty (30) minutes of the OBS facility in which the surgeon has privileges to admit patients.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Law requirements for Office Based Surgery Centers.
- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers performing liposuction.

BEH Behavioral Health

The Behavioral Health Category outlines the expectations for interventions designed to improve and enhance emotional, mental, and behavioral health. Behavioral health services are designed to improve and enhance the emotional, mental, and behavioral health of the organization's targeted client population. Services may include but are not limited to counseling or psychotherapy, psychiatry and psychotropic medication evaluation and management, crisis intervention and emergency services, consultation, and outreach, prevention and referral services.

This Category applies when licensed or certified behavioral health clinicians are providing services. This includes psychiatrists, psychologists, licensed professional counselors, licensed social workers, licensed family and marital therapists, certified addiction counselors or any other certified or licensed behavioral health provider.

The Standards address staffing requirements, resources, patient care, safety measures, medical records and care coordination.

		Compliance Rating
BEH.100 **Selective / 2** ***v42 17.A***	**Behavioral health services provided are limited to those approved by the governing body, consistent with the overall mission of the organization, and responsive to the diverse needs of the population served.**	**FC, SC, PC, MC, NC**
BEH.100.10	Documentation of the following is present:	YES, NO
BEH.100.10.1	The governing body has approved the services provided.	
BEH.100.10.2	Goals and objectives for behavioral health services are included in the organization's planning process.	
BEH.100.10.3	The plan for behavioral health supports diversity, equity and access to care.	
BEH.100.20	Evidence is present that the following reflect and meet the needs of the population served:	YES, NO
BEH.100.20.1	Scope of services.	
BEH.100.20.2	Hours of operation.	
BEH.100.20.3	Methods of delivering programs or treatment modalities used.	
BEH.100.20.4	Specific services provided.	
BEH.100.20.5	Available resources.	
BEH.100.30	A description of services includes goals and objectives of the behavioral health service and programs offered.	YES, NO
BEH.100.40	A description of services identifies the population served.	YES, NO
BEH.100.50	There is evidence that the scope of services is provided to the population served.	YES, NO

Guidance & References

- If tele-behavioral health services are offered, these services should be considered by the governing body as part of the review of new services and annual review of established services.
- If tele-behavioral health services are offered, written policies should be in place for client eligibility for tele-behavioral health services based upon specified indicators such as client diagnosis, level of functioning, symptom acuity and/or risk factors.

		Compliance Rating
BEH.110 **Selective / 1** ***v42 17.B***	**Behavioral health services are provided in accordance with all applicable federal, state, and local requirements, and to appropriate standards of professional ethics as reflected in the disciplines of the behavioral health providers within the organization.**	**FC, PC, NC**
BEH.110.10	If required by the state, the behavioral health service has obtained a license to operate.	YES, NO, NA
BEH.110.20	As documented in personnel and/or credentials files, all licensed behavioral health providers maintain current licensure.	YES, NO
BEH.110.30	Written policies reflect prevailing mental health laws and regulations regarding statutory limits to confidentiality and other restrictions, e.g., the appropriate notification when clients are at risk; mandated reporting.	YES, NO
BEH.110.40	Written policies reflect that the confidential nature of the counseling relationship is consistent with prevailing laws as well as the professional ethical guidelines reflective of the professional disciplines represented in the organization.	YES, NO

		Compliance Rating
BEH.120 **Selective / 2** ***v42 17.C***	**Behavioral health services are directed by a qualified licensed provider.**	**FC, PC, NC**
BEH.120.10	As documented in the credentialing file, the director has the necessary education, licensure, and experience to provide leadership and direction for the coordination, recruitment, training, supervision, development, and evaluation of professional and administrative staff.	YES, NO
BEH.120.20	The director is responsible for oversight of the resources and activities of the behavioral health service, as well as the administration of procedures related to the provision of supervision, crisis/emergency management, quality, and evaluation of services provided.	YES, NO

		Compliance Rating
BEH.130 **Selective / 2** ***v42 17.D***	**Behavioral health services are provided only by licensed or certified health care professionals competent to provide them.**	**FC, PC, NC**
BEH.130.10	Professional staff members have been granted privileges to provide specific behavioral health services, or have clearly defined job descriptions that outline the services they may provide.	YES, NO
BEH.130.20	Clinical supervision and case consultation are available for professional staff.	YES, NO

		Compliance Rating
BEH.140 **Selective / 2** ***v42 17.E***	**In-service training and professional development opportunities are provided for professional staff, at minimum, at time of hire and annually thereafter.**	**FC, PC, NC**
BEH.140.10	There is documented evidence of training focusing on mandated reporting policies, such as reporting child and elder abuse.	YES, NO
BEH.140.20	Cultural competence training based on the population served is provided or made available.	YES, NO
BEH.140.30	Staff is held accountable for integrating cultural competence training into their work, as evidenced by clinical supervision notes, case consultations, and/or performance reviews.	YES, NO
BEH.140.40	There is documented evidence that staff receive training on the identification, prevention, and treatment of suicidal behaviors.	YES, NO

		Compliance Rating
BEH.150 **Selective / 1** ***v42 17.F***	**If paraprofessionals or other support staff assist in the provision or administration of behavioral health services, they are appropriately trained and supervised.**	**FC, PC, NC, NA**
BEH.150.10	As documented by information in credential and/or personnel files, supervisory personnel possess applicable educational credentials and work experience.	YES, NO, NA
BEH.150.20	Documentation demonstrates that paraprofessionals and support staff have adequate specialized training to carry out their duties.	YES, NO, NA

		Compliance Rating
BEH.160 **Selective / 1** ***v42 17.G***	**The organization has sufficient and appropriate resources to support the delivery of quality behavioral health services.**	**FC, SC, PC, MC, NC**
BEH.160.10	Services are readily accessible and conveniently located.	YES, NO
BEH.160.20	Waiting lists are appropriately managed to provide services in a timely manner.	YES, NO
BEH.160.30	Case load assignments allow for a balance between direct service hours, administrative time, and case management time.	YES, NO
BEH.160.40	Appointments are scheduled at intervals consistent with client needs/severity of symptoms.	YES, NO
BEH.160.50	Observation and interviews confirm that space is sufficient to ensure privacy and confidentiality.	YES, NO
BEH.160.60	Observation, interviews and/or review of annual reports on provision of services and utilization rates confirm that adequate technology is provided to support achievement of the behavioral health service's mission and goals.	YES, NO
BEH.160.70	Technology is used appropriately.	YES, NO
BEH.160.70.1	The technology and its use comply with the organization's written policies and procedures.	
BEH.160.70.2	The technology and its use comply with relevant laws.	
BEH.160.70.3	The technology and its use protect client/patient confidentiality as evidenced by, e.g., password change policies and protection, page time-out protocols, and procedures for access to records through mobile devices and laptops.	

Guidance & References

- If tele-behavioral health services are offered, the technology platform should comply with HIPAA/HITECH regulations.

		Compliance Rating
BEH.170 **Selective / 2** ***v42 17.H***	**If present, safety measures including but not limited to security cameras and panic buttons, are appropriately installed and maintained.**	**FC, PC, NC, NA**
BEH.170.10	Safety measures were appropriately assessed for need and function by the governing body or its designee prior to installation.	YES, NO, NA
BEH.170.20	Safety measures do not compromise the privacy or confidentiality of clients.	YES, NO, NA
BEH.170.30	Safety measures are tested at intervals consistent with organizational policy.	YES, NO, NA

		Compliance Rating
BEH.180 **Selective / 2** ***v42 17.I***	**Behavioral health treatment plans are client-centered.**	**FC, PC, NC**
BEH.180.10	The treatment plan includes goals of treatment and specific measurable objectives that are achievable, measurable, time-specific and appropriate based on the needs of the client.	YES, NO
BEH.180.20	The treatment plan lists therapies, medication management, and other modalities of care and treatment as appropriate.	YES, NO
BEH.180.30	The treatment plan is developed with the participation of the client, and there is documented evidence of the client's participation.	YES, NO
BEH.180.40	The treatment plan is updated periodically based on client mental status, functioning and progress on objectives.	YES, NO

		Compliance Rating
BEH.190 **Selective / 2** ***v42 17.J***	**The informed consent of the client is obtained.**	**FC, SC, PC, MC, NC**
BEH.190.10	A written and signed consent form is present in the clinical record at the start of treatment.	YES, NO
BEH.190.20	The informed consent is inclusive of the type and scope of treatment provided, treatment expectations and parameters, confidentiality, potential risks and protections related to treatment, and conditions for the termination of treatment.	YES, NO
BEH.190.30	Instances of limited confidentiality are clearly articulated, reviewed with the client, and acknowledged by signature.	YES, NO
BEH.190.40	The consent provides a clear definition of the composition of the treatment team; clear acknowledgement of who within the team will have access to counseling and psychiatric records, and the process for rescinding this authorization if requested.	YES, NO
BEH.190.50	Client/patient consent is obtained for the coordination of care with family members and/or significant others who play a role in the plan of care or treatment of the client.	YES, NO

Guidance & References

- This Standard maintains applicability to organizations if all or part of the informed consent process occurs via tele-behavioral health.

		Compliance Rating
BEH.200 **Selective / 2** ***v42 17.K***	**Each client's clinical record contains initial behavioral health and medical histories.**	**FC, NC**

		Compliance Rating
BEH.210 **Selective / 2** ***v42 17.L***	**There is evidence that both qualitative and quantitative measures are used to make appropriate assessments related to client functioning, presenting problems, and treatment/disposition recommendations.**	**FC, NC**

		Compliance Rating
BEH.220 **Selective / 2** ***v42 17.M***	**The clinical record is periodically updated to reflect the client's current status.**	**FC, SC, PC, MC, NC**
BEH.220.10	Risk of harm to self or others is assessed and documented.	YES, NO
BEH.220.20	All known or potential co-morbidity disorders, including addictive behaviors and substance abuse, are assessed and documented.	YES, NO
BEH.220.30	Client self-understanding and level of motivation are assessed and documented.	YES, NO
BEH.220.40	Mental status, presenting symptoms, and current functioning are assessed and documented.	YES, NO
BEH.220.50	Progress on client-centered measurable goals and objectives is assessed and documented.	YES, NO
BEH.220.60	Self-management strategies that assist clients in practicing activities that reduce negative symptoms and improve quality of life are assessed and documented.	YES, NO

		Compliance Rating
BEH.230 **Selective / 2** ***v42 17.N***	**Clinical records entries address the treatment termination process.**	**FC, PC, NC**
BEH.230.10	Entries address discharge/termination planning, as appropriate.	YES, NO
BEH.230.20	Entries address collaborative after-care plans and transitions to other services, as applicable.	YES, NO

		Compliance Rating
BEH.240 **Selective / 2** ***v42 17.O***	**If psychiatric care and psychotropic medication evaluation and management are provided, clinical records contain additional entries.**	**FC, PC, NC**
BEH.240.10	A comprehensive psychiatric and medical health history is present.	YES, NO
BEH.240.20	Timely follow-up of medication evaluation is documented.	YES, NO
BEH.240.30	Documentation regarding the efficacy of the medication regimen is conducted on a regular basis and side effects are routinely assessed.	YES, NO
BEH.240.40	Collaboration between services is documented.	YES, NO

		Compliance Rating
BEH.250 **Selective / 2** ***v42 17.P***	**Behavioral health care is coordinated with medical care.**	**FC, PC, NC**
BEH.250.10	The clinical record contains documentation of any consultation, referrals and follow-up between medical care and behavioral health professionals.	YES, NO
BEH.250.20	A system is in place for medical care and behavioral health to communicate regarding shared clients.	YES, NO
BEH.250.30	Relevant information such as the client/patient problem list, medications, allergies, and progress on objectives is available to all treating providers in medical care and behavioral health.	YES, NO

		Compliance Rating
BEH.260 **Selective / 2** ***v42 17.Q***	**Written policies and procedures regarding client confidentiality, privacy and safety are present.**	**FC, PC, NC**
BEH.260.10	The policies and procedures address consistent client confidentiality and privacy assurances:	YES, NO
BEH.260.10.1	Release of information practices assure that information is released only at the written request or concurrence of a client who has full knowledge of the nature of the information being released and of the parties to whom it is released.	
BEH.260.10.2	Statements of ethical standards specify the limits to which disclosure to appropriate authorities without consent is authorized or mandated.	
BEH.260.20	The policies and procedures address the safety and security of staff, clients, and the organization.	YES, NO
BEH.260.30	The policies and procedures address the security, confidentiality, and backup of data, as well as compliance with privacy laws.	YES, NO

Guidance & References

- If tele-behavioral health services are offered, policies and procedures should address both privacy and data security at the clinician's (the distance site) location and privacy at the client's (the originating site) location.

		Compliance Rating
BEH.270 **Selective / 2** ***v42 17.R***	**Written operating policies for providing behavioral health care are present.**	**FC, SC, PC, MC, NC**
BEH.270.10	Policies address the appropriate and timely triage of clients based on presenting symptoms, acuity and level of care required.	YES, NO
BEH.270.20	Policies address the initial and periodic assessment of alcohol and other drug use.	YES, NO
BEH.270.30	Policies address the management and follow-up of client/patients who miss appointments and/or drop out of treatment.	YES, NO
BEH.270.40	Policies address the behavioral health treatment of minors, if applicable.	YES, NO, NA
BEH.270.50	Policies address the provision of consultation services as needed to other appropriate entities, staff, caregivers, and the community, if provided.	YES, NO, NA

		Compliance Rating
BEH.280 **Selective / 2** ***v42 17.S***	**Crisis intervention and emergency services are directly provided or coordinated with other departments/agencies to meet the diverse needs of the population.**	**FC, SC, PC, MC, NC**
BEH.280.10	Psychiatric services are available and can be accessed in a timely manner.	YES, NO
BEH.280.20	Written policies are in place for the appropriate referral of clients who may be in crisis, or who require a higher level of care than can be provided by the organization.	YES, NO
BEH.280.30	Written policies are in place for the documentation of timely follow-up and tracking of referrals and coordinated care plans.	YES, NO
BEH.280.40	Counseling services have procedures and guidelines consistent with organizational policy for responding to threats, emergencies, and crisis situations.	YES, NO
BEH.280.50	Systems and procedures are in place to disseminate timely and accurate information to clients, the community, and appropriate external organizations during emergency situations.	YES, NO
BEH.280.60	Clients presenting with high acuity, imminent danger, and/or high-risk behaviors are adequately monitored with appropriate treatment planning and service provision.	YES, NO
BEH.280.70	Behavioral health staff members have access to legal counsel when necessary and are provided with information regarding legal issues such as the handling of subpoenas, warrants, etc.	YES, NO

Guidance & References

- If tele-behavioral health services are offered, emergency contact information and client location should be documented/confirmed at each telehealth visit and strategies for managing a communication failure should be discussed with the client.
- If tele-behavioral health services are provided the policies outline the crisis management process for urgent and emergent patient needs.

		Compliance Rating
BEH.290 **Selective / 2** ***v42 17.T***	**Referral services are provided.**	**FC, PC, NC**
BEH.290.10	Information on referral resources within the organization and in the community is provided to the client and their family, as needed.	YES, NO
BEH.290.20	Referral resources are consistently evaluated for availability and affordability to meet the needs of the population.	YES, NO
BEH.290.30	Appropriate information is provided to the referral entity and documented in the clinical record.	YES, NO
BEH.290.40	Written policies are in place to assure coordination of care when treatment is shared or transferred to other entities, including after-hours crisis care services.	YES, NO

		Compliance Rating
BEH.300 **Selective / 1** ***v42 17.U***	**If provided, prevention services address the needs of the population served.**	**FC, PC, NC, NA**
BEH.300.10	Such services are based on data obtained through needs assessments, national data sources or other relevant data sources.	YES, NO, NA
BEH.300.20	Prevention programming focuses on issues related to risk reduction, wellness and quality of life.	YES, NO, NA

		Compliance Rating
BEH.310 **Selective / 1** ***v42 17.V***	**If provided, outreach services address the needs of the population served.**	**FC, NC, PC, NA**
BEH.310.10	Written policies are present for evaluating the efficacy of outreach activities provided.	YES, NO, NA
BEH.310.20	When outreach programs are conducted, written policies are present addressing the identification and care of individuals who need immediate services.	YES, NO, NA

		Compliance Rating
BEH.320 **Selective / 1** ***v42 17.W***	**The behavioral health service actively participates in the organization's peer review, quality improvement, and risk management programs.**	**FC, SC, PC, MC, NC**
BEH.320.10	Written policies are in place for staff input and participation in quality improvement activities.	YES, NO
BEH.320.20	A system is in place for documenting and reporting incidents and adverse events consistent with organizational policies and AAAHC Standards.	YES, NO
BEH.320.30	Professional staff members participate in peer review activities consistent with organizational policies and AAAHC Standards.	YES, NO
BEH.320.40	The behavioral health service assesses and evaluates client satisfaction with services.	YES, NO
BEH.320.50	The behavioral health service conducts outcome-based evaluation of treatment efficacy.	YES, NO

CMC Care Management and Coordination

The Care Management and Coordination Category outlines the expectations for the provisions of high-quality health care services in accordance with the principles of professional practice and ethical conduct. Care coordination places patients at the core of care services where they are empowered to engage and participate in their own wellness assuring that the objectives and goals of care are achieved.

The terms “care management” and “care coordination” are often used interchangeably and are interconnected. The Agency for Healthcare Research and Quality (AHRQ) describes care management as an episodic approach that is team-based and patient-centered. The focus is on assisting patients and their care givers in managing their medical conditions more effectively. Whereas care coordination is defined as deliberately organizing patient care activities and sharing information among all participants concerned with a patient’s care to achieve safer and more effective care. AHRQ: https://www.ahrq.gov/ncepcr/research/care-management/index.html.

The Standards address assessments, care, discharge planning, transitions of care, utilization management, and health promotion.

		Compliance Rating
CMC.100 **Universal / 2** ***v42 4.E***	**High-quality health care is provided.**	**FC, SC, PC, MC, NC**
CMC.100.10	Health care provided is consistent with the standard of care.	YES, NO
CMC.100.20	Appropriate and timely diagnoses are made based on findings of the current history and physical examination.	YES, NO
CMC.100.30	Medication reconciliation is performed.	YES, NO
CMC.100.40	Treatment provided is consistent with clinical impression or working diagnosis.	YES, NO
CMC.100.50	Appropriate and timely consultation and referrals are made.	YES, NO
CMC.100.60	When clinically indicated, patients are contacted as quickly as possible for follow-up regarding significant problems and/or abnormal findings.	YES, NO
CMC.100.70	Continuity of care and patient follow-up occurs.	YES, NO

Guidance & References

- Standard maintains applicability to organizations offering telehealth/telemedicine services that prescribe or administer medication.

		Compliance Rating
CMC.110 **Universal / 2** ***v42 4.F***	**Patients are educated regarding their condition or illness.**	**FC, PC, NC**
CMC.110.10	Patients are educated regarding the diagnosis and treatment of their condition or illness.	YES, NO
CMC.110.20	Patients are educated regarding appropriate preventive measures.	YES, NO

Guidance & References

- In surgical settings, education may include preventive measures such as, avoiding post-operative infections, deep venous thromboembolism and/or pulmonary embolism.

		Compliance Rating
CMC.120 **Universal / 2** ***v42 4.G***	**When the need arises, the organization assists patients with the transfer of their care from one health care professional to another.**	**FC, PC, NC**
CMC.120.10	Adequate specialty consultation services are available by prior arrangement.	YES, NO
CMC.120.20	Referral to another health care professional is clearly outlined to the patient and arranged with the accepting health care professional.	YES, NO

		Compliance Rating
CMC.130 **Universal / 2** ***v42 6.L***	**If a patient's primary or specialty care provider(s) or health care organization is elsewhere, timely summaries or pertinent records necessary for continuity of patient care are available.**	**FC, PC, NC**
CMC.130.10	Summaries or records are obtained from the external provider(s) or organization.	YES, NO
CMC.130.20	Summaries or records are incorporated into the clinical record.	YES, NO, NA
CMC.130.30	Summaries or records are provided to the external health care professional as appropriate.	YES, NO

Guidance & References

- Surgical organizations may choose to maintain such records in a file other than the clinical record.
- Records provided to external heath care professionals should meet the Standard requirements for patient confidentiality, as applicable.

		Compliance Rating
CMC.140 **Selective / 2** ***v42 9.K***	**A written policy regarding the assessment and management of acute pain has been adopted.**	**FC, NC**

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
CMC.190 **Selective / 2** ***v42 10.I.T***	**Patients are provided with written instructions for self-care prior to and after surgery/procedure.**	**FC, PC, NC**
CMC.190.10	Clinical records document that written instructions have been provided to the patient.	YES, NO
CMC.190.20	Written instructions for discontinuation or resumption of medications prior to and after a procedure are provided.	YES, NO, NA

Guidance & References

- Standard maintains applicability if patients are provided written instructions for self-care prior to and/or after surgery/procedure via telehealth and telemedicine services (e.g., via a patient portal).

		Compliance Rating
CMC.200 **Selective / 2** ***v42 10.I.S***	**Written guidelines for the transition of care from one provider to another are present.**	**FC, PC, NC**
CMC.200.10	The guidelines address information to be transferred about a patient's care including, at minimum:	YES, NO
CMC.200.10.1	Treatment/services.	
CMC.200.10.2	Current condition.	
CMC.200.10.3	Any recent or anticipated changes.	
CMC.200.20	The guidelines address how the information will be communicated among members of the health care team.	YES, NO

		Compliance Rating
CMC.210 **Selective / 1** ***v42 20.C***	**The scope and limitations of overnight care and services are clearly defined.**	**FC, PC, NC**
CMC.210.10	Documentation of the scope and limitations of services is present.	YES, NO
CMC.210.20	Evidence is present that the scope and limitations of services is communicated to:	YES, NO
CMC.210.20.1	Physicians who refer and admit patients to the program.	
CMC.210.20.2	Staff who provide care and services.	
CMC.210.20.3	Potential patients in advance of their referral to the program.	
CMC.210.20.4	Other health care professionals and relevant community agencies.	

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
CMC.220 **Selective / 2** ***v42 20.D***	**Written policies and procedures for overnight care are present.**	**FC, SC, PC, MC, NC**
CMC.220.10	Policies and procedures address clinical criteria for determining eligibility for admission.	YES, NO
CMC.220.20	Policies and procedures address clinical responsibilities for each patient during his/her stay.	YES, NO
CMC.220.30	Policies and procedures address provisions for emergency services.	YES, NO
CMC.220.40	Policies and procedures address arrangements for transfer to other health care services as needed.	YES, NO
CMC.220.50	Policies and procedures address staffing requirements to ensure that registered nurses and other health care professionals are available in sufficient numbers to meet patient needs.	YES, NO
CMC.220.60	Policies and procedures address isolation procedures to be followed when any patient is admitted with a suspected or diagnosed communicable disease.	YES, NO

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
CMC.230 **Selective / 1** ***v42 20.G***	**Food service and refreshments are provided to meet the needs of patients.**	**FC, PC, NC**
CMC.230.10	Evidence of compliance with local, state, and federal guidelines is present with regard to preparing, serving, disposing of, and storing food and drink for patient use.	YES, NO
CMC.230.20	Evidence is present that personnel providing food services meet local health department requirements.	YES, NO
CMC.230.30	Evidence is present that special dietary requirements for patient care are met.	YES, NO

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
CMC.240 **Selective / 2** ***v42 20.H***	**Provisions are made for patient privacy and safety.**	**FC, PC, NC**
CMC.240.10	Treatment rooms are provided to meet patient needs and physician requirements.	YES, NO
CMC.240.20	Emergency power appropriate for the size of the unit is available.	YES, NO

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
CMC.250 **Selective / 1** ***v42 16.A***	**Adequate resources are available for the health education and health promotion services provided.**	**FC, PC, NC**
CMC.250.10	Interviews and observation indicate that staff has ready access to and are able to use consultative services for health education and promotion, as needed.	YES, NO
CMC.250.20	Interviews and observation confirm that staff has ready access to appropriate reference materials.	YES, NO
CMC.250.30	Marketing, advertising or other types of promotion regarding health education and health promotion activities accurately reflects the services provided.	YES, NO

		Compliance Rating
CMC.260 **Selective / 1** ***v42 16.D***	**Health education and disease prevention programs are based on an ongoing needs assessment of the population served.**	**FC, PC, NC**
CMC.260.10	The needs assessment considers relevant health risks and health education needs.	YES, NO
CMC.260.20	The needs assessment uses a variety of data or data sources.	YES, NO
CMC.260.30	The needs assessment quantifies risk whenever possible.	YES, NO
CMC.260.40	The needs assessment is used to direct comprehensive programming on topics such as, but not limited to: • Disease-specific screening and educational programs. • Substance abuse prevention and education, including programs related to alcohol, tobacco, and other drugs. • Promotion of healthy eating. • Promotion of physical fitness. • Sexuality education and skill building for health relationships. • Sexual, physical, and emotional violence prevention. • Promotion of and education about stress management and relaxation.	YES, NO

		Compliance Rating
CMC.270 **Selective / 2** ***v42 16.E***	**Health education and disease prevention programs are included in quality management and improvement activities.**	**FC, NC**

		Compliance Rating
CMC.280 **Selective / 2** ***v42 22.D***	**A written policy requires the presence of at least one qualified licensed provider during hours of operation.**	**FC, PC, NC**

		Compliance Rating
CMC.290 **Selective / 1** ***v42 22.E***	**The scope of services offered is clearly defined.**	**FC, SC, PC, MC, NC**
CMC.290.10	Documentation of the scope of services, including hours of operation, is present.	YES, NO
CMC.290.20	Patients seeking immediate/urgent care services are seen without prior appointments.	YES, NO
CMC.290.30	Unless emergency services are also provided, patients with life-threatening conditions are not solicited.	YES, NO
CMC.290.40	Observation and interviews confirm the availability of equipment, drugs, and other agents necessary to provide the full scope of services.	YES, NO
CMC.290.50	Laboratory and imaging services, as described in the Laboratory and Radiology (LRD) Standards, are available to meet the needs of patients receiving immediate/urgent care.	YES, NO
CMC.290.60	Procedures are in place to obtain specialty consultation services as needed.	YES, NO

Guidance & References

- If telehealth and telemedicine services are offered, these services should be referenced and defined.

CPV Credentialing and Privileging

The Credentialing and Privileging Category outlines the expectations for an organized process designed and implemented to ensure health care professionals are qualified and competent to provide high quality patient care. The Standards address Credentialing and Privileging.

Credentialing is a three-phase process of assessing and validating the qualifications of an individual to provide services. The objective of credentialing is to establish that the applicant has the specialized professional background that they claim and that the position requires. This includes: 1) establishing minimum training, experience, and other requirements (i.e., credentials) for physicians and other health care professionals; 2) establishing a process to review, assess, and validate an individual's qualifications, including education, training, experience, certification, licensure, and any other competence enhancing activities against the organization's established minimum requirements; and 3) conducting review, assessment, and validation as outlined in the organization's description of the process.

Privileging is a three-phase process. The objective of privileging is to determine the specific procedures and treatments that a health care professional may perform. This includes: 1) determining the clinical procedures and treatments that are offered to patients; 2) determining the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege; and 3) establishing a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all requested privileges in a nonarbitrary manner.

Organizations may use information provided by a Credentials Verification Organization (CVO) after proper assessment of the capability and quality of the CVO. Organizations are required to conduct primary or secondary source verification of the items listed on the formal application for initial staff privileges, unless a CVO, or other organization performing primary source verification that is accredited or certified by a nationally recognized body, is used. If the organization uses a CVO or another organization to verify credentials, those entities must perform primary source verification unless such sources do not exist or are impossible to verify.

Primary source verification refers to documented verification by an entity that issued a credential indicating that an individual's statement of possession of that credential is true. Verification may be provided by mail, fax, telephone, or electronically, provided that the method by which it is obtained is documented and measures are taken to demonstrate that there was no interference in the communication by an outside party.

Secondary source verification refers to documented verification of a credential through a verification report from an entity that has performed primary source verification of that credential. Information received from any such source must meet the same transmission and documentation requirements as defined under primary source verification.

		Compliance Rating
CPV.100 **Universal / 2** ***v42 2.II.A***	**The medical and/or dental staff is accountable to the governing body through a credentialing, privileging, and reappointment process for which the governing body is responsible.**	**FC, PC, NC**
CPV.100.10	The governing body has defined specific criteria for the initial appointment and reappointment of medical staff.	YES, NO
CPV.100.20	The criteria for initial appointment and reappointment are uniformly applied.	YES, NO
CPV.100.30	Applications for clinical privileges are processed according to timeframes specified in bylaws and/or policies.	YES, NO
CPV.100.40	The organization has its own independent process of credentialing and privileging.	YES, NO

Guidance & References

- Credentials may not be approved, nor privileges granted without further review, solely on the basis that another organization, such as a hospital, approved credentials or granted privileges. Such status at another organization may be included in the governing body's consideration of the application.

		Compliance Rating
CPV.120 **Universal / 2** ***v42 2.II.B***	**The governing body has approved processes for credentialing, privileging and reappointment of the medical and/or dental staff.**	**FC, SC, PC, MC, NC**
CPV.120.10	A process for credentialing has been approved.	YES, NO
CPV.120.20	A process for initial appointment has been approved.	YES, NO
CPV.120.30	A process for reappointment has been approved.	YES, NO
CPV.120.40	A process for granting clinical privileges has been approved.	YES, NO
CPV.120.50	A process for suspending or terminating clinical privileges has been approved.	YES, NO
CPV.120.60	A process for the appeal of decisions to suspend or terminate privileges has been approved.	YES, NO
CPV.120.70	Processes for initial appointment, reappointment, and assignment or curtailment of clinical privileges of medical staff members are consistent with state law, if applicable.	YES, NO, NA

		Compliance Rating
CPV.130 **Universal / 2** ***v42 2.II.C***	**On a formal application for initial 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.**	**FC, SC, PC, MC, NC**
CPV.130.10	Information regarding relevant education, training, and experience is obtained.	YES, NO
CPV.130.20	Peer references are obtained to document current competence.	YES, NO
CPV.130.30	A current state license is obtained.	YES, NO
CPV.130.40	Information is obtained from the National Practitioner Data Bank (NPDB).	YES, NO
CPV.130.50	Drug Enforcement Administration (DEA) registration information is obtained, if applicable.	YES, NO, NA
CPV.130.60	Proof of current medical liability coverage meeting governing body requirements, if any, is obtained.	YES, NO, NA

Guidance & References

- Current competence as evidenced by peer references. At reappointment, peer review results/activities were incorporated into the decision process.
- NPDB Continuous Query is an acceptable option for meeting this requirement. For information on the National Practitioner Data Bank, see https://www.npdb.hrsa.gov/.

		Compliance Rating
CPV.140 **Universal / 2** ***v42 2.II.D***	**The application for initial staff privileges includes written attestation from the applicant addressing other information pertinent to the appointment and privileging processes.**	**FC, SC, PC, MC, NC**
CPV.140.10	The application includes professional liability information:	YES, NO
CPV.140.10.1	Claims history.	
CPV.140.10.2	Refusal or cancellation of professional liability coverage.	
CPV.140.20	The application includes information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations.	YES, NO
CPV.140.30	The application includes information about complaints or adverse action reports filed against the applicant with a local, state, or national professional society or licensure board.	YES, NO
CPV.140.40	The application includes information about denial, suspension, limitation, termination, or nonrenewal of professional privileges at any hospital, health plan, medical group, or other health care entity.	YES, NO
CPV.140.50	The application includes information about federal actions or sanctions including DEA and Medicare/Medicaid.	YES, NO
CPV.140.60	The application includes information about conviction of a criminal offense (other than minor traffic violations).	YES, NO
CPV.140.70	The application includes information about current physical, behavioral health, or chemical dependency problems that would interfere with the ability to provide high-quality patient care and professional services.	YES, NO

		Compliance Rating
CPV.150 **Universal / 2** ***v42 2.II.E***	**The application for initial staff privileges is accurate and complete.**	**FC, PC, NC**
CPV.150.10	The application includes a formal statement releasing the organization from any liability in connection with credentialing decisions.	YES, NO
CPV.150.20	The application includes the applicant's attestation to the accuracy and completeness of the application and additional information provided.	YES, NO
CPV.150.30	The application includes the applicant's dated signature.	YES, NO

		Compliance Rating
CPV.160 **Universal / 2** ***v42 2.II.F***	**Upon receipt of a completed and signed initial application, primary or secondary source verification of credentials is conducted in accordance with the organization's written procedures for credentialing.**	**FC, PC, NC**
CPV.160.10	Written procedures are present.	YES, NO
CPV.160.20	Credentials are verified using primary and/or secondary sources.	YES, NO

Guidance & References

- Refer to the Glossary for definitions.
- An accreditable organization may use information provided by a Credentials Verification Organization (CVO) after proper assessment of the capability and quality of the CVO. A CVO may demonstrate such capability and quality by becoming accredited or certified by a nationally recognized accreditation organization. Accredited organizations are required to conduct primary or secondary source verification of the items listed on the formal application for initial staff privileges, unless a CVO, or other organization performing primary source verification that is accredited or certified by a nationally recognized body, is used. If the organization uses a CVO or another organization to verify credentials, those entities must perform primary source verification unless such sources do not exist or are impossible to verify.

		Compliance Rating
CPV.170 **Universal / 1** ***v42 2.II.G***	**Members of the medical and/or dental staff apply for reappointment every three years, or more frequently if prevailing laws and regulations, or organizational policies, so stipulate.**	**FC, PC, NC**
CPV.170.10	Applicants are required to complete a formal reappointment application.	YES, NO
CPV.170.20	The reappointment application includes, at minimum:	YES, NO
CPV.170.20.1	Updated personal information.	
CPV.170.20.2	Completed attestation questions.	
CPV.170.20.3	Dated signature of the applicant.	

Guidance & References

- For more information about attestation questions, reference Standards for the application for initial staff privileges.

		Compliance Rating
CPV.180 **Universal / 2** ***v42 2.II.H***	**Upon receipt of the completed reappointment application, primary or secondary source verification is conducted.**	**FC, NC**

Guidance & References

- Examples of primary or secondary source verification of credentials include:
  (1) Current state licensure.
  (2) NPDB report.
  (3) DEA registration, if applicable.
  (4) Current medical liability coverage meeting governing body requirements, if any.
- Items requiring primary and secondary source verification are the same as the formal application for initial staff privileges (e.g., current state license and NPDB report). Please refer to those Standards for more information.

		Compliance Rating
CPV.190 **Universal / 1** ***v42 2.II.I***	**The governing body makes appointment and reappointment decisions following review of the applications or based on recommendations from an internal delegate.**	**FC, PC, NC**
CPV.190.10	Applications are reviewed by the governing body or its delegate.	YES, NO
CPV.190.20	If the governing body delegates responsibility for reviewing the applications, documentation of the delegation is present.	YES, NO, NA
CPV.190.30	Peer references and/or peer review activities and results, completed in accordance with AAAHC Standards for peer review, are incorporated into the decision process.	YES, NO
CPV.190.40	Appointment and reappointment decisions made by the governing body are documented.	YES, NO

Guidance & References

- In this context, delegate refers to an internal reviewer or reviewers, e.g., the Medical Director or a Committee that provides recommendations for appointment and reappointment to the governing body. The governing body remains responsible for making appointment and reappointment decisions. Such delegation is not an option for solo providers because a separate Standard requires review by an outside provider.

		Compliance Rating
CPV.200 **Universal / 2** ***v42 2.II.J***	**The currency of date-sensitive credentialing and privileging information is monitored and documented on an ongoing basis (at minimum, at expiration, appointment, and re-appointment).**	**FC, PC, NC**
CPV.200.10	Ongoing monitoring of licensure is documented.	YES, NO
CPV.200.20	Ongoing monitoring of DEA registrations is documented.	YES, NO
CPV.200.30	Ongoing monitoring of Board certifications, as applicable, is documented.	YES, NO
CPV.200.40	Ongoing monitoring of professional liability insurance (if required) is documented.	YES, NO, NA

		Compliance Rating
CPV.210 **Selective / 2** ***v42 2.II.K***	**Solo providers adhere to appropriate credentialing, initial appointment and reappointment procedures.**	**FC, SC, PC, MC, NC**
CPV.210.10	The provider is required to complete an application or reapplication, and the documentation is present in the credentials file.	YES, NO
CPV.210.20	Documentation in the credentials file includes a list of procedures that may be performed, or services that may be provided, by the provider in the organization/practice setting.	YES, NO
CPV.210.30	To ensure currency, accuracy, and completeness of credentials, the provider's credentials file is reviewed by an outside physician (for a medical practice) or an outside dentist (for a dental practice) at least every three years, or more frequently if state law or organizational policies so stipulate.	YES, NO
CPV.210.40	An outside physician (for medical practices) or dentist (for dental practices) has reviewed the granting of privileges and provided documentation of his/her recommendation.	YES, NO
CPV.210.50	Applications for privileges submitted by other providers are processed in the same manner.	YES, NO

Guidance & References

- For documentation required in the credentials file, refer to Standards for the formal application for initial staff privileges.

		Compliance Rating
CPV.220 **Universal / 2** ***v42 2.II.L***	**Privileges to carry out specified procedures are granted to legally and professionally qualified applicants.**	**FC, PC, NC**
CPV.220.10	Privileges are granted based on:	YES, NO
CPV.220.10.1	The applicant's written request for privileges.	
CPV.220.10.2	Qualifications for the services provided by the organization.	
CPV.220.10.3	Recommendations from qualified medical or dental personnel.	
CPV.220.20	Privileges are granted to the health care professional to practice for a specified period of time.	YES, NO

		Compliance Rating
CPV.250 **Universal / 2** ***v42 2.II.M***	**The governing body provides a process for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for allied health care professionals.**	**FC, PC, NC, NA**
CPV.250.10	The process is consistent with state law.	YES, NO, NA
CPV.250.20	The process includes verification of education, training, experience, and current competence.	YES, NO, NA
CPV.250.30	The process includes primary or secondary source verification of licensure or certification, as applicable.	YES, NO, NA

		Compliance Rating
CPV.270 **Selective / 2** ***v42 9.C***	**Anesthesia is only administered by health care professionals approved by the governing body to administer anesthesia in accordance with AAAHC Standards for credentialing and privileging.**	**FC, NC**

Guidance & References

- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.

		Compliance Rating
CPV.290 **Selective / 2** ***v42 9.D***	**Other qualified health care professionals administering anesthesia are directly supervised by a physician or dentist who has been granted privileges for supervision.**	**FC, NC**

Guidance & References

- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.
- Other qualified health care professionals are qualified by virtue of education, experience, competence, professional licensure, and state laws, rules, and regulations. Other health care professionals must be approved for the administration of anesthesia by the governing body pursuant to the AAAHC Standards for credentialing and privileging.

		Compliance Rating
CPV.300 **Selective / 1** ***v42 13.A***	**Health care professionals providing imaging services and/or interpreting results are appropriately trained and privileged.**	**FC, PC, NC**
CPV.300.10	Personnel and/or credentials files document appropriate training and credentials.	YES, NO
CPV.300.20	There is evidence that such personnel have been granted privileges to provide these services, or have job descriptions containing these duties.	YES, NO
CPV.300.30	There is evidence that such personnel have completed appropriate safety training.	YES, NO

Guidance & References

- Standard applies to organizations that provide imaging services for screening, diagnosing, monitoring, or assisting with procedures.

		Compliance Rating
CPV.310 **Selective / 2** ***v42 REG***	**The organization provides evidence of having conducted a search of the Medical Board's License Verification System (LVS) to find if an 805 report had been filed for each physician.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Business and Professions Code §805.5: Organizations are required to check the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of CA, or the Dental Board of CA, prior to granting or renewing staff privileges, to determine if an 805 report has been made indicating that the applying physician/ surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his/ her staff privileges restricted. The organization must subscribe to the Medical Board License Verification System (LVS) (http://www.mbc.ca.gov/Forms/#LVS) for access to 805 Report information. LVS access is only available to accredited organizations. On an Early Option survey or an Initial survey of an organization that has never been accredited, rate this FC if appropriate credentials verification has been done prior to privileging.

		Compliance Rating
CPV.320 **Selective / 2** ***v42 REG***	**The physicians in the organization have "adequate security by malpractice liability insurance or by participation in an interindemnity trust" as defined by California Business and Professions Code §2216.2.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Business and Professions Code §2216.2: Physicians must maintain adequate security by liability insurance or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital. The law calls for the Medical Board to determine the appropriate amount of required insurance. For purposes of Section 2216.2 of the code, "adequate security" means that a physician has coverage of the type described in Section 2216.2 of the code in the amount of not less than $1 million per incident and not less than $3 million per year. The division shall reevaluate the requirements in this regulation at least every three years.

		Compliance Rating
CPV.330 **Selective / 1** ***v42 14.I.C***	**Dental procedures are only performed by qualified dental health professionals.**	**FC, PC, NC**
CPV.330.10	As evidenced by information in credentialing files, the dental health professionals are licensed to perform such procedures within the state in which the organization is located.	YES, NO
CPV.330.20	As evidenced by information in credentialing files, the dental health professionals have been granted privileges to perform those procedures by the governing body of the organization.	YES, NO

Guidance & References

- For information in credentialing files, refer to Standards for credentialing and privileging.
- Standard maintains applicability if dental services are provided via telehealth and telemedicine (e.g., intraoral camera and hand-held intraoral radiographs).

CRD Clinical Records

The Clinical Records Category outlines the expectations for complete, comprehensive, and accurate electronic/paper clinical records that are maintained in a safe and secure manner. Complete and accurate patient record documentation facilitates provision of safe, quality health care and supports continuity of care. It creates a means of communication between providers and between providers and members about health status, preventive health services, treatment, planning, and delivery of care. All clinical records should be secured and maintained in a manner to ensure the integrity and privacy of protected health information (PHI) that complies with applicable law and regulation.

The Standards address collection, storage, and use of health information.

		Compliance Rating
CRD.120 **Universal / 1** ***v42 6.A***	**A system for the accurate collection, processing, maintenance, storage, retrieval, and distribution of clinical records is maintained.**	**FC, PC, NC**
CRD.120.10	A designated person is in charge of clinical records.	YES, NO
CRD.120.20	A designated person is in charge of the health information system.	YES, NO
CRD.120.30	The system includes measures to ensure adherence to written policies and procedures.	YES, NO
CRD.120.40	The system is monitored on a regular basis.	YES, NO

		Compliance Rating
CRD.130 **Universal / 2** ***v42 6.B***	**Written policies for clinical records are present.**	**FC, SC, PC, MC, NC**
CRD.130.10	The policies address the security of information, including accountability for editing, deletion, and access of clinical record content.	YES, NO
CRD.130.20	The policies address the release of patient records.	YES, NO
CRD.130.30	The policies address the protection of records from damage or loss, including back-up systems for electronic records.	YES, NO
CRD.130.40	The policies address methods of deterring unauthorized access to clinical records.	YES, NO
CRD.130.50	The policies ensure timely access to individual records.	YES, NO
CRD.130.60	The policies address the retention of active records.	YES, NO
CRD.130.70	The policies address the retirement of inactive records.	YES, NO

		Compliance Rating
CRD.140 **Universal / 1** ***v42 6.C***	**Clinical records are maintained in a manner that facilitates the provision of safe care.**	**FC, SC, PC, MC, NC**
CRD.140.10	Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are organized in a consistent manner.	YES, NO
CRD.140.20	Clinical record entries are legible, including items that are scanned into an electronic record.	YES, NO
CRD.140.30	Clinical record entries are easily accessible within the record by authorized personnel.	YES, NO
CRD.140.40	All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients.	YES, NO
CRD.140.50	Patients are given the opportunity to approve or refuse release of records, except when release is permitted or required by law.	YES, NO

		Compliance Rating
CRD.160 **Universal / 1** ***v42 6.D***	**Except when otherwise required by law, any record that contains clinical, social, financial, or other data about a patient is treated as strictly confidential.**	**FC, PC, NC**
CRD.160.10	Written policies require strict confidentiality of information in the clinical record.	YES, NO
CRD.160.20	Interviews and observation confirm that patient data is handled confidentially.	YES, NO

Guidance & References

- If telehealth/telemedicine services are offered, compliance with the HITECH act should be included in the policies.

		Compliance Rating
CRD.170 **Universal / 1** ***v42 6.E***	**An individual clinical record is established for each person receiving care.**	**FC, SC, PC, MC, NC**
CRD.170.10	Each clinical record includes the patient's name.	YES, NO
CRD.170.20	Each clinical record includes an identification number, if used in the organization's system.	YES, NO, NA
CRD.170.30	Each clinical record includes patient date of birth.	YES, NO
CRD.170.40	Each clinical record includes patient gender.	YES, NO
CRD.170.50	Each clinical record includes a responsible party.	YES, NO

		Compliance Rating
CRD.180 **Universal / 1** ***v42 6.F***	**Clinical record entries are consistent across records.**	**FC, SC, PC, MC, NC**
CRD.180.10	Entries for each visit include date (and department, if departmentalized).	YES, NO
CRD.180.20	Entries for each visit include chief complaint or purpose of visit and history.	YES, NO
CRD.180.30	Entries for each visit include clinical findings and studies ordered, such as laboratory or x-ray studies.	YES, NO
CRD.180.40	Entries for each visit include care rendered and therapies administered.	YES, NO
CRD.180.50	Entries for each visit include any changes in prescription and non-prescription medication with name and dosage, and frequency when available.	YES, NO
CRD.180.60	Entries for each visit include discharge diagnosis or impression, and disposition, recommendations and instructions given to the patient.	YES, NO
CRD.180.70	Entries for each visit include signature of, or authentication by, the health care professional.	YES, NO

		Compliance Rating
CRD.200 **Universal / 2** ***v42 6.G***	**The presence or absence of allergies, sensitivities and other reactions to drugs, materials, food and environmental factors is recorded in a prominent and consistently defined location in all clinical records.**	**FC, PC, NC**
CRD.200.10	Clinical records document that patients are asked to provide information about allergies and sensitivities at each encounter.	YES, NO
CRD.200.20	Clinical records document that patients reporting allergies and sensitivities describe their reaction(s) to the allergen or irritant.	YES, NO
CRD.200.30	Information about allergies, sensitivities and reactions is recorded in a prominent and consistently defined location in all clinical records.	YES, NO
CRD.200.40	Such information is verified at each patient encounter and updated when changes are reported.	YES, NO

		Compliance Rating
CRD.210 **Universal / 2** ***v42 6.H***	**Reports, histories and physicals, progress notes, and other patient information such as laboratory reports, x-ray readings, operative reports, and consultations, are reviewed and incorporated into the record, as required by the organization's policies.**	**FC, PC, NC**
CRD.210.10	There is evidence that such items were reviewed in accordance with policy prior to incorporation into the record.	YES, NO
CRD.210.20	Such items have been incorporated into the clinical record.	YES, NO

		Compliance Rating
CRD.220 **Universal / 2** ***v42 6.I***	**Clinical records document discussions with the patient concerning the necessity, appropriateness, and risks of the proposed care, surgery, or procedure, as well as discussions of treatment alternatives, as applicable.**	**FC, NC**

		Compliance Rating
CRD.230 **Selective / 1** ***v42 6.J***	**Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.**	**FC, NC**

		Compliance Rating
CRD.240 **Universal / 2** ***v42 6.K***	**Clinical records demonstrate that the organization ensures continuity of care for its patients.**	**FC, PC, NC**
CRD.240.10	Clinical records include documentation regarding missed and canceled appointments, if any.	YES, NO
CRD.240.20	Clinical records include documentation of medical advice given to a patient by text, e-mail, or telephone, including medical advice provided after-hours, if any.	YES, NO
CRD.240.30	If a patient has had three or more visits/admissions, or if a clinical record is complex and lengthy, a summary of past and current diagnoses or problems, including past procedures, is present in the record to facilitate the continuity of care.	YES, NO, NA

Guidance & References

- This Standard maintains applicability to organizations providing telehealth/telemedicine.

		Compliance Rating
CRD.250 **Selective / 2** ***v42 9.I***	**Clinical records reflect the administration of anesthesia.**	**FC, PC, NC**
CRD.250.10	Clinical record entries include:	YES, NO
CRD.250.10.1	A pre-anesthesia assessment/evaluation.	
CRD.250.10.2	A plan for anesthetic administration.	
CRD.250.10.3	A chronologic record reflecting the anesthetic administered and the clinical status of the patient.	
CRD.250.10.4	A post-anesthesia assessment/evaluation.	
CRD.250.20	Medical discharge criteria were met.	YES, NO
CRD.250.30	Patients are discharged in the company of a responsible adult except those patients exempted by the attending physician.	YES, NO

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
CRD.260 **Selective / 2** ***v42 10.I.R***	**The findings and techniques of a procedure are accurately and completely documented immediately after the procedure.**	**FC, SC, PC, MC, NC**
CRD.260.10	The health care professional who performed the procedure documents the findings and techniques.	YES, NO
CRD.260.20	The documentation is immediately available for patient care.	YES, NO
CRD.260.30	The documentation is incorporated into the patient's clinical record.	YES, NO
CRD.260.40	When pre-operative antibiotics are ordered, the antibiotic and time of administration are documented in the patient's clinical record.	YES, NO, NA
CRD.260.50	If tissues are removed during surgery:	YES, NO, NA
CRD.260.50.1	A pathologist examines the tissues, except for those exempted in writing by the governing body after medical review.	
CRD.260.50.2	The signed report of the pathologist is incorporated into the patient's clinical record.	

		Compliance Rating
CRD.270 **Selective / 2** ***v42 10.III.F***	**Clinical records include entries specific to lithotripsy services provided.**	**FC, SC, PC, MC, NC**
CRD.270.10	Clinical record entries include a history and physical indicating presence, location, and size of kidney stone.	YES, NO
CRD.270.20	Clinical record entries include documentation of the patient's symptoms.	YES, NO
CRD.270.30	Clinical record entries include method of determining location.	YES, NO
CRD.270.40	Clinical record entries include confirmation of presence of stone immediately prior to treatment.	YES, NO
CRD.270.50	Clinical record entries include the operative treatment record:	YES, NO
CRD.270.50.1	Selection of treatment modality.	
CRD.270.50.2	Number of shocks.	
CRD.270.50.3	Energy level.	
CRD.270.50.4	Radiation exposure time.	

Guidance & References

- These entries must be present, in addition to the requirements of the Clinical Records (CRD) Standards.

		Compliance Rating
CRD.280 **Selective / 1** ***v42 15.D***	**Clinical records reflect travel medicine services provided.**	**FC, PC, NC**
CRD.280.10	Clinical records reflect travel destination.	YES, NO
CRD.280.20	Clinical records include current health status.	YES, NO
CRD.280.30	Clinical records include immunization and vaccine name(s), dosage form, dosage administered, lot number, and quantity.	YES, NO
CRD.280.40	Clinical records include prescription medications given, quantity and date, dosage, and directions for use.	YES, NO

Guidance & References

- If all or part of travel medicine services provided occur via telehealth and telemedicine, appropriate documentation is present in the clinical records.

		Compliance Rating
CRD.290 **Selective / 1** ***v42 16.C***	**Whether they occur within the context of a clinical visit or not, health education and health promotion services provided are referenced or documented in the patient's clinical record, when appropriate.**	**FC, NC**

Guidance & References

- Standard maintains applicability to health education and health promotion programs provided by telehealth.

		Compliance Rating
CRD.300 **Selective / 2** ***v42 20.F***	**Clinical record entries reflect the provision of overnight care.**	**FC, PC, NC**
CRD.300.10	Clinical record entries include a current history and physical examination.	YES, NO
CRD.300.20	Clinical record entries include treatment orders.	YES, NO
CRD.300.30	Clinical record entries include nursing notes.	YES, NO
CRD.300.40	Clinical record entries include follow-up instructions to patients.	YES, NO

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
CRD.310 **Selective / 2** ***v42 21.D***	**Clinical records are maintained for occupational health services.**	**FC, SC, PC, MC, NC**
CRD.310.10	As appropriate, entries for each visit include an occupational and exposure history, including essential job functions, conditions of work, and hazards of the job.	YES, NO
CRD.310.20	As appropriate, entries for each visit include the individual's current functional abilities.	YES, NO
CRD.310.30	As appropriate, entries for each visit include whether the individual can perform essential job functions and suggestions for accommodations or restrictions.	YES, NO
CRD.310.40	As appropriate, entries for each visit include the relationship of medical conditions or abnormal findings to workplace conditions and exposures.	YES, NO
CRD.310.50	As appropriate, entries for each visit include preventive counsel concerning reduction of workplace exposures and use of personal protective equipment.	YES, NO
CRD.310.60	As appropriate, entries for each visit include relevant communications concerning the patient, work activities, or exposures, including communications with employers, insurance carriers, union representatives, and attorneys.	YES, NO

Guidance & References

- Some occupational records have special retention requirements which would be evaluated under the Clinical Records (CRD) Standards. Refer to state and federal guidelines for retention requirements.

		Compliance Rating
CRD.320 **Selective / 2** ***v42 24.G***	**Clinical record entries reflect the provision of radiation oncology treatment.**	**FC, PC, NC**
CRD.320.10	Clinical record entries include the following:	YES, NO
CRD.320.10.1	Confirmation of the presence of malignancy by histopathology or a statement of benign condition.	
CRD.320.10.2	Definition of tumor location, extent, and stage.	
CRD.320.10.3	Definition of treatment volume.	
CRD.320.10.4	Selection of dose.	
CRD.320.10.5	Selection of treatment modality.	
CRD.320.10.6	Selection of treatment technique.	
CRD.320.10.7	Dosimetry calculations.	
CRD.320.20	Supervision of treatment and record of patient progress and tolerance is documented.	YES, NO
CRD.320.30	A summary of completion and statement of follow-up plan is present.	YES, NO

		Compliance Rating
CRD.330 **Universal / 1** ***v42 25.I***	**Clinical records consistently document items important for continuity of care.**	**FC, SC, PC, MC, NC**
CRD.330.10	Consultations ordered are consistently documented.	YES, NO
CRD.330.20	Referrals for services outside of the Medical Home are consistently documented.	YES, NO
CRD.330.30	Results of consultations (medical opinions obtained from other health care professionals) are consistently documented.	YES, NO
CRD.330.40	Follow-up appointments are consistently documented.	YES, NO
CRD.330.50	After-hours encounters are consistently documented.	YES, NO
CRD.330.60	Missed appointments are consistently documented.	YES, NO

Guidance & References

- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
CRD.340 **Universal / 1** ***v42 25.N***	**There is evidence that electronic data management is continually assessed as a tool for facilitating achievement of the Medical Home Standards.**	**FC, NC**

Guidance & References

- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
CRD.350 **Universal / 1** ***v42 14.II.I***	**Clinical records consistently document items important for continuity of care.**	**FC, SC, PC, MC, NC**
CRD.350.10	Consultations ordered are consistently documented.	YES, NO
CRD.350.20	Referrals for services outside of the Dental Home are consistently documented.	YES, NO
CRD.350.30	Results of consultations (medical opinions obtained from other health care professionals) are consistently documented.	YES, NO
CRD.350.40	Follow-up appointments are consistently documented.	YES, NO
CRD.350.50	After-hours encounters are consistently documented.	YES, NO
CRD.350.60	Missed appointments are consistently documented.	YES, NO

Guidance & References

- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
CRD.360 **Universal / 1** ***v42 14.II.N***	**There is evidence that electronic data management is continually assessed as a tool for facilitating achievement of the Dental Home Standards.**	**FC, NC**

Guidance & References

- This Standard is Universal in the Medical and/or Dental Home Programs.

EMG Emergency Management

The Emergency Management Category outlines the expectations for ensuring that the organization is prepared for natural and man-made disasters through an all-hazard approach. Organizations should be prepared to assess, respond, and manage potential threats well before they occur. An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities. According to the Centers for Medicare and Medicaid, this approach includes preparedness for natural, man-made, and or facility emergencies that may include but is not limited to: care-related emergencies; equipment and power failures; interruptions in communications, including cyber-attacks; loss of a portion or all of a facility; and, interruptions in the normal supply of essentials, such as water and food; and emerging infectious disease (EID) threats.

The Standards address planning, equipment, training, and testing.

		Compliance Rating
EMG.100 **Universal / 2** ***v42 4.H***	**The organization has written procedures for managing medical emergencies and unplanned outcomes for which transfer to a higher level of care is indicated to evaluate and stabilize the patient.** **1. The procedures address decision making authority for transferring a patient.** **2. The procedures include the process for transferring a patient.** **3. The procedures include provisions for caring for the patient until the transfer occurs.** **4. The procedures describe documentation that must accompany the patient, if any.** **5. Documentation demonstrates that staff have been trained on the procedures.**	**FC, NC**

		Compliance Rating
EMG.140 **Universal / 2** ***v42 7.II.D***	**Personnel trained in basic life support (BLS) and the use of cardiac and all other emergency equipment and supplies are present in the facility when patients are present.**	**FC, PC, NC**
EMG.140.10	Personnel files include documentation of current BLS training.	YES, NO
EMG.140.20	There is documentation of training in the use of cardiac and all other emergency equipment and supplies.	YES, NO
EMG.140.30	A policy requires the presence of trained and currently certified personnel when patients are present.	YES, NO

		Compliance Rating
EMG.160 **Universal / 2** ***v42 8.H***	**A comprehensive written emergency and disaster preparedness plan addresses internal and external emergencies.**	**FC, PC, NC**
EMG.160.10	A comprehensive written emergency and disaster preparedness plan to address internal and external emergencies is present.	YES, NO
EMG.160.20	The plan includes a provision for the safe evacuation of individuals during an emergency, especially individuals who are at greater risk.	YES, NO
EMG.160.30	The plan includes participation in community health emergency or disaster preparedness, if applicable.	YES, NO, NA

		Compliance Rating
EMG.170 **Universal / 2** ***v42 8.I***	**Scenario-based drills of the internal and external emergency and disaster preparedness plan are conducted.**	**FC, SC, PC, MC, NC**
EMG.170.10	All drills are scenario-based.	YES, NO
EMG.170.20	At least one drill is conducted each calendar quarter.	YES, NO
EMG.170.30	A cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization, is conducted annually.	YES, NO
EMG.170.40	At least one drill based on the organization's emergency disaster plan, is conducted annually.	YES, NO
EMG.170.50	Documentation of drill participants is available.	YES, NO
EMG.170.60	A written evaluation of each drill is completed.	YES, NO
EMG.170.70	Any needed corrections or modifications to the emergency plan are implemented promptly.	YES, NO

		Compliance Rating
EMG.180 **Universal / 2** ***v42 8.K***	**Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of each patient care service site.**	**FC, PC, NC**
EMG.180.10	A written policy is present defining the minimum equipment and supplies required for:	YES, NO
EMG.180.10.1	Medical emergencies	
EMG.180.10.2	Other emergencies.	
EMG.180.20	Observation and interviews confirm that the required emergency equipment and supplies are maintained.	YES, NO
EMG.180.30	Emergency equipment and supplies are readily accessible to all areas of each patient care service site.	YES, NO

		Compliance Rating
EMG.200 **Selective / 2** ***v42 9.G***	**Resuscitation equipment is available.**	**FC, PC, NC**
EMG.200.10	Oxygen is available.	YES, NO
EMG.200.20	A device such as a self-inflating hand resuscitator bag capable of administering at least 90% oxygen is available.	YES, NO
EMG.200.30	Appropriate emergency drugs, supplies, and equipment are available.	YES, NO
EMG.200.40	A manual defibrillator, or an automated external defibrillator (AED), is available.	YES, NO

Guidance & References

- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.

		Compliance Rating
EMG.210 **Selective / 2** ***v42 9.N***	**At least one health care professional with current training in advanced cardiac life support (ACLS) is present to provide advanced resuscitative techniques until all patients operated on that day have been physically discharged.**	**FC, PC, NC**
EMG.210.10	Documentation of current ACLS training is present.	YES, NO
EMG.210.20	Initial ACLS training and subsequent retraining is obtained from the American Heart Association or other vendor that includes “hands-on” training and skills demonstration of airway management and automated external defibrillator (AED) use.	YES, NO
EMG.210.30	A policy requires that health care professionals with ACLS training are present until that day's patients have been physically discharged.	YES, NO

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
EMG.220 **Selective / 2** ***v42 9.P***	**If anesthetic and resuscitative agents known to trigger malignant hyperthermia are available in the facility, staff are prepared to respond to an episode of malignant hyperthermia.**	**FC, SC, PC, MC, NC**
EMG.220.10	Written treatment protocols based on current, nationally recognized guidelines have been adopted.	YES, NO
EMG.220.20	The protocols include:	YES, NO
EMG.220.20.1	The administration of dantrolene and other medications.	
EMG.220.20.2	Readily-available methods of continuous cooling and temperature monitoring.	
EMG.220.20.3	Initiation of an emergency transfer protocol.	
EMG.220.30	The protocols are posted and/or immediately available in each area where triggering agents might be used.	YES, NO
EMG.220.40	Documentation demonstrates that all appropriate staff have been educated and trained in the recognition and treatment of malignant hyperthermia.	YES, NO
EMG.220.50	At least annually, a malignant hyperthermia drill is conducted and documented.	YES, NO

Guidance & References

- An example is the Malignant Hyperthermia Association of the United States (MHAUS) protocol. See https://www.mhaus.org/.
- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
EMG.230 **Selective / 2** ***v42 9.T***	**If pediatric patients are served, health care professionals with current training in pediatric advanced life support (PALS) and age- and size-appropriate resuscitative equipment are available at all times until pediatric patients operated on that day have been physically discharged.**	**FC, PC, NC, NA**
EMG.230.10	Documentation of current PALS training and certification is present.	YES, NO, NA
EMG.230.20	Initial PALS training and subsequent retraining is obtained from the American Heart Association or another vendor that includes “hands-on” training and skills demonstration of airway management and automated external defibrillator (AED) use.	YES, NO, NA
EMG.230.30	Documentation of training in age- and size-appropriate resuscitative equipment is present.	YES, NO, NA
EMG.230.40	A policy requires that health care professionals with training in PALS and pediatric resuscitative equipment are present until that day's patients have been physically discharged.	YES, NO, NA

Guidance & References

- Pediatric Emergency Assessment, Recognition and Stabilization (PEARS) training is not accepted in lieu of PALS training.

		Compliance Rating
EMG.240 **Selective / 2** ***v42 9.U***	**If pediatric patients are served, the equipment, medication, and resuscitative capabilities required for pediatric patients are present.**	**FC, PC, NC, NA**
EMG.240.10	Age and size-appropriate anesthesia equipment is present.	YES, NO, NA
EMG.240.20	Medications in appropriate concentrations are present.	YES, NO, NA
EMG.240.30	Age and size-appropriate resuscitative equipment is present.	YES, NO, NA

		Compliance Rating
EMG.250 **Universal / 2** ***v42 10.I.C***	**A written policy requires that, whenever patients are present in the facility, at least one physician, dentist or other practitioner qualified to address medical emergencies and authorized by the governing body is present or immediately available by telephone.**	**FC, NC**

		Compliance Rating
EMG.260 **Selective / 2** ***v42 21.J***	**If the organization is responsible for emergency and/or community preparedness planning, written disaster and toxicologic exposure plans are present.**	**FC, SC, PC, MC, NC**
EMG.260.10	Written plans are present.	YES, NO
EMG.260.20	The plans include likely worksite scenarios for disasters and effects.	YES, NO
EMG.260.30	The plans include plans for medical triage, segregation, decontamination, evacuation, and transportation.	YES, NO
EMG.260.40	The plans include collaboration with community resources in emergency situations.	YES, NO
EMG.260.50	The plans include emergency patient treatment protocols.	YES, NO
EMG.260.60	The plans include requirements for sufficient drills and training to ensure that the plan is effective.	YES, NO

		Compliance Rating
EMG.270 **Selective / 2** ***v42 22.F***	**Resources to enable the successful management of medical emergencies are present.**	**FC, SC, PC, MC, NC**
EMG.270.10	Written procedures for the management of medical emergencies are present.	YES, NO
EMG.270.20	At minimum, the following equipment is present:	YES, NO
EMG.270.20.1	Oxygen.	
EMG.270.20.2	A device such as a self-inflating hand resuscitator bag capable of administering at least 90% oxygen.	
EMG.270.20.3	Appropriate emergency drugs, supplies and equipment.	
EMG.270.20.4	A reliable suction source and appropriate equipment to ensure a clear airway.	
EMG.270.30	If pediatric patients are served, age- and size-appropriate resuscitative equipment is present.	YES, NO, NA
EMG.270.40	Documentation is present demonstrating that communications are maintained with local police departments, fire departments, ambulance services, poison control centers, health departments, and hospitals as needed to address medical emergencies.	YES, NO
EMG.270.50	A written policy requires that, when patients are transferred to a higher level of care, qualified personnel and transportation equipment conduct the transfer.	YES, NO

		Compliance Rating
EMG.280 **Selective / 2** ***v42 22.B***	**Health care professionals with current training in ACLS or ATLS are present to provide advanced resuscitative techniques when patients are present.**	**FC, PC, NC**
EMG.280.10	Documentation of current training in ACLS or ATLS is present.	YES, NO
EMG.280.20	A written policy requires the presence of trained personnel when patients are present.	YES, NO

Guidance & References

- Initial ACLS, ATLS, and PALS training and subsequent retraining is obtained from the American Heart Association or another vendor that includes “hands-on” training and skills demonstration of airway management and automated external defibrillator (AED) use.

		Compliance Rating
EMG.290 **Selective / 2** ***v42 22.C***	**If pediatric patients are served, medical personnel with current training in pediatric advanced life support (PALS) are present when patients are present.**	**FC, PC, NC**
EMG.290.10	Documentation of current training in PALS is present.	YES, NO
EMG.290.20	A written policy requires the presence of trained personnel when patients are present.	YES, NO

		Compliance Rating
EMG.300 **Selective / 2** ***v42 23.F***	**If pediatric patients are served, age- and size-appropriate resuscitative equipment is present.**	**FC, NC**

		Compliance Rating
EMG.400 **Selective / 2** ***v42 REG***	**The organization must have a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergent and urgent care situations. Per the plan, if a patient is being transferred to a local accredited or licensed acute care hospital, the outpatient setting shall do all of the following:** • **Notify the individual designated by the patient to be notified in case of an emergency.** • **Ensure that the mode of transfer is consistent with the patient's medical condition.** • **Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.** **Continue to provide appropriate care to the patient until the transfer is effectuated.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Health and Safety §1248.15(D): As of January 1, 2012, in addition to the requirements imposed at 1248.15(C), outpatient settings are required to submit for approval by AAAHC, its detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergent and urgent care situations.

FAC Facilities and Equipment

The Facilities and Equipment Category outlines the expectations for providing a functionally safe and sanitary environment. Patient care is always the top concern for health care organizations. In order to care for patients properly, the facilities and equipment should be safe, well maintained and in good working order.

Maintenance refers to the process of establishing a comprehensive program that includes regular inspections, testing, calibration and cleaning of facilities and equipment. The goal of maintenance is to ensure that facilities are safe and secure, and equipment remains available, functional, reliable, and safe, thereby reducing the risk of errors, malfunctions, and breakdowns.

The Standards address equipment, building safety, security and maintenance.

		Compliance Rating
FAC.100 **Universal / 2** ***v42 8.A***	**Documentation demonstrates that the facility complies with applicable building codes and regulations.**	**FC, NC**

Guidance & References

- Examples of such documentation include an occupancy permit, a report or letter from a relevant fire authority, and/or a report or letter from the relevant building approval authority.

		Compliance Rating
FAC.110 **Universal / 2** ***v42 8.D***	**The facility is operated in a safe and secure manner.**	**FC, PC, NC**
FAC.110.10	Written policies addressing safety and security practices are present.	YES, NO
FAC.110.20	Observation and/or interviews confirm that security practices are followed.	YES, NO

		Compliance Rating
FAC.120 **Universal / 1** ***v42 8.E***	**The physical environment supports patient comfort and privacy.**	**FC, SC, PC, MC, NC**
FAC.120.10	Reception areas and restroom facilities are appropriate for patient and visitor volume.	YES, NO
FAC.120.20	Examination rooms, dressing rooms, and reception areas are constructed and maintained to ensure patient privacy during interviews, examinations, treatment, and consultation.	YES, NO
FAC.120.30	Smoking is prohibited within the facility.	YES, NO
FAC.120.40	Provisions are made to reasonably accommodate disabled individuals.	YES, NO
FAC.120.50	Adequate lighting and ventilation are provided in all areas.	YES, NO
FAC.120.60	Observation and interviews confirm that the space allocated for a particular function or service is adequate for the activities performed therein.	YES, NO

Guidance & References

- In telehealth and telemedicine settings, clinical staff must ensure that visual, auditory and electronic privacy are maintained on the clinical side. Staff should encourage the patient/client to take steps to ensure their privacy (e.g., private location, and auditory/visual privacy).

		Compliance Rating
FAC.130 **Universal / 2** ***v42 8.F***	**Facilities are clean and properly maintained.**	**FC, NC**

Guidance & References

- Elements of “clean and properly maintained” include but are not limited to: Surfaces are free of dust and visible soil; wall finishes are smooth, uniform and easy to clean; lack of mold and rust in the facility; plumbing, window and door hardware, and HVAC systems are in working order; there is no visible damage or wear on electrical receptacles and light switches.

		Compliance Rating
FAC.140 **Universal / 2** ***v42 8.I.G***	**There are no visible hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma.**	**FC, NC**

		Compliance Rating
FAC.150 **Universal / 2** ***v42 8.B***	**The facility is equipped to protect occupants from fire.**	**FC, SC, PC, MC. NC**
FAC.150.10	Fire extinguishers are provided at visually obvious locations such that the nearest "2A" or larger extinguisher is no more than 75 feet walking distance from any location in the facility.	YES, NO
FAC.150.20	Monthly inspections of the extinguishers are conducted, as demonstrated by current inspection tags or logs.	YES, NO
FAC.150.30	Documentation of annual inspection of the extinguishers in accordance with manufacturer's instructions is present.	YES, NO
FAC.150.40	If more than five gallons of flammable liquid (including alcohol-based hand rub) are present, the nearest visually obvious "20B" or larger extinguisher is no more than 50 feet walking distance from any location in the facility.	YES, NO, NA
FAC.150.50	The facility has emergency lighting to facilitate evacuation during loss of normal power.	YES, NO
FAC.150.60	If a fire alarm and/or suppression system is present, inspection, testing and maintenance are performed and documented per manufacturer recommendations and the requirements of fire authorities having jurisdiction (AHJ).	YES, NO, NA

Guidance & References

- Extinguishers rated for both A and B type fires, such as “2A-40B,” are suitable extinguishers to use to meet the Standard element requirements for location visibility and monthly inspections.

		Compliance Rating
FAC.160 **Universal / 2** ***v42 8.C***	**The facility is designed to provide safe exiting in an emergency.**	**FC, PC, NC**
FAC.160.10	The facility has prominently displayed illuminated exit signs with emergency power capability at all exits, including exits from each floor or hall.	YES, NO
FAC.160.20	If the facility has stairwells that are part of the required exiting, they are enclosed in fire walls, including fire-rated doors.	YES, NO, NA

		Compliance Rating
FAC.240 **Universal / 2** ***v42 8.J***	**Medical equipment is appropriately maintained.**	**FC, SC, PC, MC, NC**
FAC.240.10	Written policies and procedures for equipment maintenance are present.	YES, NO
FAC.240.20	At minimum, the policies address:	YES, NO
FAC.240.20.1	Standardized use of the equipment.	
FAC.240.20.2	Requirements for periodic calibration according to manufacturer's specifications (if equipment requiring calibration is used).	
FAC.240.20.3	Requirements for periodic testing and preventive maintenance according to manufacturer specifications.	
FAC.240.30	Documentation of periodic calibration according to manufacturer's specifications is present (if equipment requiring calibration is used).	YES, NO, NA
FAC.240.40	Documentation of preventive maintenance according to manufacturer's instructions is present.	YES, NO

Guidance & References

- If telehealth and telemedicine services are offered, medical equipment utilized by staff or provided to the patient is appropriately maintained according to this Standard.

		Compliance Rating
FAC.250 **Selective / 2** ***v42 9.O***	**Alternate power adequate for the types of surgery/procedures performed is available in operative and recovery areas.**	**FC, PC, NC**
FAC.250.10	Alternate power is available in operative and recovery areas.	YES, NO
FAC.250.20	The alternate power is adequate for the types of surgery/procedures performed.	YES, NO

Guidance & References

- Standard applies to organizations that administer moderate sedation/analgesia, regional anesthesia, deep sedation/analgesia, or general anesthesia.

		Compliance Rating
FAC.260 **Selective / 2** ***v42 10.III.C***	**Equipment, adequate supplies, and written policies and procedures for providing appropriate lithotripsy treatment are present.**	**FC, PC, NC**
FAC.260.10	Observation and interviews confirm that the following are adequate to provide treatment in accordance with manufacturer's guidelines:	YES, NO
FAC.260.10.1	Equipment.	
FAC.260.10.2	Supplies.	
FAC.260.20	The written guidelines address the following in accordance with manufacturer's instructions:	YES, NO
FAC.260.20.1	Indications.	
FAC.260.20.2	Contraindications.	
FAC.260.20.3	Maximum power setting.	
FAC.260.20.4	Maximum number of shocks.	
FAC.260.20.5	Position of patient.	
FAC.260.20.6	Patient size and weight.	
FAC.260.20.7	Utilization of equipment.	

		Compliance Rating
FAC.270 **Selective / 2** ***v42 24.H***	**The radiation oncology service has adequate equipment to provide teletherapy treatments.**	**FC, SC, PC, MC, NC**
FAC.270.10	Super voltage or megavoltage machine(s) capable of producing x-ray, gamma-ray, or proton beams for external beam treatments (includes isocentric and non-isocentric linear accelerators, Gamma Knife, TomoTherapy, and cobalt-60 machines) are present or available.	YES, NO
FAC.270.20	A kilovoltage x-ray source or electron-beam for skin lesions is present or available.	YES, NO
FAC.270.30	Computerized dosimetry is accessible.	YES, NO
FAC.270.40	Simulation and/or CT imaging equipment is accessible.	YES, NO
FAC.270.50	Patient transport is accessible.	YES, NO
FAC.270.60	Personal immobilization devices are present or available, with procedures to ensure proper identification to match each device to the proper patient.	YES, NO
FAC.270.70	Technologies for shaping dose distributions include, but are not limited to, multi-leaf collimators, metal alloy or sheet lead, procedures for properly identifying and linking each device (or electronic file) to the patient and radiation field; and established procedures for the identification, handling, storage, and removal of devices made of metal alloys.	YES, NO

GOV Governance

The Governance Category outlines the expectations of the governing body's role in ensuring the provision of high-quality health care services and fulfillment of the organization's mission, goals, and objectives. The governing body plays an integral role in safeguarding care provided, designing systems of organizational control and shaping culture. This includes complying with state and federal requirements, as well as ensuring organizational policies and procedures such as credentialing and privileging, patient care, quality, risk management etc., are adopted and that there are processes in place for monitoring and improving compliance. Embracing a total systems approach to safety includes establishing priorities for action, identifying and implementing resources, and communicating with staff.

The Standards address strategic planning, oversight, operations and regulatory compliance.

		Compliance Rating
GOV.130 **Universal / 1** ***v42 2.I.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, as 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.**	**FC, NC**

		Compliance Rating
GOV.150 **Universal / 1** ***v42 2.I.B***	**The governing body is responsible for establishing strategic direction and supporting its accomplishment.**	**FC, PC, NC**
GOV.150.10	The governing body determines the mission, goals, and objectives of the organization.	YES, NO
GOV.150.20	The governing body formulates long-range plans in accordance with the mission, goals, and objectives of the organization.	YES, NO
GOV.150.30	The governing body ensures that facilities and personnel are adequate and appropriate to carry out the mission.	YES, NO

		Compliance Rating
GOV.160 **Universal / 1** ***v42 2.I.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.**	**FC, SC, PC, MC, NC**
GOV.160.10	The governing body establishes an organizational structure and specifies functional relationships among various components of the organization.	YES, NO
GOV.160.20	The governing body adopts bylaws or similar rules and regulations for the orderly development and management of the organization.	YES, NO
GOV.160.30	The governing body adopts policies and procedures necessary for the orderly conduct of the organization, including the organization's scope of clinical activities.	YES, NO
GOV.160.40	The governing body establishes a system of financial management and accountability appropriate to the organization.	YES, NO
GOV.160.50	The governing body ensures fulfillment of all applicable obligations under prevailing laws and regulations, such as those addressing disabilities, medical privacy, grievances, fraud and abuse, self-referral, anti-trust, reporting to the National Practitioner Data Bank, etc.	YES, NO
GOV.160.60	The governing body oversees compliance with applicable AAAHC Standards.	YES, NO
GOV.160.70	The governing body approves products sold to patients.	YES, NO, NA

Guidance & References

- For information on the National Practitioner Data Bank, see http://www.npdb.hrsa.gov.
- If telehealth and telemedicine services are offered, these services should be referenced, defined, and approved in the governing body scope of clinical activities (e.g., new services and annual review of established services).
- The governing body should ensure that if telehealth and telemedicine services are offered, they fulfill all applicable obligations under prevailing laws and regulations, including those addressing medical privacy, grievances, and practice across state lines.

		Compliance Rating
GOV.170 **Universal / 2** ***v42 2.I.D***	**The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the clinical operations and performance of the organization.**	**FC, SC, PC, MC, NC**
GOV.170.10	The governing body is responsible for the employment or contracting of health care professionals.	YES, NO
GOV.170.20	The governing body establishes and maintains a policy on the rights and responsibilities of patients.	YES, NO
GOV.170.30	The governing body establishes and maintains a written policy regarding the care of pediatric patients.	YES, NO, NA
GOV.170.40	The governing body ensures that the quality of care is evaluated and that identified problems are appropriately addressed.	YES, NO
GOV.170.50	The governing body establishes, implements and oversees a risk management program appropriate to the organization that includes review of risk management activities.	YES, NO
GOV.170.60	The governing body establishes, implements and oversees the organization's infection prevention and control and safety programs to ensure a safe environment of care.	YES, NO
GOV.170.70	The governing body establishes policies on patient education and continuing education for staff.	YES, NO

		Compliance Rating
GOV.180 **Universal / 2** ***v42 2.I.E***	**The governing body is responsible for approving and ensuring compliance of all major contracts or arrangements affecting the medical and/or dental care provided under its auspices.**	**FC, SC, PC, MC, NC, NA**
GOV.180.10	The governing body approves and ensures compliance with contracts or arrangements for the provision of external services, such as those for radiology, pathology, medical laboratory, and housekeeping services.	YES, NO, NA
GOV.180.20	The governing body approves and ensures compliance with contracts or arrangements for provision of education to students and postgraduate trainees.	YES, NO, NA
GOV.180.30	The governing body approves and ensures compliance with contracts or arrangements for the provision of after-hours patient information or telephone triage services, including the review of protocols.	YES, NO, NA
GOV.180.40	The governing body approves and ensures compliance with contracts or arrangements with The Centers for Medicare & Medicaid Services (CMS) requirements, if the organization participates in the Medicare/Medicaid program.	YES, NO, NA
GOV.180.50	The governing body approves and ensures compliance with contracts or arrangements for activities or services delegated to another entity.	YES, NO, NA
GOV.180.60	The governing body ensures that services rendered under all major contracts or arrangements are provided in a safe and effective manner.	YES, NO, NA

		Compliance Rating
GOV.200 **Universal / 1** ***v42 2.I.F***	**The governing body is responsible for ensuring appropriate communication within and on behalf of the organization.**	**FC, SC, PC, MC, NC**
GOV.200.10	The governing body reviews all legal and ethical matters concerning the organization and its staff, and responds appropriately when necessary.	YES, NO
GOV.200.20	The governing body ensures maintenance of effective communication throughout the organization, including ensuring links between quality management and improvement activities and other management functions of the organization.	YES, NO
GOV.200.30	The governing body ensures that marketing, advertising and other statements regarding the competence and capabilities of the organization are not misleading.	YES, NO
GOV.200.40	Evidence is present that policies, procedures and other information are communicated throughout the organization, as documented in staff meeting minutes, emails, intranet, manuals, and other forms of communication.	YES, NO
GOV.200.50	Evidence is present of organizational procedures to permit appropriate responses to inquiries from entities such as, but not limited to, government agencies, attorneys, consumer advocate groups, and the media.	YES, NO

		Compliance Rating
GOV.210 **Universal / 1** ***v42 2.I.G***	**The governing body meets at least annually, or more frequently as determined by the governing body, as evidenced by minutes or other records kept as necessary for the orderly conduct of the organization.**	**FC, NC**

		Compliance Rating
GOV.220 **Universal / 1** ***v42 2.I.J***	**Documentation demonstrates at least annual governing body review of AAAHC accreditation requirements.**	**FC, SC, PC, MC, NC**
GOV.220.10	Patients' rights and responsibilities are reviewed.	YES, NO
GOV.220.20	Delegated administrative responsibilities are reviewed.	YES, NO
GOV.220.30	Key programs are reviewed:	YES, NO
GOV.220.30.1	The quality improvement program is reviewed.	
GOV.220.30.2	The infection prevention and control program is reviewed.	
GOV.220.30.3	The safety program is reviewed.	
GOV.220.30.4	The emergency and disaster preparedness plan is reviewed.	
GOV.220.30.5	The risk management program is reviewed according to the established process defined by the organization.	
GOV.220.40	The organization's policies and procedures are reviewed.	YES, NO
GOV.220.50	The appointment and reappointment processes are reviewed.	YES, NO
GOV.220.60	The scope of procedures performed, and/or services provided, by the organization is reviewed.	YES, NO
GOV.220.70	Documentation demonstrates at least annual governing body review of AAAHC accreditation requirements.	YES, NO

		Compliance Rating
GOV.230 **Universal / 1** ***v42 2.I.K***	**The authority, responsibility and functions of officers and administrators elected, appointed, or employed to carry out governing body directives are clearly defined by the governing body.**	**FC, NC**

		Compliance Rating
GOV.250 **Selective / 2** ***v42 9.A***	**Anesthesia services provided by the organization are limited to those techniques that have been approved by the governing body upon the recommendation of qualified professional personnel.**	**FC, NC**

Guidance & References

- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.

		Compliance Rating
GOV.260 **Selective / 1** ***v42 9.B***	**The governing body has appointed one or more qualified physicians or dentists to supervise the anesthesia service.**	**FC, NC**

Guidance & References

- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.

		Compliance Rating
GOV.270 Selective / 2 *v42 10.I.A*	**Surgical procedures performed are limited to those approved by the governing body upon the recommendation of qualified medical staff.**	**FC, NC**

		Compliance Rating
GOV.280 Selective / 1 *v42 10.I.B*	**The governing body has appointed one or more qualified physicians, dentists, or other qualified practitioners to supervise surgical services.**	**FC, NC, NA**

Guidance & References

- NA may be applied depending on services provided by the organization.

		Compliance Rating
GOV.290 Selective / 2 *v42 10.II.A*	**The governing body has granted each provider privileges for each energy-emitting device that they use.**	**FC, NC**

Guidance & References

- Standard applies to organizations providing surgery or procedures that involve lasers, light-based technologies, or other energy-emitting equipment.

		Compliance Rating
GOV.300 Selective / 2 *v42 10.III.A*	**The governing body has designated one or more qualified urologists to oversee lithotripsy services.**	**FC, NC**

		Compliance Rating
GOV.310 Selective / 1 *v42 12.B*	**If the organization has obtained a CLIA Certificate for Provider Performed Microscopy Procedures, or a CLIA Certificate of Registration, Compliance or Accreditation, services are provided under the direction of a pathologist, other physician, or other qualified individual as delineated under CLIA.**	**FC, NC, NA**

Guidance & References

- NA may be applied if State licensure or certification program is exempt from CLIA program requirements.

		Compliance Rating
GOV.320 Selective / 1 *v42 12.E*	**If the organization has obtained a CLIA Certificate of Waiver or a state license or certificate to perform waived testing, services are provided under the direction of an individual holding the qualifications required by the state, if any, for this position. If the state does not have qualification requirements, services are provided under the direction of a person holding the qualifications required by the organization for this position.**	**FC, NC**

		Compliance Rating
GOV.330 **Selective / 1** ***v42 13.G***	**Diagnostic imaging services are directed by a qualified physician or dentist.**	**FC, PC, NC, NA**
GOV.330.10	Documentation of qualifications is present in the credentials file.	YES, NO, NA
GOV.330.20	There is evidence that the physician or dentist has been designated by the governing body to hold this responsibility.	YES, NO, NA

Guidance & References

- NA may be applied if the organization only provides peri-operative imaging services.

		Compliance Rating
GOV.340 **Selective / 1** ***v42 14.I.A***	**Dental services provided are consistent with the definition of dentistry according to state regulation.**	**FC, NC**

		Compliance Rating
GOV.350 **Selective / 1** ***v42 14.I.B***	**Dental services provided are limited to those procedures approved by the governing body upon the recommendation of qualified dental personnel.**	**FC, NC**

Guidance & References

- Standard maintains applicability if dental services are provided via telehealth and telemedicine (e.g., intraoral camera and hand-held intraoral radiographs).

		Compliance Rating
GOV.360 **Selective / 1** ***v42 19.A***	**Research activities are performed in accordance with ethical and professional practices and legal requirements.**	**FC, PC, NC**
GOV.360.10	All research is appropriate for the expertise of the organization's providers and staff.	YES, NO
GOV.360.20	Available resources are appropriate for the research conducted.	YES, NO
GOV.360.30	Documentation demonstrates that, when reviewing and approving clinical research studies, the governing body reviews any Institutional Review Board (IRB) review completed to ensure that appropriate steps are taken to protect the rights and welfare of patients and others participating as subjects in a research study.	YES, NO
GOV.360.40	Documentation demonstrates that the governing body reviews all current research at least annually.	YES, NO

Guidance & References

- Research activities include, but are not limited to, clinical trials of drugs and other biologicals; the use of devices, implants, or instruments that are classified as investigational or experimental; and the use of techniques that are new, experimental, innovative, or otherwise not yet accepted as standard medical or dental practice.

		CMS CfC Identifier	CMS Tag	Compliance Rating
GOV.370 **Selective / 1** ***v42 20.A***	**If required by the state, the overnight care unit has obtained a license to operate.**	-	-	**FC, NC**

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
GOV.380 **Selective / 1** ***v42 23.A***	**If required by the state, the emergency facility has obtained a license to operate.**	**FC, NC**

		Compliance Rating
GOV.390 **Selective / 2** ***v42 24.A***	**The governing body has appointed qualified personnel to direct and oversee radiation oncology services.**	**FC, SC, PC, MC, NC**
GOV.390.10	The governing body has appointed at least one physician to direct the service.	YES, NO
GOV.390.20	The directing physician(s) has been credentialed and privileged to provide radiation oncology services in accordance with AAAHC Standards for credentialing and privileging.	YES, NO
GOV.390.30	The governing body has appointed a radiation safety officer.	YES, NO
GOV.390.40	A radiation safety committee meets periodically to review safety issues, policies, etc.	YES, NO
GOV.390.50	Documentation is present to demonstrate that a qualified medical physicist conducts at least an annual review of the safety and quality control policies and procedures.	YES, NO

		Compliance Rating
GOV.400 **Selective / 2** ***v42 24.C***	**The governing body has adopted written policies addressing the quality of care for radiation oncology.**	**FC, SC, PC, MC, NC**
GOV.400.10	Methodologies for diagnosis and treatment are limited to those approved by the governing body.	YES, NO
GOV.400.20	Therapeutic services are performed only upon the written order of a radiation oncologist.	YES, NO
GOV.400.30	A policy for staffing requirements during treatment includes:	YES, NO
GOV.400.30.1	A requirement that a physician be present or immediately available during treatment.	
GOV.400.30.2	A requirement for the presence of qualified support personnel during treatment when a physician is not present.	
GOV.400.40	A signed consent form is present in the clinical record prior to treatment.	YES, NO
GOV.400.50	Chart and port film for ongoing therapies are reviewed on a weekly basis.	YES, NO, NA
GOV.400.60	Treatment setups are documented with photographs.	YES, NO, NA
GOV.400.70	Emergency treatment is accessible when needed.	YES, NO

IPC Infection Prevention and Control

The Infection Prevention and Control Category outlines the expectations for an infection prevention and control program that seeks to minimize infections and communicable diseases. Organizations must adhere to safe practices for patients, staff, and all others and maintain ongoing programs designed to prevent and control infections and communicable diseases and provide a safe and sanitary environment of care. The written infection prevention and control program describes how infections and transmission of communicable diseases are prevented, identified, and managed. The plan includes a written exposure control plan designed to systematically assess your organization's practices and guide quality improvement activities. Both the infection prevention and control plan and the exposure control plan should be reviewed and updated at least annually or when construction is anticipated.

The Standards address a written program, risk assessment, oversight, training, surveillance and processes.

		Compliance Rating
IPC.100 **Universal / 2** ***v42 7.I.A***	**The organization has a written program for infection prevention and control.**	**FC, SC, PC, MC, NC**
IPC.100.10	The infection prevention and control program is approved by the governing body.	YES, NO
IPC.100.20	The infection prevention and control program is relevant to the organization as demonstrated by a formal, documented infection prevention risk assessment.	YES, NO
IPC.100.30	The infection prevention and control program is based on nationally-recognized infection prevention and control guidelines considered and selected by the governing body.	YES, NO
IPC.100.40	The infection prevention and control program is an integral part of the organization's quality improvement program, as demonstrated by applicable policies and procedures, and by surveillance and monitoring activities.	YES, NO
IPC.100.50	The infection prevention and control program complies with all applicable state, federal and/or tribal requirements including, but not limited to, OSHA.	YES, NO

Guidance & References

- If the organization is in the Medicare Deemed Status program and it does not follow nationally recognized infection control guidelines, AAAHC Standards associated with 42 CFR 416.51(b) must be marked as deficient. Based on the level of non-compliance with national guidelines, a condition-level citation may also be appropriate.

		Compliance Rating
IPC.130 **Universal / 2** ***v42 7.I.B***	**The written infection prevention and control program describes how infections and transmission of communicable diseases are prevented, identified, and managed.**	**FC, PC, NC**
IPC.130.10	The infection prevention and control program requires immediate implementation of corrective and preventive measures when problems are identified.	YES, NO
IPC.130.20	To reduce the risk of health care-acquired infection, the infection prevention and control program requires education and active surveillance consistent with:	YES, NO
IPC.130.20.1	WHO, CDC, or other nationally recognized guidelines for hand hygiene.	
IPC.130.20.2	CDC or other nationally recognized guidelines for safe injection practices.	
IPC.130.30	A written policy outlines appropriate hand hygiene using products according to the product manufacturer's instructions for use.	YES, NO

		Compliance Rating
IPC.150 **Universal / 2** ***v42 7.I.C***	**The infection control program is under the direction of a designated and qualified professional who has training in infection control.**	**FC, PC, NC**
IPC.150.10	The governing body or its designee has assigned a qualified health care professional to direct the program.	YES, NO
IPC.150.20	There is documented evidence that the assigned person:	YES, NO
IPC.150.20.1	Has obtained training in infection prevention and control.	
IPC.150.20.2	Demonstrates current competence in infection prevention and control.	

		Compliance Rating
IPC.170 **Universal / 2** ***v42 7.I.D***	**Safe processes are used for the cleaning, decontamination, high-level disinfection, and sterilization of instruments, equipment, supplies, and implants.**	**FC, SC, PC, MC, NC**
IPC.170.10	Sterilization equipment is available, if needed.	YES, NO, NA
IPC.170.20	Internal and external indicators, including biological indicators, are used with items undergoing sterilization.	YES, NO, NA
IPC.170.30	A written policy addresses the identification and processing of medical equipment and instruments that fail to meet high-level disinfection or sterilization parameters.	YES, NO, NA
IPC.170.40	Cleaning, decontamination, high-level disinfection, and sterilization processes adhere to:	YES, NO
IPC.170.40.1	Nationally recognized guidelines.	
IPC.170.40.2	Manufacturer's instructions for use.	
IPC.170.40.3	State and federal guidelines.	
IPC.170.50	A written policy is in place for monitoring and documenting the cleaning, decontamination, high-level disinfection, and sterilization of medical equipment, accessories, instruments, and implants.	YES, NO
IPC.170.60	Observation confirms that sterile packs of equipment and instruments are handled and stored to maintain their sterility.	YES, NO

		Compliance Rating
IPC.180 **Universal / 2** ***v42 7.I.E***	**A written sharps injury prevention program is present in the organization.**	**FC, PC, NC**
IPC.180.10	The program requires disposal of intact needles and syringes into appropriate puncture-resistant sharps containers, in accordance with current state and federal guidelines.	YES, NO
IPC.180.20	The program requires placement of sharps containers in appropriate care areas, secured from tampering.	YES, NO
IPC.180.30	The program requires replacement of sharps containers when the fill line is reached.	YES, NO
IPC.180.40	The program requires handling, storage, and disposal of filled sharps containers in accordance with applicable regulations.	YES, NO

		Compliance Rating
IPC.190 **Universal / 2** ***v42 7.I.F***	**Safeguards are in place to protect patients and others from cross-infection.**	**FC, PC, NC**
IPC.190.10	Written policies and procedures for patients with communicable diseases require appropriate referral of care.	YES, NO
IPC.190.20	Written policies and procedure require that public health authorities are notified of reportable conditions.	YES, NO
IPC.190.30	Written policies and procedures require adequate surveillance to minimize the sources and transmission of infections.	YES, NO
IPC.190.40	Written policies identify people authorized to be in patient care areas.	YES, NO

		Compliance Rating
IPC.200 **Universal / 2** ***v42 7.I.G***	**Resources are sufficient to protect patients and others from cross-infection.**	**FC, PC, NC**
IPC.200.10	Space is sufficient.	YES, NO
IPC.200.20	Equipment is sufficient.	YES, NO
IPC.200.30	Supplies are sufficient.	YES, NO
IPC.200.40	Personnel are sufficient.	YES, NO

		Compliance Rating
IPC.210 **Universal / 2** ***v42 7.I.H***	**Written policies address the cleaning of patient treatment and care areas.**	**FC, PC, NC**
IPC.210.10	Policies address cleaning before use.	YES, NO
IPC.210.20	Policies address cleaning between patients.	YES, NO
IPC.210.30	Policies address terminal cleaning frequency based upon use of the area.	YES, NO
IPC.210.40	Policies address requirements for using cleaning products according to the manufacturer's instructions for use.	YES, NO

		Compliance Rating
IPC.220 **Universal / 2** ***v42 7.I.I***	**Medical devices for use with multiple patients are processed between patients according to the manufacturer's instructions or nationally recognized guidelines, whichever are more stringent.**	**FC, PC, NC**
IPC.220.10	Policies provide direction for how such devices are processed or cleaned.	YES, NO
IPC.220.20	Manufacturer's instructions and/or nationally recognized guidelines are available to appropriate staff.	YES, NO
IPC.220.30	There is documented evidence of training and competency assurance of staff responsible for processing or cleaning these devices.	YES, NO

		Compliance Rating
IPC.230 **Selective / 2** ***v42 10.I.L***	**The surgical environment contains safeguards to protect patients and others from cross-infection.**	**FC, SC, PC, MC, NC**
IPC.230.10	Written policies define the proper attire of all persons entering operating or procedure rooms.	YES, NO
IPC.230.20	Written policies address acceptable aseptic techniques to be used by all persons in the surgical area.	YES, NO
IPC.230.30	Written policies address the removal or covering of patient clothing prior to the patient's entry into a surgical area, as needed to minimize the potential contamination of the surgical environment and surgical staff.	YES, NO, NA
IPC.230.40	Written policies require freshly laundered attire to be donned in an area inside of the organization prior to entry into areas designated as restricted.	YES, NO, NA
IPC.230.50	Written policies address appropriate and timely surgical hand antisepsis (scrub) using either an antimicrobial soap or an alcohol-based hand rub according to product manufacturer's recommended guidelines.	YES, NO, NA
IPC.230.60	Written policies address pre-procedure site antisepsis, as appropriate to service(s) provided and patient requirements and needs.	YES, NO, NA
IPC.230.70	Environmental controls adopted by the organization for temperature, humidity and air pressure following nationally recognized guidelines.	YES, NO, NA

Guidance & References

- NA may be applied if only non-sterile procedures are conducted (e.g., endoscopy).

		Compliance Rating
IPC.240 **Selective / 2** ***v42 10.I.M***	**Attire contaminated with blood or body fluid is laundered by an approved laundry.**	**FC, PC, NC**
IPC.240.10	The laundry adheres to nationally recognized guidelines.	YES, NO
IPC.240.20	The laundry has been approved by the organization.	YES, NO

LRD Laboratory and Radiology

The Laboratory and Radiology Category outlines the expectations for the provision of laboratory and radiology services in a safe, effective, timely and efficient manner. Clinical laboratory services support evidence based clinical decision making and aid the physicians in carrying out the diagnosis, treatment, and management of patients. Clinical laboratory test systems are assigned a moderate or high complexity category on the basis of criteria given in the CLIA regulations. The main categories of laboratory testing, as defined by CLIA regulation, are:

- Provider-performed microscopy (PPM) procedures are a select group of moderately complex microscopy tests commonly performed by health care providers during a patient office visit. Examples include pinworm examinations, fern tests, urine sediment examinations, etc.
- Highly complex tests require clinical laboratory expertise beyond normal automation to perform. Examples include cytology, peripheral smears, and most molecular diagnostic tests including RT-PCR, multiplexed analyses, dot blots, viral loads, etc.
- Moderately complex tests are usually automated and more complex than waived tests. Examples include automated immunoassays, chemistry profiles, complete blood count, electrolyte profiles, urinalysis, urine drug screen, etc.
- Waived tests are simple low risk tests, if performed inaccurately, have little risk of error. Such tests have been cleared by the Food and Drug Administration for home use and those tests that have been approved for waiver under the CLIA criteria. Examples include dipstick blood glucose monitoring, fecal occult blood, urinalysis, urine pregnancy tests, etc.
- "Point-of-care testing" includes screenings and tests at or near the point of care, which produce rapid and actionable results within minutes.

Imaging services, including those used for screening, diagnosing, monitoring, or assisting with procedures provided, meet the needs of the patients, and are provided in accordance with ethical and professional practices and legal requirements. Imaging services may include, but are not limited to radiographic, fluoroscopic, magnetic resonance, and/or ultrasonic imaging.

The Standards address oversight, safety, training, maintenance, and regulatory compliance.

		Compliance Rating
LRD.130 **Selective / 1** ***v42 12.A***	**As appropriate for the laboratory services performed, a current CLIA Certificate of Waiver, and/or a current Certificate for Provider Performed Microscopy Procedures (PPMP), and/or a current Certificate of Registration, Compliance or Accreditation is present.**	**FC, NC, NA**

Guidance & References

- NA may be applied if State licensure or certification program is exempt from CLIA program requirements.

		Compliance Rating
LRD.140 **Selective / 1** ***v42 12.C***	**A current state medical laboratory license or certificate appropriate for the level of testing performed is present.**	**FC, NC**

Guidance & References

- Standard applies if State licensure program is or is not exempt from CLIA program requirements.

		Compliance Rating
LRD.150 **Selective / 1** ***v42 12.F***	**Laboratory services are conducted by qualified personnel.**	**FC, PC, NC**
LRD.150.10	Staff members with laboratory responsibilities are appropriately trained for their roles, as demonstrated by documented competency tests.	YES, NO
LRD.150.20	Observation and interviews confirm that a sufficient number of trained and experienced personnel are available to supervise and conduct the work of the laboratory.	YES, NO

		Compliance Rating
LRD.160 **Selective / 1** ***v42 12.G***	**Pathology and medical laboratory services provided adequately support the organization's clinical capabilities.**	**FC, PC, NC**
LRD.160.10	Tests are performed in a timely manner, as defined by the organization's policies.	YES, NO
LRD.160.20	Test results are made available to the ordering provider.	YES, NO
LRD.160.30	Test results are documented in the patient's medical record in accordance with the organization's policies.	YES, NO

		Compliance Rating
LRD.170 **Selective / 2** ***v42 12.H***	**Laboratory test results are reviewed and acknowledged in writing (manually or electronically) by the ordering provider or qualified designee.**	**FC, NC**

		Compliance Rating
LRD.180 **Selective / 1** ***v42 12.I***	**Laboratory quality control procedures are performed.**	**FC, PC, NC**
LRD.180.10	Quality controls are performed in accordance with manufacturer instructions.	YES, NO
LRD.180.20	The results of quality control procedures are documented.	YES, NO
LRD.180.30	Equipment is calibrated in accordance with manufacturer instructions.	YES, NO, NA
LRD.180.40	Validation tests for new equipment are performed in accordance with manufacturer instructions.	YES, NO, NA

Guidance & References

- NA may be applied if moderate or complex testing is not performed.

		Compliance Rating
LRD.190 **Selective / 2** ***v42 12.K***	**Established laboratory procedures are followed.**	**FC, PC, NC**
LRD.190.10	At minimum, procedures are established for obtaining, identifying, storing, and transporting specimens.	YES, NO
LRD.190.20	Staff members with laboratory responsibilities demonstrate understanding of the established procedures.	YES, NO
LRD.190.30	Procedures are in place to obtain routine and emergency laboratory services outside of the organization's capabilities from a hospital or licensed medical or clinical laboratory.	YES, NO

		Compliance Rating
LRD.200 **Selective / 1** ***v42 12.L***	**Complete written descriptions of each test procedure performed are available to staff with laboratory responsibilities.**	**FC, NC**

Guidance & References

- As applicable for each test, such descriptions include information about patient preparation, specimen requirements and criteria for specimen rejection, reagents, calibration procedures, quality control, step-by-step instructions for performance of the test, result reporting, reporting of critical values, and reference ranges.

		Compliance Rating
LRD.210 **Selective / 1** ***v42 12.M***	**Laboratory work is performed with optimal accuracy, precision, efficiency, and safety.**	**FC, PC, NC**
LRD.210.10	All test kits, laboratory devices and supporting supplies are FDA approved for use under the type of CLIA or state certificate obtained.	YES, NO
LRD.210.20	Observation and interviews confirm that the following are sufficient:	YES, NO
LRD.210.20.1	Space.	
LRD.210.20.2	Equipment.	
LRD.210.20.3	Supplies.	

Guidance & References

- Not all “supporting supplies” must be FDA approved, e.g., cotton balls.

		Compliance Rating
LRD.220 **Selective / 2** ***v42 12.J***	**Proficiency testing is performed if required by CLIA, the CLIA accrediting body, the state, and/or the organization's policies.**	**FC, NC**

		Compliance Rating
LRD.230 **Selective / 2** ***v42 12.N***	**If the laboratory is testing for Department of Transportation (DOT) regulated industries or federal agency employees, a licensed physician approved as a Medical Review Officer is responsible for receiving and reviewing laboratory results, and evaluating medical explanations for non-negative drug test results.**	**FC, NC, NA**

Guidance & References

- See https://www.transportation.gov/odapc/mro.

		Compliance Rating
LRD.280 **Selective / 2** ***v42 13.B***	**Imaging services provided are appropriate to the needs of patients and support the organization's clinical capabilities.**	**FC, PC, NC**
LRD.280.10	Image interpretation is appropriately documented in a timely manner.	YES, NO
LRD.280.20	Records or reports of services provided are maintained.	YES, NO
LRD.280.30	Observation and interviews indicate that the following are sufficient to ensure the provision of quality services:	YES, NO
LRD.280.30.1	Space.	
LRD.280.30.2	Supplies.	
LRD.280.30.3	Equipment.	

Guidance & References

- Standard applies to organizations that provide imaging services for screening, diagnosing, monitoring, or assisting with procedures.

		Compliance Rating
LRD.290 **Selective / 2** ***v42 13.F***	**Documentation demonstrates that patients are involved in identification of the correct site to be imaged.**	**FC, NC**

Guidance & References

- Standard applies to organizations that provide imaging services for screening, diagnosing, monitoring, or assisting with procedures.

		Compliance Rating
LRD.300 **Selective / 1** ***v42 13.H***	**Diagnostic imaging tests are performed, authenticated, and documented appropriately.**	**FC, PC, NC, NA**
LRD.300.10	Diagnostic imaging tests are performed only upon the order of a health care professional.	YES, NO, NA
LRD.300.20	The order includes the reason for the examination.	YES, NO, NA
LRD.300.30	A radiologist authenticates all examination reports.	YES, NO, NA
LRD.300.40	If a radiologist does not authenticate all examination reports:	YES, NO, NA
LRD.300.40.1	The governing body has determined that specialist physicians or dentists may authenticate reports of specific procedures.	
LRD.300.40.2	Such physicians or dentists have been granted privileges by the governing body or its designee to authenticate these reports.	
LRD.300.50	Authenticated, dated reports of all examinations performed are made a part of the patient's clinical record.	YES, NO, NA

Guidance & References

- NA may be applied if the organization only provides peri-operative imaging services.
- NA will be applicable depending on who authenticates all examination reports.
- Standard maintains applicability if authentication of diagnostic images takes place via telehealth and telemedicine.

		Compliance Rating
LRD.310 **Selective / 1** ***v42 13.I***	**Diagnostic images are accessible and appropriately retained and stored.**	**FC, PC, NC, NA**
LRD.310.10	A policy addresses:	YES, NO, NA
LRD.310.10.1	The storage of diagnostic images.	
LRD.310.10.2	The retention of diagnostic images.	
LRD.310.20	Diagnostic images are maintained in a readily accessible location for the time required by policy and by any applicable laws.	YES, NO, NA

Guidance & References

- NA may be applied if the organization only provides peri-operative imaging services.

MED Medication Management

The Medication Management Category outlines the expectations for management of drugs and biologicals in a safe and effective manner. As a vital part of the continuum of care, Medication Management is a safeguard against errors and aims to prevent patient harm or even death related to non-compliance with prescribed medications or drug interactions. This Category applies to any organization that uses drugs or pharmaceutical medical supplies and samples, regardless of the presence or absence of an onsite pharmacy.

The Standards address oversight, prescription, dispensing, administration, storage, and disposal.

		Compliance Rating
MED.100 **Universal / 2** ***v42 11.D***	**Pharmaceutical services are provided in accordance with standards of care and prevailing laws and regulations.**	**FC, PC, NC**
MED.100.10	If state licensure is required, a current license is posted.	YES, NO, NA
MED.100.20	When controlled substances are present, current DEA certification is maintained onsite and readily retrievable by authorized personnel.	YES, NO, NA
MED.100.30	Through interviews, staff demonstrates knowledge of prevailing pharmaceutical laws and regulations.	YES, NO
MED.100.40	Direct access to current drug information and other decision support resources is available to all relevant staff.	YES, NO

Guidance & References

- Standard maintains applicability if all or part of pharmaceutical services are provided via telehealth or telemedicine.

		Compliance Rating
MED.130 **Selective / 2** ***v42 11.E***	**Pharmaceutical services made available through a contractual agreement are provided in accordance with the same professional practices and legal requirements required if such services were provided directly by the organization.**	**FC, PC, NC**
MED.130.10	A current contract is in place.	YES, NO
MED.130.20	Documentation is present demonstrating that the pharmacy contractor is appropriately licensed and/or certified.	YES, NO

		Compliance Rating
MED.140 **Universal / 2** ***v42 11.F***	**The medication inventory is monitored to track the presence or absence of high-alert medications and medications with confused drug names.**	**FC, PC, NC**
MED.140.10	A written policy describes the monitoring process and responsibility(ies) for its implementation.	YES, NO
MED.140.20	Documentation demonstrates that relevant staff have been trained on the policy.	YES, NO
MED.140.30	Monitoring activities are documented.	YES, NO

		Compliance Rating
MED.150 **Universal / 2** ***v42 11.G***	**Procedures are in place to prevent errors from high-alert medications.**	**FC, PC, NC, NA**
MED.150.10	A list of high-alert medications currently present in the facility is maintained.	YES, NO, NA
MED.150.20	Processes are in place to prevent errors from administration of these medications, in accordance with nationally recognized guidelines.	YES, NO, NA

Guidance & References

- For a list of high-alert medications, see https://www.ismp.org/sites/default/files/attachments/2017-11/highAlert-community.pdf.

		Compliance Rating
MED.160 **Universal / 2** ***v42 11.H***	**Procedures are in place to prevent errors from medications with confused drug names.**	**FC, PC, NC, NA**
MED.160.10	A list of medications with confused drug names currently present in the facility is present.	YES, NO, NA
MED.160.20	Processes are in place to prevent errors from administration of these medications, in accordance with nationally-recognized guidelines.	YES, NO, NA

Guidance & References

- "Confused drug names" refers to drugs that were previously called "look-alike, sound-alike" medications. For a list of such drugs, see https://www.ismp.org/recommendations/confused-drug-names-list.

		Compliance Rating
MED.170 **Universal / 2** ***v42 11.I***	**Drug storage and security, including recordkeeping, are maintained to ensure the control and safe dispensing of drugs (including samples), to minimize medication errors, and to prevent diversion in compliance with prevailing laws and regulations.**	**FC, SC, PC, MC, NC**
MED.170.10	Procedures are in place to ensure that prescription pads, if used, are controlled and secured from unauthorized access.	YES, NO, NA
MED.170.20	Pre-signed and/or post-dated prescriptions are prohibited by written policy.	YES, NO
MED.170.30	Procedures are in place to ensure that electronic prescribing systems, if used, are controlled and secured from unauthorized access.	YES, NO, NA
MED.170.40	Medications are segregated into organized, labeled storage areas designed to minimize drug selection errors.	YES, NO
MED.170.50	If a high-alert medication is present for which there is an antidote, rescue, or reversal agent, the agent is stocked in the same area as the medication along with appropriate directions for use.	YES, NO, NA
MED.170.60	Medications are stored and managed in accordance with manufacturer requirements, and state and/or CDC guidelines.	YES, NO

		Compliance Rating
MED.180 **Universal / 2** ***v42 11.J***	**Interviews with staff, and/or observations of patient interaction, confirm that patients are provided with information concerning the safe and effective use of medications consistent with legal requirements and patient needs.**	**FC, NC**

		Compliance Rating
MED.190 **Universal / 2** ***v42 11.K***	**If not administered immediately, all medications (injectable, oral, etc.) removed from the original container or packaging are labeled in a standard format in accordance with law, regulation and standards of practice.**	**FC, PC, NC, NA**
MED.190.10	A written policy addresses the labeling of such medications.	YES, NO, NA
MED.190.20	At minimum, the policy requires that labels include:	YES, NO, NA
MED.190.20.1	Drug name(s).	
MED.190.20.2	Drug strength(s).	
MED.190.20.3	Amount(s) or volume(s) if not apparent from the container or packaging.	
MED.190.20.4	Expiration date and time.	
MED.190.20.5	Name or initials of person transferring the drug(s).	

Guidance & References

- Immediate administration is when the person who prepares or transfers the drug(s) in a new container completely administers (or directly witnesses the administration of the drug(s) to the patient without any break in the process, and administers some amount of the medication within 4 hour of preparation or transfer.
- “Original container or packaging” includes syringes, basins, bottles, bags, etc.

		Compliance Rating
MED.210 **Universal / 1** ***v42 11.L***	**A written policy is present addressing the disposal or return of expired, damaged, and recalled medications in accordance with prevailing laws and regulations and accepted guidelines.**	**FC, PC, NC**
MED.210.10	A written policy is present.	YES, NO
MED.210.20	The policy requires the monitoring of all medications, including vaccines and samples, for expiration dates on a regular basis.	YES, NO
MED.210.30	The policy requires that expired, damaged and recalled drugs to be removed are segregated from drugs available for active use.	YES, NO
MED.210.40	The policy requires that such drugs are disposed of or returned in a safe manner that prevents unauthorized access and diversion.	YES, NO

		Compliance Rating
MED.220 **Universal / 2** ***v42 11.M***	**Procedures are in place for the maintenance, cleaning, distribution, and use of devices such as nebulizer units, intravenous infusion pumps, or other mechanical device used in the medication delivery process.**	**FC, PC, NC, NA**
MED.220.10	Procedures adhere to manufacturers' instructions.	YES, NO, NA
MED.220.20	Documentation is present to demonstrate that relevant staff has been trained in the procedures.	YES, NO, NA

		Compliance Rating
MED.230 **Universal / 2** ***v42 11.N***	**Nationally recognized guidelines for vaccine storage and handling are followed.**	**FC, SC, PC, MC, NC, NA**
MED.230.10	Nationally recognized guidelines have been adopted by the governing body.	YES, NO, NA
MED.230.20	Written policies and procedures are present for routine storage and handling.	YES, NO, NA
MED.230.30	Written policies and procedures are present for storage, handling and transport in case of emergency (e.g., equipment failure, power outage, natural disasters).	YES, NO, NA
MED.230.40	Documentation demonstrates that staff who receive, handle and/or administer vaccines have been trained on the policies and procedures.	YES, NO, NA
MED.230.50	The vaccine storage unit is equipped with a temperature monitoring device in accordance with the adopted guidelines.	YES, NO, NA
MED.230.60	Staff demonstrate knowledge of procedures to follow if vaccines are exposed to a temperature excursion.	YES, NO, NA

Guidance & References

- For an example, see www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf. This Standard applies to all organizations that store and handle vaccines for administration to patients and/or staff.

MHM Medical Home

The Medical Home Category outlines the expectations for the provision of patient-centered, comprehensive, accessible, continuous, and organized services that seek to meet the needs of individuals, partnering with patients and their families (as appropriate). The services provided are patient-centered, physician, nurse practitioner, or physician assistant-directed (as permitted by state law/regulation), comprehensive, accessible, continuous, and organized to meet the needs of the individual patients served.

The foundation of a Medical Home is the relationship between the patient, their family, as appropriate, and the Medical Home. Within the patient-centered Medical Home, patients are empowered to be responsible for their own health care. As used in these Standards, a Medical Home is the primary point of care for the patient. The Medical Home is assessed from both the organizational structure/systems perspective and from the perspective of the patient on the following Standards. The Standards in this Category are Universal and apply to all Medical Home programs.

The Standards address communication, access, continuity of care, comprehensiveness of care and education.

		Compliance Rating
MHM.100 **Universal / 2** ***v42 25.A***	**The Medical Home establishes relationships with its patients.**	**FC, SC, PC, MC, NC**
MHM.100.10	Patients are provided with information and explanation regarding the Medical Home approach to care.	YES, NO
MHM.100.20	Patients can identify their provider and patient care team members.	YES, NO
MHM.100.30	Patients feel fully empowered to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.	YES, NO
MHM.100.40	The Medical Home provides services within a team framework, and the "team" provider concept has been conveyed to the patient.	YES, NO
MHM.100.50	The patient's family is included, as appropriate, in patient care decisions, treatment, and education.	YES, NO
MHM.100.60	The Medical Home treats its patients with cultural sensitivity.	YES, NO
MHM.100.70	Patients are kept informed regarding delayed appointments.	YES, NO

Guidance & References

- In this context, “provider” refers to the physician or the physician, nurse practitioner, or physician assistant-directed health care team.

		Compliance Rating
MHM.110 **Universal / 2** ***v42 25.B***	**Providers communicate effectively with their patients.**	**FC, SC, PC, MC, NC**
MHM.110.10	The provider knows important facts about the patient's health history.	YES, NO
MHM.110.20	The provider listens carefully to the patient and, when appropriate, the patient's personal caregiver(s).	YES, NO
MHM.110.30	The provider explains information in a way that is easy to understand.	YES, NO
MHM.110.40	The provider spends sufficient time with the patient.	YES, NO
MHM.110.50	The provider is as thorough as the patient feels is needed.	YES, NO
MHM.110.60	The needs of the patient's personal caregiver, when known, are assessed and addressed to the extent that they impact the care of the patient.	YES, NO

Guidance & References

- Surveyors may assess compliance with the elements of this Standard through observation, interviews and/or document reviews.
- Caregivers may include a parent, legal guardian, or person with the patient’s power of attorney.
- “Easy to understand” may vary based on language preferences and literacy levels of the population served.

		Compliance Rating
MHM.120 **Universal / 2** ***v42 25.C***	**Providers and patients discuss the patient's health problems and concerns.**	**FC, PC, NC**
MHM.120.10	The provider addresses specific principles to prevent illness.	YES, NO
MHM.120.20	The provider assesses risk factors and speaks with the patient about making lifestyle changes to help prevent illness, if warranted.	YES, NO
MHM.120.30	The provider asks about the patient's concerns/worries/stressors.	YES, NO
MHM.120.40	The provider asks about the patient's mental health status (e.g., sad, empty, or depressed).	YES, NO

Guidance & References

- Surveyors may assess compliance with the elements of this Standard through observation, interviews and/or document reviews.

		Compliance Rating
MHM.130 **Universal / 1** ***v42 25.D***	**Written policies supporting patient access are present.**	**FC, SC, PC, MC, NC**
MHM.130.10	The policies address provider availability.	YES, NO
MHM.130.20	The policies address treatment plan information.	YES, NO
MHM.130.30	The policies address clinical record contents.	YES, NO
MHM.130.40	The policies address advice.	YES, NO
MHM.130.50	The policies address routine care.	YES, NO
MHM.130.60	The policies address urgent care.	YES, NO
MHM.130.70	Data is present to demonstrate that the Medical Home meets its access policies or, if not, is actively taking steps to meet them.	YES, NO

Guidance & References

- If all or part of medical/dental home services are provided via telehealth and telemedicine, this Standard maintains applicability to those services.

		Compliance Rating
MHM.140 **Universal / 2** ***v42 25.E***	**Patients are provided with information regarding how to obtain medical care at any time, 24 hours per day, every day of the year.**	**FC, PC, NC**
MHM.140.10	Documentation demonstrates that patients are provided with information regarding access to care.	YES, NO
MHM.140.20	There is evidence that patients are routinely and continuously assessed for their perceptions regarding access to the Medical Home (provider availability, treatment plan information, clinical record contents, advice, routine care, and urgent care).	YES, NO
MHM.140.30	There is evidence that the Medical Home ensures on-call coverage (pre-arranged access to a clinician) when the Medical Home is not open.	YES, NO

Guidance & References

- If all or part of medical/dental home services on-call coverage is provided via telehealth and telemedicine, this Standard maintains applicability to those services.

		Compliance Rating
MHM.150 **Universal / 1** ***v42 25.F***	**The Medical Home provides comprehensive care.**	**FC, SC, PC, MC, NC**
MHM.150.10	If the Medical Home limits the population served, there is evidence that those limitations are disclosed to prospective patients.	YES, NO, NA
MHM.150.20	The scope of service includes preventive care.	YES, NO
MHM.150.30	The scope of services includes wellness care.	YES, NO
MHM.150.40	The scope of service includes health risk appraisal and assessment, including discussions with the patient.	YES, NO
MHM.150.50	The scope of service includes acute illness and injury care.	YES, NO
MHM.150.60	The scope of service includes chronic illness management.	YES, NO
MHM.150.70	The scope of service includes counseling regarding end-of-life or palliative care, as appropriate.	YES, NO

Guidance & References

- Preventive care includes surveillance, anticipatory medical and oral health guidance, and age-appropriate screening including well baby care.
- Wellness care refers to health lifestyle issues, such as appropriate sleep, stress relief, weight management, healthy diet, oral care, and others as appropriate.

		Compliance Rating
MHM.160 **Universal / 1** ***v42 25.G***	**The Medical Home provides patient education and self-management resources.**	**FC, PC, NC**
MHM.160.10	Patient education literature is provided in appropriate languages and literacy levels.	YES, NO
MHM.160.20	There is evidence that the Medical Home has knowledge of community resources that support the patient's (and as appropriate, the family's) needs.	YES, NO
MHM.160.30	There is evidence that the community's service limitations are known and alternate sources are coordinated by the Medical Home.	YES, NO

		Compliance Rating
MHM.170 **Universal / 2** ***v42 25.H***	**The Medical Home ensures continuity of care for its patients.**	**FC, SC, PC, MC, NC**
MHM.170.10	More than 50% of the Medical Home visits of any patient are with the same physician/physician team.	YES, NO
MHM.170.20	Referrals are disease- or procedure-specific, as appropriate to the patient's needs.	YES, NO
MHM.170.30	There is evidence that, when referrals occur, the Medical Home collaborates with the specialist.	YES, NO
MHM.170.40	Tracking and follow-up procedures for referrals, consultations, diagnostic studies and missed appointments are followed, as evidenced in tracking logs, policies, clinical records and/or other written formats.	YES, NO
MHM.170.50	There is evidence that transitions of care (e.g., pediatric to adult or adult to geriatric) are proactively planned, coordinated, and documented in the clinical record when appropriate.	YES, NO

		Compliance Rating
MHM.180 **Universal / 2** ***v42 25.J***	**The Medical Home provides high-quality patient care.**	**FC, SC, PC, MC, NC**
MHM.180.10	A physician, nurse practitioner, or physician assistant directs patient care.	YES, NO
MHM.180.20	Clinical record documentation consistently includes appropriate and timely diagnosis based on findings of the current history and physical examination.	YES, NO
MHM.180.30	Clinical record documentation consistently includes medication reconciliation and if indicated, use of recreational drugs and substances.	YES, NO
MHM.180.40	Clinical record documentation consistently demonstrates appropriate ordering of diagnostic tests.	YES, NO
MHM.180.50	Clinical record documentation consistently demonstrates the absence of clinically unnecessary diagnostic or therapeutic procedures.	YES, NO
MHM.180.60	Clinical record documentation consistently demonstrates appropriate utilization of consultations and referrals.	YES, NO

DHM Dental Home

The Dental Home Category outlines the expectations for the provision of patient-centered, comprehensive, accessible, continuous, and organized services that seek to meet the dental needs of individuals, partnering with patients and their families (as appropriate).

The services provided by a Dental Home are patient centered, dentist directed, comprehensive, accessible, continuous, and organized to meet the needs of the individual patient served. The Dental Home emphasizes wellness through improved oral health status, collaboration among health care providers and health promotion. The foundation of a Dental Home is the relationship between the patient, their family (as appropriate), and the Dental Home. A Dental Home is the primary point of care for the patient. Standards in this Category are Universal and apply to all Dental Home programs.

The Standards address communication, access, continuity of care, comprehensiveness of care and education.

		Compliance Rating
DHM.100 **Universal / 2** ***v42 14.II.A***	**The Dental Home establishes relationships with its patients.**	**FC, SC, PC, MC, NC**
DHM.100.10	Patients can identify their dentist and patient care team members.	YES, NO
DHM.100.20	The Dental Home provides services within a team framework, and the "team provider" concept has been conveyed to the patient.	YES, NO
DHM.100.30	The patient's family is included, as appropriate, in patient care decisions, treatment, and education.	YES, NO
DHM.100.40	The Dental Home treats its patients with cultural sensitivity.	YES, NO
DHM.100.50	Patients are kept informed regarding delayed appointments.	YES, NO

Guidance & References

- In this context, “dentist” refers to the dentist or the physician- or dentist-directed health care team.

		Compliance Rating
DHM.110 **Universal / 2** ***v42 14.II.B***	**Dentists communicate effectively with their patients.**	**FC, SC, PC, MC, NC**
DHM.110.10	The dentist knows important facts about the patient's health history.	YES, NO
DHM.110.20	The dentist listens carefully to the patient and, when appropriate, the patient's personal caregiver(s).	YES, NO
DHM.110.30	The dentist explains information in a way that is easy to understand.	YES, NO
DHM.110.40	The dentist spends sufficient time with the patient.	YES, NO
DHM.110.50	The dentist is as thorough as the patient feels is needed.	YES, NO
DHM.110.60	The needs of the patient's personal caregiver, when known, are assessed and addressed to the extent that they impact the care of the patient.	YES, NO

Guidance & References

- “Easy to understand” may vary based on language preferences and literacy levels of the population served.
- Caregivers may include a parent, legal guardian, or person with the patient’s power of attorney.

		Compliance Rating
DHM.120 **Universal / 2** ***v42 14.II.C***	**Dentists and patients discuss the patient's health problems and concerns.**	**FC, PC, NC**
DHM.120.10	The dentist addresses specific principles to prevent dental-related diseases.	YES, NO
DHM.120.20	The dentist assesses risk factors and speaks with the patient about making lifestyle changes to help prevent dental-related disease, if warranted.	YES, NO
DHM.120.30	The dentist inquires about the patient's concerns/worries/stressors regarding his/her dental health.	YES, NO

		Compliance Rating
DHM.130 **Universal / 1** ***v42 14.II.D***	**Written policies supporting patient access are present.**	**FC, SC, PC, MC, NC**
DHM.130.10	The policies address provider availability.	YES, NO
DHM.130.20	The policies address treatment plan information.	YES, NO
DHM.130.30	The policies address clinical record contents.	YES, NO
DHM.130.40	The policies address advice.	YES, NO
DHM.130.50	The policies address routine care.	YES, NO
DHM.130.60	The policies address urgent care.	YES, NO
DHM.130.70	Data is present to demonstrate that the Dental Home meets its access policies or, if not, is actively taking steps to meet them.	YES, NO

Guidance & References

- If all or part of medical/dental home services are provided via telehealth and telemedicine, this Standard maintains applicability to those services.

		Compliance Rating
DHM.140 **Universal / 1** ***v42 14.II.E***	**Patients are provided with information regarding how to obtain dental care at any time, 24 hours per day, every day of the year.**	**FC, PC, NC**
DHM.140.10	Documentation demonstrates that patients are provided with information regarding access to care.	YES, NO
DHM.140.20	There is evidence that patients are routinely and continuously assessed for their perceptions regarding access to the Dental Home (provider availability, treatment plan information, clinical record contents, advice, routine care, and urgent care).	YES, NO
DHM.140.30	There is evidence that the Dental Home ensures on-call coverage (pre-arranged access to a clinician) when the Dental Home is not open.	YES, NO

Guidance & References

- If all or part of medical/dental home services on-call coverage is provided via telehealth and telemedicine, this Standard maintains applicability to those services.

		Compliance Rating
DHM.150 **Universal / 1** ***v42 14.II.F***	**The Dental Home provides comprehensive care.**	**FC, SC, PC, MC, NC**
DHM.150.10	If the Dental Home limits the population served, there is evidence that those limitations are disclosed to prospective patients.	YES, NO
DHM.150.20	The scope of service includes preventive care.	YES, NO
DHM.150.30	The scope of service includes wellness care.	YES, NO
DHM.150.40	The scope of service includes acute pain and injury care.	YES, NO
DHM.150.50	The scope of service includes chronic disease management.	YES, NO
DHM.150.60	The scope of service includes advanced geriatric care.	YES, NO

Guidance & References

- Preventive care includes surveillance and screening for special needs or assessment.
- Wellness care refers to healthy lifestyle issues such as appropriate diet, tobacco cessation, home care.

		Compliance Rating
DHM.160 **Universal / 1** ***v42 14.II.G***	**The Dental Home provides patient education and self-management resources.**	**FC, PC, NC**
DHM.160.10	Patient education literature is provided in appropriate languages and literacy levels.	YES, NO
DHM.160.20	There is evidence that the Dental Home has knowledge of community resources that support the patient's (and as appropriate, the family's) needs.	YES, NO
DHM.160.30	There is evidence that the community's service limitations are known and alternate sources are coordinated by the Dental Home.	YES, NO

		Compliance Rating
DHM.170 **Universal / 2** ***v42 14.II.H***	**The Dental Home ensures continuity of care for its patients.**	**FC, SC, PC, MC, NC**
DHM.170.10	More than 50% of the Dental Home visits of any patient are with the same dentist/dental care team.	YES, NO
DHM.170.20	Referrals are appropriate to the patient's needs.	YES, NO
DHM.170.30	There is evidence that, when referrals occur, the Dental Home collaborates with the specialist.	YES, NO
DHM.170.40	Tracking and follow-up procedures for referrals, consultations, diagnostic studies and missed appointments are followed, as evidenced in tracking logs, policies, clinical records and/or other written formats.	YES, NO
DHM.170.50	There is evidence that transitions of care (e.g., pediatric to adult or adult to geriatric) are proactively planned, coordinated, and documented in the clinical record when appropriate.	YES, NO

		Compliance Rating
DHM.180 **Universal / 2** ***v42 14.II.J***	**The Dental Home provides high-quality supervision of patient care.**	**FC, SC, PC, MC, NC**
DHM.180.10	Patient care is dentist-directed.	YES, NO
DHM.180.20	Dental record documentation consistently demonstrates appropriate ordering of diagnostic radiographs (avoidance of redundancies and unnecessary exposure).	YES, NO
DHM.180.30	Dental record documentation consistently demonstrates appropriate management of patient referrals (avoidance of unnecessary referrals).	YES, NO

OCS Other Clinical Services

The Other Clinical Services Category outlines the expectations for additional clinical activities that support patient care needs. The Standards address radiology, travel medicine, occupational health, urgent care and emergency medicine.

		Compliance Rating
OCS.100 **Universal / 1** ***v42 14.I.E***	**An appropriate history and physical of the patient is conducted.**	**FC, PC, NC**
OCS.100.10	The history and physical includes an assessment of the hard and soft tissues of the mouth.	YES, NO
OCS.100.20	The history and physical is updated at each visit.	YES, NO

Guidance & References

- Standard maintains applicability if all or part of the history and physical is conducted via telehealth and telemedicine.

		Compliance Rating
OCS.110 **Selective / 1** ***v42 14.I.G***	**Guidelines for diagnostic radiographs are present.**	**FC, PC, NC**
OCS.110.10	Guidelines for diagnostic radiographs are present.	YES, NO
OCS.110.20	At minimum, the guidelines address:	YES, NO
OCS.110.20.1	Types of diagnostic radiographs.	
OCS.110.20.2	Frequency of use.	
OCS.110.20.3	Indications for use.	

		Compliance Rating
OCS.120 **Selective / 2** ***v42 14.I.H***	**Written policies and procedures for dental services are present.**	**FC, PC, NC**
OCS.120.10	Written policies and procedures are present.	YES, NO
OCS.120.20	Policies and procedures address the identification, treatment and management of pain.	YES, NO
OCS.120.30	Policies and procedures address the evaluation of dental laboratories to ensure appropriate support of the organization's clinical capabilities.	YES, NO
OCS.120.40	Policies and procedures address staffing requirements to ensure that personnel assisting in the provision of dental services are available in sufficient numbers for the dental procedures provided.	YES, NO

		Compliance Rating
OCS.130 **Selective / 2** ***v42 14.I.F***	**Prior to a dental procedure, the operative tooth is marked on a radiograph or dental diagram.**	**FC, PC, NC**
OCS.130.10	A written site marking policy is present.	YES, NO
OCS.130.20	The patient or their authorized representative is involved in the site marking process.	YES, NO
OCS.130.30	Clinical records contain documentation of site marking.	YES, NO

		Compliance Rating
OCS.140 **Selective / 2** ***v42 15.B***	**The travel medicine program provides current, quality service.**	**FC, PC, NC**
OCS.140.10	Appropriate medical oversight is in place.	YES, NO
OCS.140.20	There are clearly defined standing orders and protocols, including management of adverse reactions to immunizations.	YES, NO
OCS.140.30	Access to current Centers for Disease Control (CDC) and U.S. Department of State travel recommendations is provided.	YES, NO

		Compliance Rating
OCS.150 **Selective / 2** ***v42 15.C***	**Travel medicine services are destination-specific.**	**FC, PC, NC**
OCS.150.10	Comprehensive, destination-specific risk assessments are conducted and documented.	YES, NO
OCS.150.20	Preventive medicine interventions are appropriate to mitigate risks posed by the destination.	YES, NO
OCS.150.30	Education regarding risks and risk reduction is provided and documented in the clinical record.	YES, NO

Guidance & References

- If all or part of the travel medicine risk assessment and education occurs via telehealth and telemedicine service, appropriate documentation is present.

		Compliance Rating
OCS.160 **Selective / 1** ***v42 21.A***	**Occupational health services are accurately portrayed to patients, employees, and purchasers of the services.**	**FC, NC**

Guidance & References

- Occupational medicine is a specialty devoted to the prevention and management of occupational and environmental injury, illness, and disability, and promotion of the health and productivity of workers, their families, and communities.
- Standards within the SAF category are used to survey organizations that provide basic employee health services to their own employees.

		Compliance Rating
OCS.170 **Selective / 2** ***v42 21.E***	**If the organization provides care for individuals under worker compensation insurance programs, specific requirements are met.**	**FC, PC, NC, NA**
OCS.170.10	Patients are informed of their rights under the worker compensation insurance program.	YES, NO, NA
OCS.170.20	The organization and its providers comply with participation requirements such as use of guidelines, education, etc.	YES, NO, NA
OCS.170.30	Patients have care plans that address functional recovery and work limits.	YES, NO, NA
OCS.170.40	Individuals whose recovery is delayed are identified and barriers to recovery are addressed.	YES, NO, NA

		Compliance Rating
OCS.180 **Selective / 2** ***v42 21.F***	**If the organization provides examinations used for work placement, specific factors are assessed.**	**FC, PC, NC, NA**
OCS.180.10	Current ability to perform the job is assessed.	YES, NO, NA
OCS.180.20	Past and current job demands are assessed.	YES, NO, NA
OCS.180.30	For return to work or fitness exams, the assessment includes how recent medical conditions have affected the individual's ability to safely perform their job.	YES, NO, NA

Guidance & References

- Examples include placement, transfer, return to work, fitness for duty.
- This Standard maintains applicability if all or part of the return to work or fitness exam is conducted by telehealth/telemedicine.

		Compliance Rating
OCS.190 **Selective / 2** ***v42 21.G***	**If the organization provides medical surveillance evaluations, specific requirements are met.**	**FC, PC, NC, NA**
OCS.190.10	The health care professional providing the service can describe the hazardous agent, its health effects, and monitoring requirements.	YES, NO, NA
OCS.190.20	The examinee is informed of the results of the evaluation, their relationship to the exposure, and any recommendations.	YES, NO, NA
OCS.190.30	The organization meets all regulatory requirements to perform the exam.	YES, NO, NA

Guidance & References

- These evaluations are intended to identify individuals at high risk for medical problems from workplace exposure; they may be required through OSHA standards or by an employer.

		Compliance Rating
OCS.200 **Selective / 2** ***v42 21.H***	**If the organization provides certification examinations mandated under regulations or company policy, specific requirements are met.**	**FC, PC, NC, NA**
OCS.200.10	The health care professional performing the examination has a copy of the regulation or company policy governing the program.	YES, NO, NA
OCS.200.20	The health care professional can describe requirements of the job or work activity.	YES, NO, NA
OCS.200.30	There is evidence of compliance with regulatory or company requirements governing the exam.	YES, NO, NA

Guidance & References

- This includes a variety of examinations, such as truck driver assessments under FMCSA, crane operators and respirator clearance exams.

		Compliance Rating
OCS.210 **Selective / 2** ***v42 21.I***	**If the organization provides occupational health testing and ancillary service programs, these programs follow standards of care and are administered under written protocols.**	**FC, PC, NC, NA**
OCS.210.10	Written protocols address how the service is to be performed, e.g., specimen collection, handling transportation, and receipt and report of results.	YES, NO, NA
OCS.210.20	Written protocols address appropriate record retention and management.	YES, NO, NA
OCS.210.30	Written protocols address required equipment, calibration and maintenance.	YES, NO, NA
OCS.210.40	Records and practices are current.	YES, NO, NA

Guidance & References

- Examples of such programs include urine collection for drugs of abuse, breath alcohol content testing, blood lead determinations, audiograms and chest x-rays.

		Compliance Rating
OCS.220 **Selective / 2** ***v42 23.G***	**A written policy requires the presence of at least one qualified physician at all times.**	**FC, NC**

		Compliance Rating
OCS.230 **Selective / 2** ***v42 23.H***	**Unless otherwise provided for by the governing body in writing, equipment, drugs, and other agents recommended by the Emergency Department Planning and Resource Guidelines of the American College of Emergency Physicians are available.**	**FC, NC**

		Compliance Rating
OCS.240 **Selective / 2** ***v42 23.I***	**Appropriate clinical and other support is available for emergency services.**	**FC, SC, PC, MC, NC**
OCS.240.10	Adequate specialty consultation services are immediately available, as demonstrated by a list of on-call physicians to provide further evaluation and/or treatment.	YES, NO
OCS.240.20	Laboratory and imaging services, as described in Laboratory and Radiology Standards, are immediately available.	YES, NO
OCS.240.30	Emergency power is available when needed.	YES, NO
OCS.240.40	Documentation is present demonstrating that communications are maintained with local police departments, fire departments, ambulance services, poison control centers, and hospitals as needed to address medical emergencies.	YES, NO
OCS.240.50	A written policy requires that, when patients are transferred to a higher level of care, qualified personnel and transportation equipment conduct the transfer.	YES, NO

Guidance & References

- Examples of such programs include urine collection for drugs of abuse, breath alcohol content testing, blood lead determinations, audiograms and chest x-rays.
- This Standard maintains applicability if specialty consultation services are provided by telehealth/telemedicine.

		Compliance Rating
OCS.250 **Selective / 1** ***v42 24.E***	**Comprehensive radiation oncology services are provided.**	**FC, PC, NC**
OCS.250.10	The following services are provided:	YES, NO
OCS.250.10.1	Consultation services.	
OCS.250.10.2	Simulation of treatment.	
OCS.250.10.3	Treatment planning.	
OCS.250.10.4	Clinical treatment management including, but not limited to, the use of teletherapy and/or brachytherapy.	
OCS.250.10.5	Maintenance of reports of services and radiographic images appropriate to the therapy, as required by applicable laws and organization policy.	
OCS.250.10.6	Appropriate follow-up care of all patients.	
OCS.250.20	Support services, including diagnostic laboratories and imaging facilities, are accessible as needed.	YES, NO

QUA Quality

The Quality Category outlines the expectations for organizations to improve the quality of care, while promoting effective and efficient use of facilities and services. In striving to improve clinical quality outcomes, promote effective care delivery, and provide efficient utilization of health care services, organizations maintain a multidimensional, multidisciplinary quality management and improvement program based on comprehensive data analysis of clinical needs, risk levels, and opportunities for interventions and improvements. Quality management and improvement in an organization accounts for all stakeholders and intersects clinical and service performance indicators with risk management in an organized, systematic manner.

Quality improvement activities include an active and organized process for peer review that is integrated into the quality management program. Organizations may determine which health care professionals can peer review each other, within the following guidelines: 1) differently licensed practitioners reviewing each other must be privileged to provide similar services to similar patients; and 2) prevailing laws must permit peer review by differently licensed practitioners.

The Standards address a quality management and improvement program that links peer review, quality improvement activities, infection prevention and control, safety, and risk management in an organized, systematic way.

		Compliance Rating
QUA.100 **Universal / 2** ***v42 4.B***	**Health care professionals practice their professions in accordance with standards of care and prevailing laws and regulations.**	**FC, NC**

Guidance & References

- If telehealth and telemedicine services are offered, services are provided in accordance with prevailing laws and regulations, including laws regarding practice of telehealth and telemedicine services across state lines.

		Compliance Rating
QUA.110 **Universal / 2** ***v42 2.III.A***	**Each physician, dentist or health care professional is reviewed by at least one similarly-privileged and/or similarly-licensed peer.**	**FC, NC**

		Compliance Rating
QUA.120 **Selective / 2** ***v42 2.III.B***	**In organizations with solo practitioners, an outside peer provides peer review.**	**FC, NC**

		Compliance Rating
QUA.130 **Universal / 1** ***v42 2.III.C***	**Privileged health care professionals participate in the development and application of peer review criteria.**	**FC, SC, PC, MC, NC**
QUA.130.10	Privileged health care professionals participate in the development and application of the peer review criteria used to evaluate the care they provide.	YES, NO
QUA.130.20	Clinical care is selected for review on an ongoing basis.	YES, NO
QUA.130.30	The selection process for care to be reviewed applies to all similarly privileged health care professionals.	YES, NO
QUA.130.40	All clinical incidents are reviewed in accordance with the organization's peer review policies and procedures.	YES, NO
QUA.130.50	All privileged health care professionals are reviewed at least annually by a peer or supervising health care professional.	YES, NO

Guidance & References

- Examples of peer review criteria include but are not limited to: date of care; compliance with disease management guidelines; following treatment protocols; complications during surgery; post-operative infections; and wrong-site surgery. Refer to glossary for definition of “incident”.

		Compliance Rating
QUA.140 **Universal / 2** ***v42 2.III.D***	**Ongoing monitoring of important aspects of the care provided by physicians, dentists, and other health care professionals is conducted.**	**FC, PC, NC**
QUA.140.10	Data are collected in an ongoing manner.	YES, NO
QUA.140.20	The data are periodically evaluated to identify trends or occurrences that affect patient outcomes.	YES, NO
QUA.140.30	The data are used to establish internal benchmarks against which performance is compared to identify areas in which improvement is needed.	YES, NO

		Compliance Rating
QUA.150 **Universal / 1** ***v42 2.III.E***	**The results of peer review activities are reported to the governing body.**	**FC, NC**

		Compliance Rating
QUA.160 **Universal / 2** ***v42 2.III.F***	**The results of peer review are used as part of the process for granting continuation of clinical privileges.**	**FC, NC**

		Compliance Rating
QUA.170 **Universal / 1** ***v42 2.III.G***	**Ongoing professional development and the improvement of staff performance are supported.**	**FC, PC, NC**
QUA.170.10	Convenient access to reliable, up-to-date information pertinent to the organization's clinical, educational, administrative, and research services is provided.	YES, NO
QUA.170.20	As demonstrated in the organization's policies or procedures, health care professionals are encouraged to participate in internal or external educational programs and activities, consistent with the organization's mission, goals, and objectives.	YES, NO

		Compliance Rating
QUA.180 **Universal / 1** ***v42 3.F***	**Patient satisfaction with services and facilities provided is periodically assessed.**	**FC, PC, NC**
QUA.180.10	Patient satisfaction is assessed on an ongoing basis.	YES, NO
QUA.180.20	Patient satisfaction assessment results are analyzed on an ongoing basis.	YES, NO
QUA.180.30	The governing body reviews the patient satisfaction assessment results.	YES, NO
QUA.180.40	Corrective actions are taken as needed.	YES, NO

		Compliance Rating
QUA.230 **Universal / 2** ***v42 5.I.A***	**The organization has a written quality improvement program.**	**FC, SC, PC, MC, NC**
QUA.230.10	The program addresses the full scope of the organization's health care delivery services and describes how these services are assessed for quality.	YES, NO
QUA.230.20	The specific committee(s) or individual(s) responsible for development, implementation, and oversight of the program are identified.	YES, NO
QUA.230.30	The program includes participation by health care professionals, one or more of whom is a physician or dentist.	YES, NO
QUA.230.40	The purpose of the program and specific objectives to be achieved are identified.	YES, NO
QUA.230.50	The program describes the ongoing data collection processes used to measure quality and identify quality-related problems or concerns.	YES, NO
QUA.230.60	The program describes how the organization integrates quality improvement activities, peer review, and the risk management and infection prevention and control programs.	YES, NO
QUA.230.70	The program is evaluated at least annually for effectiveness and to determine if the program's purposes and objectives continue to be met.	YES, NO

Guidance & References

- “Full scope” includes clinical, administrative, and cost-of-care performance issues, as well as actual patient outcomes, i.e., results of care, including safety of patients.
- In organizations where a physician or a dentist is not on the provider staff, and the organization is therefore led by an advanced practice registered nurse or a physician assistant, or in a behavioral health setting led by a licensed clinical behavioral health professional, one or more of such similarly-licensed health care providers is a participant.
- Refer to the Standard for ongoing data collection processes for information on the requirements for measuring quality and identifying concerns.
- If telehealth and telemedicine services are offered, they are included in the program’s overall assessment for quality (e.g., telemedicine visits are included as part of a review of clinical visits in quality improvement activities).
- Standard maintains applicability to organizations providing telehealth/telemedicine.

		Compliance Rating
QUA.240 **Universal / 1** ***v42 5.I.B***	**The quality improvement program includes processes to ensure communication of the results of quality improvement activities.**	**FC, PC, NC**
QUA.240.10	The program includes processes to ensure that the results of quality improvement activities are reported to the governing body.	YES, NO
QUA.240.20	The program includes processes to ensure that the results of quality improvement activities are reported throughout the organization, as appropriate.	YES, NO
QUA.240.30	The program includes processes to ensure that the results of the annual program evaluation are reported to the governing body.	YES, NO
QUA.240.40	The program includes processes to ensure that the results of the annual program evaluation are reported throughout the organization, as appropriate.	YES, NO

		Compliance Rating
QUA.250 **Universal / 2** ***v42 5.I.C***	**Ongoing data collection processes are in place to measure quality and to identify quality-related problems or concerns.**	**FC, SC, PC, MC, NC**
QUA.250.10	Processes include analysis of the results of peer review activities.	YES, NO
QUA.250.20	Periodic audits of critical processes are conducted, as appropriate for the services provided. (Refer to Glossary for "audit" definition.)	YES, NO
QUA.250.30	Ongoing monitoring of important processes and outcomes of care is conducted, as appropriate for the services provided. (Refer to Glossary for “quality monitoring” definition.)	YES, NO
QUA.250.40	The organization's performance is compared to internal and external benchmarks.	YES, NO
QUA.250.50	Processes include methods to systematically collect information from other pertinent sources.	YES, NO
QUA.250.60	The information and data obtained through the data collection processes is evaluated on an ongoing basis to identify the existence of unacceptable variation or results that require improvement.	YES, NO

Guidance & References

- Examples of other pertinent sources include, but are not limited to, patient satisfaction surveys, financial data, medical/legal issues, and outcomes data.

		Compliance Rating
QUA.270 **Universal / 2** ***v42 5.I.D***	**The organization demonstrates that continuous improvement is occurring by conducting quality improvement studies when the data collection processes indicate that improvement is or may be warranted.**	**FC, PC, NC**
QUA.270.10	As evidenced by documentation of quality improvement studies conducted, the studies include the applicable components of the quality improvement process.	YES, NO
QUA.270.20	At least one current quality improvement study demonstrates that improvement occurred and has been sustained.	YES, NO
QUA.270.30	As documented in committee and/or staff meeting minutes, and/or in records of educational activities, the findings of quality improvement activities are communicated:	YES, NO
QUA.270.30.1	To the governing body.	
QUA.270.30.2	Throughout the organization, as appropriate.	

Guidance & References

- Refer to the *1095 Engage* portal and the AAAHC website for additional resources such as meaningful QI studies, evidence-based tools, and focused educational opportunities to support your QI journey.
- "Current" is defined as within the current accreditation/certification term, or within the last twelve months for initial surveys.
- Refer to the Standard for ongoing data collection processes for information on the requirements for measuring quality and identifying concerns.

		Compliance Rating
QUA.300 **Universal / 2** ***v42 5.I.E***	**The organization participates in external benchmarking activities that compare key performance measures with other similar organizations, with recognized best practices, and/or with national or professional targets or goals.**	**FC, SC, PC, MC, NC**
QUA.300.10	External benchmarking activities include the selection and use of performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served.	YES, NO
QUA.300.20	External benchmarking activities include collecting and analyzing data related to the selected performance measures on an ongoing basis.	YES, NO
QUA.300.30	External benchmarking activities include comparing internal performance to external benchmarks that are based on valid and reliable local, state, national, or published data.	YES, NO
QUA.300.40	External benchmarking activities include tracking changes in the organization's performance on the selected performance measures.	YES, NO
QUA.300.50	The results of benchmarking activities are incorporated into other quality improvement activities of the organization.	YES, NO
QUA.300.60	As documented in meeting minutes and/or records of educational activities, the results of benchmarking activities are reported:	YES, NO
QUA.300.60.1	To the governing body.	
QUA.300.60.2	Throughout the organization, as appropriate.	

		Compliance Rating
QUA.310 **Universal / 2** ***v42 14.II.K/25.K***	**Evidence-based guidelines and performance measures are employed.**	**FC, PC, NC**
QUA.310.10	Guidelines and measures are incorporated into the delivery of clinical services.	YES, NO
QUA.310.20	Guidelines and measures are periodically assessed to ensure they are current.	YES, NO
QUA.310.30	Guidelines and measures are periodically assessed to ascertain whether they are used effectively and appropriately, as evidenced in the peer review process.	YES, NO

Guidance & References

- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
QUA.320 **Universal / 1** ***v42 14.II.L***	**The quality improvement program includes activities focused on improving Dental Home services.**	**FC, PC, NC**
QUA.320.10	Clinical performance measures relevant to the Dental Home are employed.	YES, NO
QUA.320.20	Quality improvement studies are conducted.	YES, NO
QUA.320.30	Trending of Dental Home-related data is performed.	YES, NO
QUA.320.40	Dental Home services are benchmarked.	YES, NO

Guidance & References

- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
QUA.330 **Universal / 1** ***v42 14.II.M***	**Key characteristics of the Dental Home are included in quality improvement studies at least once every three years.**	**FC, SC, PC, MC, NC**
QUA.330.10	A quality improvement study understanding and collaboration between the patient/provider.	YES, NO
QUA.330.20	A quality improvement study addresses accessibility of care.	YES, NO
QUA.330.30	A quality improvement study addresses comprehensiveness of care.	YES, NO
QUA.330.40	A quality improvement study addresses continuity of care.	YES, NO
QUA.330.50	A quality improvement study addresses a clinical topic related to quality of care.	YES, NO

Guidance & References

- A single quality improvement study may address more than one of the five topic areas.
- Understanding and collaboration refers to studies assessing provider, medical/dental home team, and patient understanding of the patient-centered medical/dental home concepts, and/or collaborative care between the provider, medical/dental home team, and patient/family.
- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
QUA.340 **Selective / 1** ***v42 16.B***	**Health education and health promotion programs are evaluated for effectiveness and patient satisfaction.**	**FC, SC, PC, MC, NC**
QUA.340.10	Health education and health promotion programs offered have clearly defined educational goals and objectives.	YES, NO
QUA.340.20	There is evidence that health education and health promotion programs are evaluated to determine whether the goals or objectives are being met.	YES, NO
QUA.340.30	There is evidence that patient satisfaction with health education and health promotion services is assessed.	YES, NO

Guidance & References

- Standard maintains applicability to health education and health promotion programs provided by telehealth.

		Compliance Rating
QUA.350 **Selective / 1** ***v42 20.I***	**There is evidence that overnight care and services are reviewed as part of the organization's quality management and improvement program.**	**FC, NC**

Guidance & References

- Standard applies to an ASC that may in a rare circumstance provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, may be receiving treatment for non-critical illnesses, or may need only short-term or custodial care.

		Compliance Rating
QUA.360 **Universal / 1** ***v42 25.L***	**The quality improvement program includes activities focused on improving Medical Home services.**	**FC, PC, NC**
QUA.360.10	Clinical performance measures relevant to the Medical Home are employed.	YES, NO
QUA.360.20	Quality improvement studies are conducted.	YES, NO
QUA.360.30	Trending of Medical Home-related data is performed.	YES, NO
QUA.360.40	Medical Home services are benchmarked.	YES, NO

Guidance & References

- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
QUA.370 **Universal / 1** ***v42 25.M***	**Key characteristics of the Medical Home are included in quality improvement studies at least once every three years.**	**FC, SC, PC, MC, NC**
QUA.370.10	A quality improvement study understanding and collaboration between the patient/provider.	YES, NO
QUA.370.20	A quality improvement study addresses accessibility of care.	YES, NO
QUA.370.30	A quality improvement study addresses comprehensiveness of care.	YES, NO
QUA.370.40	A quality improvement study addresses continuity of care.	YES, NO
QUA.370.50	A quality improvement study addresses a clinical topic related to quality of care.	YES, NO

Guidance & References

- A single quality improvement study may address more than one of the five topic areas.
- Understanding and collaboration refers to studies assessing provider, medical/dental home team, and patient understanding of the patient-centered medical/dental home concepts, and/or collaborative care between the provider, medical/dental home team, and patient/family.
- This Standard is Universal in the Medical and/or Dental Home Programs.

		Compliance Rating
QUA.380 **Selective / 2** ***v42 REG***	**Health education and health promotion programs are evaluated for effectiveness and patient satisfaction.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.390 **Selective / 2** ***v42 REG***	**The Florida office surgery facility or surgical center quality assurance program shall be based on the following [64B8-9.0092(4)(a)(1)(a)]:** • **The mission and plans of the organization,** • **The needs and expectations of the patients and staff,** • **Up-to-date sources of information,** • **Performance of the processes and their outcomes.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.400 **Selective / 2** ***v42 REG***	**Each system for quality assurance, which shall include utilization review, must be defined in writing, approved by the accrediting agencies governing body, enforced, and shall include [64B8-9.0092(4)(a)(1)(b)]:** • **A written delineation of responsibilities for key staff,** • **A policy for all members of the organized medical staff, whereby staff members do not initially review their own cases for quality assessment and improvement program purposes,** • **A confidentiality policy that complies with all applicable federal and state confidentiality laws,** • **Written, measurable criteria and norms,** • **A description of the methods used for: identifying problems; assessing problems; determining the priorities for investigation; resolving problems,** • **A description of the methods for monitoring activities to assure that the desired results are achieved and sustained,** • **Documentation of the activities and results of the program.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.410 **Selective / 2** ***v42 REG***	**Each quality assurance program shall include a peer review system that entails the following [64B8-9.0092(4)(a)(1)(c)]:** • **Peer review is performed at least every six months and includes reviews of both random cases and unanticipated adverse office incidents as defined in Florida 64B8-9.0092 Section 458.351, F.S., and as set forth in sub-subparagraph (4)(a)1.d., of this rule.** • **If the peer review sources external to the facility are employed to evaluate delivery of medical care, the patient consent form is so written as to waive confidentiality of the medical records or in the alternative medical records reviewed by such external peer review sources must use confidential patient identifiers rather than patient names.** • **Peer review must be conducted by a recognized peer review organization or a licensed medical doctor or osteopathic physician other than the operating surgeon.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.420 Selective / 2 *v42 REG*	**Each Florida quality assurance program shall include a system where all adverse incidents as defined in Section 458.351, F.S., are reviewed. In addition to those incidents set forth in Section 458.351, F.S., the following incidents shall also be reviewed [64B8-9.0092(4)(a)(1)(d)]:** • **-Unplanned hospital admissions that occurred within seven (7) days from the date the patient left the facility or unscheduled return to the operating room for complication of a previous procedure.** • **-Untoward result of procedure such as infection, bleeding, wound dehiscence or inadvertent injury to other body structure.** • **-Cardiac or respiratory problems during stay at facility or within 48 hours of discharge.** • **-Allergic reaction of medication.** • **-Incorrect needle or sponge count.** • **-Patient or family complaint.** • **-Equipment malfunction leading to injury or potential injury to patient.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.430 Selective / 2 *v42 REG*	**Each Florida quality assurance program shall include an adverse incident chart review program which shall include the following information, in addition to the operative procedure performed [64B8-9.0092(4)(a)(1)(e)]:** • **Identification of the problem.** • **Immediate treatment or disposition of the case.** • **Outcome.** • **Analysis of reason for problem.** • **Assessment of efficacy of treatment.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.440 Selective / 2 *v42 REG*	**Each Florida office surgery facility shall have in place a systematic process to collect data on process outcomes, priority issues chosen for improvement, and the satisfaction of the patient. Processes measured shall include [64B8-9.0092(4)(a)(2)]:** • **Appropriate surgical procedures.** • **Preparation of patient for the procedure.** • **Performance of the procedure and monitoring of the patient.** • **Provision of post-operative care.** • **Use of medications including administration and monitoring of effects.** • **Risk management activities and results of autopsies if needed.** • **Quality assurance activities including at least clinical laboratory services and radiology services.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.450 Selective / 2 *v42 REG*	**Each Florida center shall have a process to assess data collected to determine [64B8-9.0092(4)(a)(3)]:** • **The level and performance of existing activities and procedures.** • **Priorities for improvement.** • **Actions to improve performance.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.460 Selective / 2 *v42 REG*	**Each center shall have a process to incorporate quality assurance and improvement activities in existing office surgery facility processes and procedures [64B8-9.0092(4)(a)(4)]**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.470 Selective / 2 *v42 REG*	**The accrediting agency must implement, administer and monitor anesthesia related accreditation standards and quality assurance processes that meet the following minimum standards and are reviewed and approved by the Board of Medicine:** • **Each accredited facility must have an anesthesia provider who participates in an ongoing continuous quality improvement and risk management activities related to the administration of anesthesia in that facility [64B8-9.0092(4)(b)(1)].** • **Each facility must have a written quality improvement plan that specifies the individuals who are responsible for performing each element of the plan [64B8-9.0092(4)(b)(2)].** **The written plan should be in place to continually assess, document and improve the outcome of the anesthesia care provided [64B8-9.0092(4)(b)(3)].** **The plan must include a review of quality indicators, to include measures of patient satisfaction [64B8-9.0092(4)(b)(4)].** • **The plan must include an annual review and check of anesthesia equipment to ensure compliance with current safety standards and the standards for the release of waste anesthetic gases [64B8-9.0092(4)(b)(5)].** • **The quality assurance plan should include routine review of anesthesia and surgical morbidity and adverse, sentinel or outcome events which include but are not limited those defined in the Guidance [64B8-9.0092(4)(b)(6)].** • **Each Florida facility quality improvement plan must require annual reviews conducted by, at a minimum, the medical director, a representative of the anesthesia provider currently providing patient care and a representative of the operating room or recovery nursing staff [64B8-9.0092(4)(b)(7)]**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.480 Selective / 2 *v42 REG*	**Level II office surgery facility transfer agreement requirements are met. 64B8-9.009(4)(b)(1)** • **The physician, or the facility where the procedure is being performed, must have a transfer agreement with a licensed hospital within reasonable proximity if the physician performing the procedure does not have staff privileges to perform the same procedure as that being performed in the out-patient setting at a licensed hospital not exceeding (30) minutes transport time to the hospital.** • **The transfer agreement required by this rule must be current and have been entered into no more than five (5) years prior to the date of the inspection.** • **A transfer agreement must affirmatively disclose an effective date.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.490 Selective / 2 *v42 REG*	**When performing gluteal fat grafting procedures, the surgeon must comply with the following standards:** • **Fat may only be injected into the subcutaneous space and must never cross the fascia overlying the gluteal muscle fascia (intramuscular or submuscular fat injections are prohibited).** • **The surgeon performing the procedure must use ultrasound guidance when placing and navigating the canula and injecting fat into the subcutaneous space to ensure that the fat is placed above the fascia overlying the gluteal muscle.** • **The surgeon must maintain the ultrasound video recordings in the patient's medical record including the time and the date stamp of the ultrasound video recording.** • **A surgeon must not perform more than three (3) gluteal fat grafting procedures in one calendar day.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable Florida Administrative Code requirements for Office Based Surgery Centers.

		Compliance Rating
QUA.500 Selective / 2 *v42 REG*	**The organization conducts peer review for each physician:** • **Peer review is conducted at least every two years for each physician.** • **Peer review is performed by similarly licensed and privileged peers.** • **Results of the peer review are reported to the governing body.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Health and Safety Code §1248.15: This bill requires that each licensee who performs procedures in an accredited outpatient setting be peer reviewed, at least every two years, by licensees who are qualified by education and experience to perform the same types of, or similar, procedures. The bill requires the findings of the peer review to be reported to the governing body, which shall determine if the licensee continues to be professionally qualified and appropriately credentialed for the performance of privileges granted.

PRR Patient Rights, Responsibilities and Protections

The Patient Rights, Responsibilities and Protections Category outlines the expectations for ensuring processes that support patient rights during each episode of care. Organizations must recognize the basic human rights of patients. A patient's rights and responsibilities protect the patient's legal and ethical entitlements, and emphasis should be placed on increasing the patients' awareness about their rights and engaging them when making decisions whenever possible. Patient rights are also a quality assurance mechanism that measures and protects patients while promoting ethical and accountable practice.

According to the Office of Personnel Management, the Patients' Bill of Rights and Responsibilities has three major objectives:

1. To strengthen consumer confidence by assuring the health care system is fair and responsive to consumers' needs, provides consumers with credible and effective mechanisms to address their concerns, and encourages consumers to take an active role in improving and assuring their health.
2. To reaffirm the importance of a strong relationship between patients and their health care professionals.
3. To reaffirm the critical role consumers play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

The Standards address documentation, communication, privacy, consent, advanced directives, and complaint / grievance resolution.

		Compliance Rating
PRR.100 **Universal / 1** ***v42 1.A***	**Patients are treated with respect, consideration, and dignity.**	**FC, PC, NC**
PRR.100.10	The patient has the right to personal privacy.	YES, NO
PRR.100.10.1	At check-in.	
PRR.100.10.2	In evaluation and treatment areas.	
PRR.100.20	Patients are provided appropriate privacy:	YES, NO
PRR.100.30	Interpretation services are available.	YES, NO
PRR.100.40	To the degree that it is known, patients are provided with information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.	YES, NO

Guidance & References

- In telehealth and telemedicine settings, clinical staff must ensure that visual, auditory and electronic privacy are maintained on the clinical side. Staff should encourage the patient/client to take steps to ensure their privacy (e.g., private location, and auditory/visual privacy).

		Compliance Rating
PRR.190 **Universal / 1** ***v42 1.B***	**Prior to receiving care, patients are informed of their rights.**	**FC, SC, PC, MC, NC**
PRR.190.10	Patients and staff are informed of patient rights.	YES, NO
PRR.190.20	Patients and staff are informed of how to voice grievances regarding treatment or care.	YES, NO
PRR.190.30	Patients and staff are informed of methods for providing feedback, including complaints.	YES, NO
PRR.190.40	Patients and staff are informed of the patient's right to change providers if other qualified providers are available.	YES, NO, NA
PRR.190.50	Patients and staff are informed about advance directives, as required by prevailing laws and regulations.	YES, NO, NA

		Compliance Rating
PRR.200 **Universal / 1** ***v42 1.C***	**Prior to receiving care, patients are informed of their responsibilities.**	**FC, SC, PC, MC, NC**
PRR.200.10	Patients are informed of the responsibility to provide complete and accurate information to the best of their ability about their health, any medications taken, including over-the-counter products and dietary supplements, and any allergies or sensitivities.	YES, NO
PRR.200.20	Patients are informed of the responsibility to follow the agreed-upon treatment plan prescribed by their provider and participate in their care.	YES, NO
PRR.200.30	Patients are informed of the responsibility to provide a responsible adult to provide transportation home and to remain with him/her as directed by the provider or as indicated on discharge instructions.	YES, NO, NA
PRR.200.40	Patients are informed of the need to accept personal financial responsibility for any charges not covered by insurance.	YES, NO, NA
PRR.200.50	Patients are informed of the responsibility to behave respectfully toward all health care professionals and staff, as well as other patients and visitors.	YES, NO

Guidance & References

- If the organization is in the Medicare Deemed Status Program, CMS limits what an ASC may charge its patients for the facility fee. An ASC may charge its patients the coinsurance and deductible, if applicable. For Medicare-certified facilities, the responsibility of the patient outlined above is therefore limited to any applicable deductible and coinsurance.

		Compliance Rating
PRR.210 **Universal / 1** ***v42 1.D***	**Information about the organization is available to patients.**	**FC, SC, PC, MC, NC**
PRR.210.10	Information about services provided by the organization is available.	YES, NO
PRR.210.20	Information about provisions for after-hours and emergency care is available.	YES, NO
PRR.210.30	Information about fees for services is available.	YES, NO, NA
PRR.210.40	Information about payment policies is available.	YES, NO, NA
PRR.210.50	Information about the credentials of health care professionals is available.	YES, NO
PRR.210.60	Information about the absence of malpractice coverage is available.	YES, NO, NA

Guidance & References

- If telehealth and telemedicine services are offered, information about after-hours and emergency care should include information that can help patients/clients access these services at distant sites.
- If telehealth and telemedicine services are offered, an accurate fee schedule should be available to patients/clients for the services rendered.

		Compliance Rating
PRR.250 **Selective / 2** ***v42 9.F***	**The informed consent of the patient or of the patient's representative, if applicable, is obtained before the procedure is performed.**	**FC, NC**

Guidance & References

- One consent form may be used to satisfy the Standard requirements for the anesthesia and surgical consents.
- Standard applies to all organizations involved in the administration of sedation and anesthesia, including those where only local or topical anesthesia or only minimal sedation is administered.
- Standard maintains applicability if all or part of the informed consent process occurs via telehealth and telemedicine services.

		Compliance Rating
PRR.260 **Universal / 2** ***v42 10.I.J***	**Informed consent for the proposed procedure is obtained.**	**FC, PC, NC**
PRR.260.10	Documentation is present to demonstrate that the following have been discussed with the patient:	YES, NO
PRR.260.10.1	The necessity or appropriateness of the proposed procedure or surgery.	
PRR.260.10.2	Alternative treatment techniques.	
PRR.260.20	The clinical record demonstrates that the patient's written consent, or that of the patient's representative, was obtained before the surgery or procedure was performed.	YES, NO

Guidance & References

- Standard maintains applicability if all or part of the informed consent process occurs via telehealth and telemedicine services.

		Compliance Rating
PRR.300 **Selective / 1** ***v42 11.C***	**Documentation is present to demonstrate that patients are not required to use a pharmacy owned or operated by the organization.**	**FC, NC**

		Compliance Rating
PRR.310 **Selective / 2** ***v42 14.I.D***	**The informed consent of the patient is obtained prior to the procedure(s).**	**FC, PC, NC**
PRR.310.10	The necessity or appropriateness of the proposed dental procedure(s) is discussed with the patient.	YES, NO
PRR.310.20	Alternative treatments and the order of care are discussed with the patient.	YES, NO
PRR.310.30	The informed consent is incorporated into the dental record.	YES, NO

Guidance & References

- Standard maintains applicability if all or part of the informed consent process occurs via telehealth and telemedicine services.

		Compliance Rating
PRR.320 **Selective / 1** ***v42 19.C***	**The rights and welfare of all patients participating in research are protected.**	**FC, PC, NC**
PRR.320.10	Information is available to patients and staff concerning a patient's right to refuse to participate in research.	YES, NO
PRR.320.20	The informed consent of each patient is obtained in the language or manner they primarily use.	YES, NO
PRR.320.30	A research medical record is maintained for each patient participating in research which contains, at minimum:	YES, NO
PRR.320.30.1	Evidence that the patient has provided informed consent.	
PRR.320.30.2	Name of the study.	
PRR.320.30.3	Start date of the study.	
PRR.320.30.4	Other pertinent information, as applicable to the study.	

		Compliance Rating
PRR.330 **Selective / 2** ***v42 REG***	**The organization posts the required notice informing patients that they are licensed by the Medical Board of California and includes contact information for the Medical Board.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Business and Professions Code §138: Physicians in California are required to inform their patients that they are licensed by the Medical Board of California, and include the board's contact information. Complete information and a sample posting notice is available at: http://www.mbc.ca.gov/Licensees/Notices/Notice_to_Consumers.aspx

		Compliance Rating
PRR.340 **Selective / 1** ***v42 21.C***	**Individuals who agree to laboratory testing or medical examinations at the request of their employer are provided with information specific to such tests and exams.**	**FC, SC, PC, MC, NC**
PRR.340.10	Information about the purpose and scope of the test or evaluation is provided.	YES, NO
PRR.340.20	Information about confidentiality protections is provided.	YES, NO
PRR.340.30	Information about the role of the examiner or organization is provided.	YES, NO
PRR.340.40	Information that may be conveyed to the employer is explained.	YES, NO
PRR.340.50	Information about the results of the exam or test is provided.	YES, NO
PRR.340.60	Information about necessary medical follow-up is provided.	YES, NO

SAF Safety

The Safety Category outlines the expectations for a safety program that seeks to prevent injury and illness and minimize risks to patients, staff, and visitors by ensuring a safe and healthy environment. Developing and implementing safety systems provides patients, staff, and visitors with a safe and healthy environment that seeks to prevent injury and illness and minimize risks. The safety program should include a risk assessment and processes for managing identified hazards, potential threats, near misses, and other safety concerns and be approved by the governing body.

The purpose of a risk assessment is to detect, mitigate, monitor, and prevent risk. Assessing risks and incorporating preventive measures into safety programs is key to establishing and prioritizing risk areas. Examples include operational, clinical, life safety, hazard vulnerability, cyber security, emergency preparedness, and workforce risks.

The Standards address risk management, hazards, safety measures and fire protection.

		Compliance Rating
SAF.100 **Universal / 1** ***v42 5.II.A***	**The risk management program includes written policies.**	**FC, SC, PC, MC, NC**
SAF.100.10	The policies include methods by which a patient may be dismissed from care or refused care.	YES, NO
SAF.100.20	The policies include methods for managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure.	YES, NO
SAF.100.30	The policies include methods of addressing a situation involving an impaired health care professional.	YES, NO
SAF.100.40	The policies require documentation of responsibility for coverage after normal working hours.	YES, NO
SAF.100.50	The policies require documentation of clinical advice provided after normal working hours.	YES, NO, NA
SAF.100.60	The policies define restrictions on observers in patient care areas.	YES, NO
SAF.100.70	The policies include requirements for evidence of patient consent for all persons permitted in patient care areas who are not authorized staff.	YES, NO

Guidance & References

- Examples of unauthorized persons include students, visiting physicians, health care industry representatives, surveyors, maintenance workers and vendors.

		Compliance Rating
SAF.110 **Universal / 2** ***v42 5.II.B***	**The risk management policies address ongoing processes regarding patient safety and other important issues.**	**FC, SC, PC, MC, NC**
SAF.110.10	Policies address encouraging the reporting of near-miss events.	YES, NO
SAF.110.20	Policies address the communication of reportable events as required by law and regulation.	YES, NO
SAF.110.30	Policies address the periodic review of all litigation involving the organization and its staff and health care professionals.	YES, NO
SAF.110.40	Policies address the ongoing review of patient complaints and grievances and includes defined response times, as required by law and regulation.	YES, NO
SAF.110.50	Policies address the documentation of timely notification to the professional liability insurance carrier, in accordance with organization or carrier policy, when adverse or reportable events occur.	YES, NO, NA
SAF.110.60	Policies address the periodic review of clinical records and clinical record policies.	YES, NO
SAF.110.70	Policies address other state or federal risk management requirements.	YES, NO, NA

		Compliance Rating
SAF.120 **Universal / 2** ***v42 5.II.C***	**The organization's risk management program and/or policies define incidents and adverse events.**	**FC, PC, NC**
SAF.120.10	The definition of an incident includes any clinical or non-clinical occurrence that is not consistent with the routine care or operation of the organization. Incidents may involve patients, visitors, employees, and medical or dental staff members and include circumstances or events that could have resulted in an adverse event but did not result in harm (i.e., near miss events).	YES, NO
SAF.120.20	The definition of an adverse event includes:	YES, NO
SAF.120.20.1	An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.	
SAF.120.20.2	Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.	
SAF.120.20.3	Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient.	
SAF.120.20.4	Events involving reactions to drugs and materials.	

		Compliance Rating
SAF.130 **Universal / 2** ***v42 5.II.D***	**Incidents and adverse events are reviewed and corrective actions are taken as needed.**	**FC, PC, NC**
SAF.130.10	All incidents and adverse events are reviewed.	YES, NO
SAF.130.20	When appropriate, incidents are acted upon.	YES, NO
SAF.130.30	All adverse events and incidents that could have resulted in an adverse event (i.e., near miss events) are analyzed to identify the underlying basic or causal factors and potential improvements in processes or systems, if any exist, to reduce the likelihood of such incidents in the future.	YES, NO
SAF.130.40	Improvements that reduce the likelihood of future adverse events are implemented, when indicated.	YES, NO

		Compliance Rating
SAF.140 **Universal / 2** ***v42 7.II.A***	**A written safety program addresses the environment of care, the safety of patients, staff, and others, and meets or exceeds local, state, or federal safety requirements.**	**FC, SC, PC, MC, NC**
SAF.140.10	The governing body has approved the written safety program.	YES, NO
SAF.140.20	The program includes processes for managing identified hazards, potential threats, near misses, and other safety concerns.	YES, NO
SAF.140.30	The program includes processes to reduce and avoid medication errors.	YES, NO
SAF.140.40	The program includes practices employed to prevent falls and other physical injuries, and to ensure the accurate and timely reporting of such events.	YES, NO
SAF.140.50	The program includes practices employed to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposure.	YES, NO
SAF.140.60	The program includes methods of ensuring that food and drink for patient use is stored, prepared, served, and disposed of in compliance with local, state, and federal guidelines.	YES, NO, NA

Guidance & References

- Examples related to safety concerns include ergonomic exposures, violence in the workplace, and external physical threats, such as terrorism.
- If telehealth and telemedicine services are offered, the need for obtaining emergency contact information at the patient's location is addressed in the safety program.

		Compliance Rating
SAF.150 **Universal / 2** ***v42 7.II.E***	**A written policy and process addresses the recall of items including drugs and vaccines, blood and blood products, medical devices, equipment and supplies, and food products.**	**FC, SC, PC, MC, NC**
SAF.150.10	The policy addresses sources of recall information (FDA, CDC, manufacturers, and other local, state, or federal sources).	YES, NO
SAF.150.20	The policy addresses how applicable staff members are notified.	YES, NO
SAF.150.30	The policy addresses how the organization determines if a recalled product is present or has been given or administered to patients.	YES, NO
SAF.150.40	The policy addresses the response to recalled products.	YES, NO
SAF.150.50	The policy addresses the disposition or return of recalled items.	YES, NO
SAF.150.60	The policy addresses patient notification, as appropriate.	YES, NO

		Compliance Rating
SAF.160 **Universal / 2** ***v42 7.II.F***	**All products, including medications, reagents, solutions, and supplies that have a manufacturer's printed expiration date are monitored and disposed of in compliance with facility policy and manufacturers' guidelines.**	**FC, PC, NC**
SAF.160.10	A written policy for the monitoring and disposal of products with expiration dates is present.	YES, NO
SAF.160.20	The policy describes the process for ensuring that products with a manufacturer's printed expiration date are monitored for currency.	YES, NO
SAF.160.30	The policy for disposal or return of expired items complies with prevailing laws and regulations, and manufacturer guidelines.	YES, NO

		Compliance Rating
SAF.170 **Universal / 2** ***v42 7.II.G***	**A system exists for the proper identification, management, handling, transport, and disposal of hazardous materials and wastes, whether solid, liquid, or gas.**	**FC, PC, NC**
SAF.170.10	Hazardous materials and waste are properly labeled.	YES, NO
SAF.170.20	Hazardous materials and waste are managed and disposed of in accordance with prevailing laws and regulations.	YES, NO
SAF.170.30	Staff responsible for hazardous waste management and disposal demonstrate knowledge of prevailing laws and regulations.	YES, NO

		Compliance Rating
SAF.180 **Universal / 2** ***v42 7.II.H***	**The temperature of items that are frozen, refrigerated, and/or heated is continuously monitored to ensure that the product manufacturer's recommended temperature range is maintained.**	**FC, PC, NC, NA**
SAF.180.10	A mechanism is present for continuously measuring the temperature of frozen, refrigerated, and/or heated items.	YES, NO, NA
SAF.180.20	Logs or other documentation demonstrate that temperature monitoring occurs.	YES, NO, NA
SAF.180.30	Recommended temperature ranges are readily available to staff performing the monitoring function.	YES, NO, NA
SAF.180.40	Documentation and/or interviews confirm that staff performing the monitoring function have been trained what to do if the temperature falls outside of the recommended range.	YES, NO, NA

		Compliance Rating
SAF.190 **Universal / 2** ***v42 7.II.I***	**A written policy requires documentation of the pre-cleaning, transport, and handling of medical devices intended for external vendor reprocessing, inspection, or repair.**	**FC, NC**

		Compliance Rating
SAF.200 **Universal / 2** ***v42 7.II.J***	**Reprocessing of manufacturer-labeled single-use devices complies with FDA regulation and is limited to devices approved for reprocessing in accordance with FDA 510(k) clearance.**	**FC, PC, NC, NA**
SAF.200.10	Documentation demonstrates that reprocessed single-use devices have been approved for reprocessing in accordance with FDA 510(k) clearance.	YES, NO, NA
SAF.200.20	If a third-party reprocessor is used, documentation demonstrates that the reprocessor is FDA-registered.	YES, NO, NA
SAF.200.30	If reprocessing is conducted in-house, documentation demonstrates that the organization is FDA-registered.	YES, NO, NA

		Compliance Rating
SAF.220 **Universal / 2** ***v42 7.II.K***	**If medical devices are provided to patients, instructions to the patients regarding use of the devices are documented.**	**FC, NC, NA**

		Compliance Rating
SAF.230 **Universal / 2** ***v42 7.II.L***	**Prior to use, appropriate education is provided to intended operators of newly-acquired devices or products to be used in the care of patients.**	**FC, PC, NC**
SAF.230.10	A designated person is responsible for ensuring that clinical education occurs prior to the use of the devices or products.	YES, NO
SAF.230.20	Vendor representatives are not used as the sole source for clinical education.	YES, NO

		Compliance Rating
SAF.240 **Universal / 2** ***v42 7.II.M***	**Fire prevention and safety are addressed in the written safety program.**	**FC, PC, NC**
SAF.240.10	Policies and procedures to educate medical staff members, employees, volunteers, and other providers and personnel in fire prevention and fire hazard reduction are followed.	YES, NO
SAF.240.20	The safety program requires that fire safety, fire prevention, and fire drills are included in the surveillance activities of personnel responsible for safety and risk management.	YES, NO

		Compliance Rating
SAF.250 **Universal / 2** ***v42 7.II.N***	**Health care workers are protected from biologic hazards, consistent with prevailing laws and regulations and nationally recognized guidelines.**	**FC, SC, PC, MC, NC**
SAF.250.10	The governing body has approved and implemented policies that comply with all applicable occupational health and safety regulations for health care workers designed to eliminate and/or minimize exposures.	YES, NO
SAF.250.20	A written exposure control plan is reviewed and updated at least annually, including an evaluation of the availability of safer medical devices and changes in technology.	YES, NO
SAF.250.30	An immunization program offered to all staff includes vaccinations for infectious agents of risk to staff and patients as indicated by the infection prevention risk assessment.	YES, NO
SAF.250.40	A tuberculosis detection and protection plan is in place and follows requirements of prevailing health authorities. If no such requirements exist, nationally recognized guidelines for tuberculosis detection and prevention in health care are followed.	YES, NO
SAF.250.50	Programs that address other relevant biological hazards as indicated by the infection prevention risk assessment, such as bioterrorism, are provided as needed for safety and health.	YES, NO

Guidance & References

- Evidence is present in the personnel health record of employee acceptance/declination of immunization(s) program, based on state and/or organization policy (when applicable).

		Compliance Rating
SAF.260 **Universal / 2** ***v42 7.II.O***	**Procedures addressing bloodborne pathogens are in place.**	**FC, PC, NC**
SAF.260.10	The procedures include a hepatitis B immunization program.	YES, NO
SAF.260.20	The procedures include post-exposure evaluation and treatment.	YES, NO
SAF.260.30	The procedures include appropriate training in and communication of hazards to health care workers.	YES, NO
SAF.260.40	The procedures include appropriate record keeping and management.	YES, NO

Guidance & References

- Signed hepatitis B vaccination acceptance/declination is present (when applicable) in the personnel records.

		Compliance Rating
SAF.270 **Universal / 2** ***v42 7.II.P***	**A program is maintained to assess and reduce risks associated with occupational chemical exposures.**	**FC, PC, NC**
SAF.270.10	The program includes a hazard assessment of chemicals used in the workplace, conducted at least annually and as new products are added.	YES, NO
SAF.270.20	The program includes engineering measures to reduce the risk of chemical exposure.	YES, NO
SAF.270.30	The program includes worker training programs, as documented in personnel files, meeting minutes, or in another manner.	YES, NO

		Compliance Rating
SAF.280 **Universal / 2** ***v42 7.II.Q***	**Work injuries and illnesses are appropriately documented and investigated with records maintained as applicable.**	**FC, PC, NC**
SAF.280.10	Work injury and illness records are documented and maintained in accordance with state and federal reporting requirements and any other insurance requirements.	YES, NO
SAF.280.20	Work injury and illness records detail the issue and any investigation of the occurrence.	YES, NO
SAF.280.30	Work injury and illness health records are maintained in compliance with state and federal confidentiality and security standards (e.g., OSHA).	YES, NO

		Compliance Rating
SAF.290 **Universal / 2** ***v42 7.II.B***	**The safety program requires performance of a proactive, documented risk assessment before commencing demolition, construction or renovation while the facility is occupied.**	**FC, PC, NC**
SAF.290.10	The risk assessment identifies potential risks to occupant health and/or safety.	YES, NO
SAF.290.20	The risk assessment identifies actions necessary to eliminate or adequately mitigate such risks.	YES, NO
SAF.290.30	The risk assessment identifies provisions for monitoring and mitigating risks during the process, and for updating or expanding the risk assessment if necessary to ensure continued protection of all occupants.	YES, NO

		Compliance Rating
SAF.300 **Universal / 2** ***v42 7.II.C***	**Documentation demonstrates that the risk assessment was conducted or is underway in accordance with the requirements of the organization's safety program.**	**FC, NC, NA**

Guidance & References

- NA may be applied on reaccreditation surveys if no facility updates or expansions have occurred in the last three years, or no such project is anticipated. For initial surveys, apply the NA rating.

		Compliance Rating
SAF.310 **Selective / 2** ***v42 10.II.B***	**Written policies and procedures for each device are present.**	**FC, PC, NC**
SAF.310.10	The policies and procedures include a list of each type of laser used in the facility.	YES, NO
SAF.310.20	The policies and procedures require a laser safety program.	YES, NO
SAF.310.20.1	The program is supervised by an individual delegated the responsibility and authority to serve as Medical Laser Safety Officer (MLSO).	
SAF.310.20.2	The MLSO has the requisite education and training applicable to each type of laser used in the facility, including knowledge of laser-specific information (e.g., wave lengths, pulse shapes, modes, power/energy classification, controlled areas).	
SAF.310.20.3	The policies and procedures require that laser operators have no competing responsibilities that would leave the laser unattended during active use.	
SAF.310.30	The policies and procedures include a requirement for all personnel working with these devices to be adequately trained in the safety and use of each type of device used.	YES, NO
SAF.310.40	The policies and procedures require safe practices to be followed.	YES, NO
SAF.310.40.1	All procedures are performed in accordance with the device manufacturer's guidelines.	
SAF.310.40.2	All procedures are performed consistent with the current version of the ANSI Standard for Safe Use of Lasers in Health Care Facilities.	

Guidance & References

- Standard applies to organizations providing surgery or procedures that involve lasers, light-based technologies, or other energy-emitting equipment.

		Compliance Rating
SAF.320 **Selective / 2** ***v42 10.II.C***	**Safety measures for the laser(s) used are in place.**	**FC, SC, PC, MC, NC**
SAF.320.10	Safety measures include the use of door and window coverings, where appropriate.	YES, NO
SAF.320.20	Safety measures include prominently displayed warning signs at the entrance to treatment areas during procedures, specific to the type of laser in use.	YES, NO
SAF.320.30	Safety measures include a requirement for personnel in treatment areas to use protective eyewear as recommended by the device manufacturer.	YES, NO
SAF.320.40	Safety measures include the use of smoke evacuators and other devices to control tissue debris.	YES, NO, NA
SAF.320.50	Safety measures include the use of high filtration masks and/or wall suction with filters to minimize laser plume inhalation, when appropriate.	YES, NO, NA
SAF.320.60	Safety measures include appropriate disinfection or sterilization of components that have direct patient contact.	YES, NO
SAF.320.70	Safety measures include inspection and testing of the devices according to the manufacturer's instructions, as documented by maintenance logs.	YES, NO

Guidance & References

- Standard applies to organizations providing surgery or procedures that involve lasers, light-based technologies, or other energy-emitting equipment.

		Compliance Rating
SAF.330 **Selective / 2** ***v42 10.II.D***	**Fire protection measures for lasers are in place.**	**FC, SC, PC, MC, NC**
SAF.330.10	Fire protection measures include the immediate availability of electrical-rated fire extinguishers for equipment fires.	YES, NO
SAF.330.20	Fire protection measures include the maintenance of a wet environment around the operative field.	YES, NO, NA
SAF.330.30	Fire protection measures include the immediate availability of an open container of saline or water where ignition of flammable materials is possible.	YES, NO, NA
SAF.330.40	Fire protection measures include the adoption of nationally recognized safety guidelines for the use of laser equipment.	YES, NO
SAF.330.50	Fire protection measures include the use of noncombustible materials, supplies, and solutions as appropriate.	YES, NO
SAF.330.60	Fire protection measures include procedures for ensuring that nothing is in front of the laser other than the tissue being lasered.	YES, NO

Guidance & References

- Standard applies to organizations providing surgery or procedures that involve lasers, light-based technologies, or other energy-emitting equipment.

		Compliance Rating
SAF.340 **Selective / 2** ***v42 10.II.E***	**Safeguards are in place to ensure patient safety when lasers are used.**	**FC, PC, NC**
SAF.340.10	Patient safety measures include protection of the patient's eyes, skin, hair, and other exposed areas.	YES, NO
SAF.340.20	Patient safety measures include the use of non-reflective surgical instruments and supplies, when available.	YES, NO
SAF.340.30	Patient safety measures include educating patients regarding procedure risks and potential complications, as documented by the informed consent.	YES, NO

Guidance & References

- Standard applies to organizations providing surgery or procedures that involve lasers, light-based technologies, or other energy-emitting equipment.

		Compliance Rating
SAF.350 **Selective / 2** ***v42 10.III.E***	**Written policies addressing the safety aspects of lithotripsy treatment are present.**	**FC, SC, PC, MC, NC**
SAF.350.10	The policies require daily logging of lithotripter calibration/equipment checks on days when lithotripsy is provided.	YES, NO
SAF.350.20	The policies require preventive maintenance logs.	YES, NO
SAF.350.30	The policies require maintenance records, including current documentation from the service contract provider that any malfunctions have been corrected.	YES, NO
SAF.350.40	If outside providers of lithotripsy services are used, the policies require that equipment maintenance records are available to the accredited organization when the equipment is onsite.	YES, NO, NA
SAF.350.50	The policies require documentation from contracted vendors performing equipment calibration and preventive maintenance that work has been completed according to the contract.	YES, NO

		Compliance Rating
SAF.360 **Selective / 2** ***v42 13.C***	**Written policies and procedures addressing safety aspects of imaging services are present.**	**FC, PC, NC**
SAF.360.10	Written policies and procedures address precautions to safeguard against electrical, mechanical, magnetic, radiation, and other potential hazards.	YES, NO
SAF.360.20	Written policies and procedures require periodic evaluation by qualified personnel of energy sources and of all safety measures followed, including calibration of equipment and testing the integrity of personal protective devices in compliance with federal, state, and local laws and regulations.	YES, NO

Guidance & References

- Standard applies to organizations that provide imaging services for screening, diagnosing, monitoring, or assisting with procedures.

		Compliance Rating
SAF.370 **Selective/ 2** ***v42 13.D***	**Written policies and procedures address the management of potentially hazardous energy sources.**	**FC, PC, NC**
SAF.370.10	Written policies and procedures comply with prevailing laws and regulations for the use, removal, handling, and storage of potentially hazardous materials.	YES, NO
SAF.370.20	Written policies and procedures require proper shielding where radiation and other potentially hazardous energy sources are used.	YES, NO
SAF.370.30	Written policies and procedures include instructions for dealing with accidental hazardous energy exposure.	YES, NO
SAF.370.40	If radiation exposure is monitored, appropriate exposure records are maintained.	YES, NO, NA
SAF.370.50	If radiation exposure is not monitored, documentation exists within the organization to support this decision.	YES, NO, NA

Guidance & References

- Standard applies to organizations that provide imaging services for screening, diagnosing, monitoring, or assisting with procedures.

		Compliance Rating
SAF.380 **Selective / 2** ***v42 13.E***	**Proper warning signs are in place alerting pregnant females to the presence of hazardous energy fields.**	**FC, NC**

Guidance & References

- Standard applies to organizations that provide imaging services for screening, diagnosing, monitoring, or assisting with procedures.

		Compliance Rating
SAF.390 **Selective / 2** ***v42 13.J***	**If magnetic resonance imaging is conducted, proper warning signs are in place.**	**FC, PC, NC, NA**
SAF.390.10	Signs warn patients and other personnel with metal implants.	YES, NO, NA
SAF.390.20	Signs warn patients and other personnel with magnetically inscribed credit cards, identification cards, and similar items.	YES, NO, NA
SAF.390.30	Signs warn patients and other personnel wearing metallic objects capable of potentially dangerous motion.	YES, NO, NA
SAF.390.40	Signs warn patients and other personnel with pacemakers, internal defibrillators, cochlear implants, cardiac stents, insulin pumps, or nerve stimulators.	YES, NO, NA

Guidance & References

- NA may be applied if the organization only provides peri-operative imaging services.

		Compliance Rating
SAF.400 **Selective / 2** ***v42 24.F***	**If teletherapy is provided, written safety policies and procedures for testing, maintenance and quality control have been approved by the governing body.**	**FC, SC, PC, MC, NC, NA**
SAF.400.10	Teletherapy units are calibrated annually.	YES, NO, NA
SAF.400.20	The interlock systems of all treatment units are inspected according to policy.	YES, NO, NA
SAF.400.30	Records of machine performance, maintenance, repair, and malfunctions are maintained.	YES, NO, NA
SAF.400.40	All sealed sources are tested periodically in accordance with radiation regulations.	YES, NO, NA
SAF.400.50	Documentation demonstrates that quality control procedures for all therapeutic equipment are followed.	YES, NO, NA

		Compliance Rating
SAF.410 **Selective / 2** ***v42 24.D***	**Radiation safety processes are followed.**	**FC, PC, NC**
SAF.410.10	Personnel exposure records are maintained.	YES, NO
SAF.410.20	Potentially hazardous materials are acquired, stored, used, handled and removed in accordance with prevailing laws and regulations.	YES, NO

		Compliance Rating
SAF.420 **Selective / 2** ***v42 24.I***	**If High Dose Rate (HDR) brachytherapy, Low Dose Rate (LDR) brachytherapy, or similar procedures using radioactive seeds or other devices that are implanted or injected are used, steps are taken to ensure that no potentially harmful residual radiation is present on site.**	**FC, PC, NC, NA**
SAF.420.10	Appropriate storage containers are used.	YES, NO, NA
SAF.420.20	The containers and the procedure room are tested for residual radiation as stipulated by the organization's policies.	YES, NO, NA

		Compliance Rating
SAF.430 **Selective / 2** ***v42 REG***	**If the organization had any adverse events as defined in Health and Safety Code §1279.1, they were reported as directed in the California Business and Professions Code 2216.3 using the required form and the documentation was reviewed.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Business and Professions Code §2216.3: Adverse events as defined in HSC Section 1279.1, are reported to the Medical Board of California no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected.

		Compliance Rating
SAF.440 **Selective / 2** ***v42 REG***	**If the organization had any deaths or transfer as defined in California Business and Professions Code §2240, the required forms were available and the documentation was reviewed.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Business and Professions Code §2240 regulation: Physicians performing or supervising a scheduled medical procedure outside of a general acute care hospital that results in a death must file a report with the Medical Board of California, Central Complaint Unit. A transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours requires the physician to send the facility a completed report (Parts A and B) and to send Part B within 15 days of the occurrence to the Office of Statewide Health Planning and Development. Copies of the reporting forms can be obtained from the Medical Board of California at 916/263-2389.

		Compliance Rating
SAF.450 **Selective / 2** ***v42 REG***	**If the organization had any patient deaths as defined in California Business and Professions Code §2240, the Outpatient Surgery Patient Death Reporting Form was submitted by the physician to the Medical Board of California, Central Complaint Unit within 15 days for each occurrence and the documentation was reviewed.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Business and Professions Code §2240 regulation: This is a reporting requirement for physicians. The patient death reporting form can be obtained by clicking on this link: http://www.mbc.ca.gov/Forms/Reporting/patient_death.pdf - the physician must complete the form and send it to the Medical Board of California, Central Complaint Unit.

		Compliance Rating
SAF.460 **Selective / 2** ***v42 REG***	**If the organization had any transfers exceeding 24 hours, Parts A and B were filed in the patient's medical record, each Part B of the Patient Transfer Reporting Form was submitted to the Office of Statewide Health Planning and Development within 15 days for each occurrence and the documentation was reviewed.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable California Business and Professions Code and Health and Safety Code requirements for Outpatient Surgery settings, where the level of anesthesia administered has the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.
- As defined in California Business and Professions Code §2240 regulation: This is a reporting requirement for physicians. The patient transfer reporting form can be obtained by clicking on this link: http://www.mbc.ca.gov/Forms/Reporting/enf-2240b.pdf - The physician is to complete and send Parts A and B to the facility who transferred the patient and only Part B must be submitted within 15 days of the transfer to the Office of Statewide Health Planning and Development.

VAL Validation

The Validation Category allows for an evaluation of certain organization profile / application information to ensure accuracy and completeness.

The Standards verify information such as services, state requirements, and eligibility.

		Compliance Rating
VAL.190 **Selective / 1**	**Procedures are performed in the outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes and this is accurately reflected in the organization's AAAHC application/profile. (California Business and Professions Code §2216)**	**FC, NC**

Guidance & References

- As defined in California Business and Professional Code section §2216: On or after July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Section 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

		Compliance Rating
VAL.200 **Selective / 1**	**The organization meets the "outpatient setting" definition in the California Health and Safety Code §1248 and this is accurately reflected in the organization's AAAHC application/profile.**	**FC, NC**

Guidance & References

- As defined in California Health and Safety Code §1248(b):

  (1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

  (2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

  (3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

  (c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

		Compliance Rating
VAL.210 **Selective / 1**	**The types of health care professionals employed by the practice are accurately recorded in the organization's AAAHC application/profile. (NYS PHL 230-d(1)(a))**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers.

		Compliance Rating
VAL.220 **Selective / 1**	**The practice has a separate entity for billing purposes and this is accurately reflected in the organization's AAAHC application/profile. (NYS PHL 230-d(1)(a))**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers.

		Compliance Rating
VAL.230 **Selective / 1**	**The practice uses a billing and collection service for all accounts receivable and this is accurately reflected in the organization's AAAHC application/profile. (NYS PHL 230-d(1)(a))**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers.

		Compliance Rating
VAL.240 **Selective / 1**	**The type of legal entity is accurately recorded in the organization's AAAHC application/profile (NYS PHL 230-d(1)(a)):** • **All physicians are partners if the practice is organized as a general partnership or as a registered limited liability partnership.** • **All of the shareholders, officers and directors are physicians if the practice is organized as a professional corporation.** • **All of the members and managers are physicians if the practice is organized as a limited liability company.** • **All of the members and managers are physicians if the practice is organized as a university faculty practice corporation.**	**FC, NC**

Guidance & References

- Standard assesses compliance with applicable New York Public Health Guidelines for Office Based Surgery Centers.

Resources

AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE

AAAHC Documentation Requirements

AAAHC Standards Revisions

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Evaluation with Compliance to Standards

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Resources

AAAHC Documentation Requirements

This resource is designed to help you ensure that you have the written documentation required to comply with AAAHC Standards. Note that within the Standard, the documentation requirement may be at the Statement (SOR), Element (EOC), or Sub Element (SEOC) of Compliance level. The grid below also includes whether the Standard is Universal applying to all organizations, or Selective based on your scope of services as indicated in your application/profile. This resource is not meant to be all inclusive of all written documentation that your organization may choose or need to maintain.

For details on the specific documentation required, refer to the specific Standards.

Instructions: Use the column labeled "Present" to indicate whether a document exists: **Y** = Yes; **N**= No; **NA** = Not Applicable

Category	Statement of Requirement (SOR)	Universal or Selective / Level	Present	Notes
ADM Administration	ADM.100	Universal / 2		
	ADM.120	Universal / 1		
	ADM.130	Universal / 1		
	ADM.140	Universal / 1		
	ADM.160	Universal / 2		
	ADM.180	Selective / 2		
	ADM.190	Universal / 2		
	ADM.240	Selective / 2		
	ADM.250	Selective / 2		
	ADM.260	Selective / 1		
	ADM.270	Selective / 1		
	ADM.280	Selective / 2		
	ADM.290	Selective / 2		
ASG Anesthesia and Surgery	ASG.100	Selective / 2		
	ASG.110	Selective / 1		
	ASG.150	Selective / 2		
	ASG.170	Selective / 2		
	ASG.200	Selective / 2		
	ASG.210	Selective / 2		
	ASG.220	Selective / 2		
	ASG.230	Selective / 2		
	ASG.240	Selective / 2		
	ASG.250	Selective / 2		
	ASG.260	Selective / 2		
	ASG.270	Universal / 2		
	ASG.280	Selective / 2		
	ASG.300	Selective / 2		

Category	Statement of Requirement (SOR)	Universal or Selective / Level	Present	Notes
BEH Behavioral Health	BEH.100	Selective / 2		
	BEH.110	Selective / 1		
	BEH.120	Selective / 2		
	BEH.140	Selective / 2		
	BEH.150	Selective / 1		
	BEH.160	Selective / 1		
	BEH.180	Selective / 2		
	BEH.200	Selective / 2		
	BEH.210	Selective / 2		
	BEH.220	Selective / 2		
	BEH.230	Selective / 2		
	BEH.240	Selective / 2		
	BEH.250	Selective / 2		
	BEH.260	Selective / 2		
	BEH.270	Selective / 2		
	BEH.280	Selective / 2		
	BEH.290	Selective / 2		
	BEH.310	Selective / 1		
	BEH.320	Selective / 1		
CMC Care Management and Coordination	CMC.130	Universal / 2		
	CMC.140	Selective / 2		
	CMC.190	Selective / 2		
	CMC.200	Selective / 2		
	CMC.210	Selective / 1		
	CMC.220	Selective / 2		
	CMC.280	Selective / 2		
	CMC.290	Selective / 1		
CPV Credentialing and Privileging	CPV.130	Universal / 2		
	CPV.140	Universal / 2		
	CPV.150	Universal / 2		
	CPV.160	Universal / 2		
	CPV.170	Universal / 1		
	CPV.190	Universal / 1		
	CPV.200	Universal / 2		
	CPV.210	Selective / 2		
	CPV.220	Universal / 2		
	CPV.300	Selective / 1		

Category	Statement of Requirement (SOR)	Universal or Selective / Level	Present	Notes
CRD Clinical Records	CRD.130	Universal / 2		
	CRD.160	Universal / 1		
	CRD.170	Universal / 1		
	CRD.180	Universal / 1		
	CRD.200	Universal / 2		
	CRD.210	Universal / 2		
	CRD.220	Universal / 2		
	CRD.230	Selective / 1		
	CRD.240	Universal / 2		
	CRD.250	Selective / 2		
	CRD.260	Selective / 2		
	CRD.270	Selective / 2		
	CRD.280	Selective / 1		
	CRD.290	Selective / 1		
	CRD.300	Selective / 2		
	CRD.310	Selective / 2		
	CRD.320	Selective / 2		
	CRD.330	Universal / 1		
	CRD.350	Universal / 1		
DHM Dental Home	DHM.130	Universal / 1		
	DHM.140	Universal / 1		
	DHM.170	Universal / 2		
	DHM.180	Universal / 2		
EMG Emergency Management	EMG.100	Universal / 2		
	EMG.140	Universal / 2		
	EMG.160	Universal / 2		
	EMG.170	Universal / 2		
	EMG.180	Universal / 2		
	EMG.210	Selective / 2		
	EMG.220	Selective / 2		
	EMG.230	Selective / 2		
	EMG.250	Universal / 2		
	EMG.260	Selective / 2		
	EMG.270	Selective / 2		
	EMG.280	Selective / 2		
	EMG.290	Selective / 2		
FAC Facilities and Equipment	FAC.100	Universal / 2		
	FAC.110	Universal / 2		
	FAC.150	Universal / 2		
	FAC.240	Universal / 2		
	FAC.260	Selective / 2		

AAAHC Documentation Requirements

Category	Statement of Requirement (SOR)	Universal or Selective / Level	Present	Notes
GOV Governance	GOV.130	Universal / 1		
	GOV.170	Universal / 2		
	GOV.180	Universal / 1		
	GOV.200	Universal / 1		
	GOV.210	Universal / 1		
	GOV.220	Universal / 1		
	GOV.330	Selective / 1		
	GOV.360	Selective / 1		
	GOV.370	Selective / 1		
	GOV.380	Selective / 1		
	GOV.390	Selective / 2		
	GOV.400	Selective / 2		
IPC Infection Prevention and Control	IPC.100	Universal / 2		
	IPC.130	Universal / 2		
	IPC.150	Universal / 2		
	IPC.170	Universal / 2		
	IPC.180	Universal / 2		
	IPC.190	Universal / 2		
	IPC.210	Universal / 2		
	IPC.220	Universal / 2		
	IPC.230	Selective / 2		
LRD Laboratory and Radiology	LRD.130	Selective / 1		
	LRD.140	Selective / 1		
	LRD.150	Selective / 1		
	LRD.160	Selective / 1		
	LRD.170	Selective / 2		
	LRD.180	Selective / 1		
	LRD.200	Selective / 1		
	LRD.280	Selective / 2		
	LRD.290	Selective / 2		
	LRD.300	Selective / 1		
	LRD.310	Selective / 1		
MED Medication Management	MED.100	Universal / 2		
	MED.130	Selective / 2		
	MED.140	Universal / 2		
	MED.150	Universal / 2		
	MED.160	Universal / 2		
	MED.170	Universal / 2		
	MED.190	Universal / 2		
	MED.210	Universal / 1		
	MED.220	Universal / 2		
	MED.230	Universal / 2		

AAAHC Documentation Requirements

Category	Statement of Requirement (SOR)	Universal or Selective / Level	Present	Notes
MHM Medical Home	MHM.130	Universal / 1		
	MHM.140	Universal / 2		
	MHM.180	Universal / 2		
OCS Other Clinical Services	OCS.120	Selective / 2		
	OCS.130	Selective / 2		
	OCS.140	Selective / 2		
	OCS.150	Selective / 2		
	OCS.200	Selective / 2		
	OCS.210	Selective / 2		
	OCS.220	Selective / 2		
	OCS.230	Selective / 2		
	OCS.240	Selective / 2		
	OCS.250	Selective / 1		
PRR Patient Rights, Responsibilities and Protections	PRR.260	Universal / 2		
	PRR.300	Selective / 1		
	PRR.310	Selective / 2		
	PRR.320	Selective / 1		
	PRR.350	Selective / 1		
QUA Quality	QUA.230	Universal / 2		
	QUA.270	Universal / 2		
	QUA.300	Universal / 2		

Category	Statement of Requirement (SOR)	Universal or Selective / Level	Present	Notes
SAF Safety	SAF.100	Universal / 1		
	SAF.110	Universal / 2		
	SAF.120	Universal / 2		
	SAF.140	Universal / 2		
	SAF.150	Universal / 2		
	SAF.160	Universal / 2		
	SAF.180	Universal / 2		
	SAF.190	Universal / 2		
	SAF.200	Universal / 2		
	SAF.220	Universal / 2		
	SAF.250	Universal / 2		
	SAF.270	Universal / 2		
	SAF.280	Universal / 2		
	SAF.290	Universal / 2		
	SAF.300	Universal / 2		
	SAF.310	Selective / 2		
	SAF.320	Selective / 2		
	SAF.340	Selective / 2		
	SAF.350	Selective / 2		
	SAF.360	Selective / 2		
	SAF.370	Selective / 2		
	SAF.380	Selective / 2		
	SAF.390	Selective / 2		
	SAF.400	Selective / 2		

AAAHC Standards Revisions

In addition to the new Standards architecture described in the Policies and Procedures section, the *Accreditation Handbook for Ambulatory Health Care*, v43 Standards include changes that improve Standards clarity and consistency. Most requirements remain the same. While not a comprehensive list of every change from the prior version, this Appendix provides an easy reference to Standards that are new or significantly revised.

Category	v43 Identifier	v42 Identifier	Type of Change	Additional Notes
ADM Administration	ADM.140.20	3.C.3	Revision for clarity	Wellness programs added
	ADM.140.40	-	New Requirement	Organizations are required to have procedures for handling of workplace violence and aggression
	ADM.150.10	-	New Requirement	Requirement that requires the organization's statement of Patient Rights and Responsibilities and associated policies and procedures should be included in orientation and training
	ADM.150.20	-	New Requirement	Requirement that requires the organization's procedures for handling of workplace violence and aggression should be included in orientation and training
	ADM.150.30	3.D.1	Revision for clarity	
	ADM.150.30.1	3.D.4	Revision for clarity	
	ADM.150.30.2	3.D.2	Revision for clarity	
	ADM.150.40	3.D.1	Revision for clarity	
CRD Clinical Records	CRD.120	6.A	Revision to separate the CMS Condition for Coverage (MDS Program Only)	No change to requirement
	CRD.180.50	6.F.5	Revision for clarity	Refer to glossary for medication reconciliation definition
EMG Emergency Management	EMG.170.50	-	New element added for clarity	
GOV Governance	GOV.220.10	2.I.J.1	Revision for clarity	
	GOV.220.30.1	2.I.J.3.a	Revision for consistency	For consistent use of terms
	GOV.220.30.3	2.I.J.3.c	Revision for clarity	To clarify the safety program is different than the emergency and disaster preparedness plan and risk management program
	GOV.220.30.4	2.I.J.3	Revision for clarity	To clarify what is intended by key programs
	GOV.220.30.5	2.I.J.3	Revision for clarity	To clarify what is intended by key programs
MHM Medical Home	MHM.180.30	25.J.3	Revision for consistency	Refer to glossary for medication reconciliation definition

Category	v43 Identifier	v42 Identifier	Type of Change	Additional Notes
QUA Quality	QUA.180.10	3.F.1	Revision for consistency	Consistent use of terms with v42 16.B, 17.W
	QUA.180.20	3.F.2	Revision for consistency	For consistent use of terms
	QUA.180.30	3.F.3	Revision for consistency	For consistent use of terms

Records Worksheet Crosswalk: Clinical, Credentialing, and Personnel

The list below reflects Standards that evaluate compliance with related requirements. Organizations should refer to the Statements of Requirement (SOR), Elements of Compliance (EOC) and Sub Elements of Compliance (SEOC) for additional requirements that may not be listed below. This list is not exhaustive and does not include every possible document that Surveyors may request as part of the onsite survey to verify compliance with the Standards. This document may also be used by the organization as a self-assessment, support completion of the record, and monitor compliance with policies and procedures.

Credentialing Records Worksheet

Category: CPV Credentialing & Privileging

v43 Identifier	Most Recent Credentialing Cycle
CPV.130.10	Initial appointment
CPV.130.20	Initial appointment
CPV.130.30	Initial appointment
CPV.130.40	Initial appointment
CPV.130.50	Initial appointment
CPV.130.60	Initial appointment
CPV.140.10.1	Initial appointment
CPV.140.10.2	Initial appointment
CPV.140.20	Initial appointment
CPV.140.30	Initial appointment
CPV.140.40	Initial appointment
CPV.140.50	Initial appointment
CPV.140.60	Initial appointment
CPV.140.70	Initial appointment
CPV.150.10	Initial appointment
CPV.150.20	Initial appointment
CPV.150.30	Initial appointment
CPV.160	Initial appointment

v43 Identifier	Most Recent Credentialing Cycle
CPV.170.10	Reappointment
CPV.170.20.1	Reappointment
CPV.170.20.2	Reappointment
CPV.170.20.3	Reappointment
CPV.180	Reappointment
CPV.190.10	Both
CPV.190.30	Both
CPV.190.40	Both
CPV.210.10	Both
CPV.210.20	Both
CPV.210.30	Both
CPV.210.40	Both
CPV.220.10.1	Initial appointment
CPV.220.10.2	Initial appointment
CPV.220.10.3	Initial appointment
CPV.220.20	Initial appointment
CPV.250.10	Both
CPV.250.20	Both
CPV.250.30	Both

Clinical Records Worksheet

Category	v43 Identifier		
ASG Anesthesia and Surgery	ASG.130	ASG.270.30	ASG.280.50
CMC Care Management and Coordination	CMC.100.20	CMC.130.10	CMC.190.10
	CMC.100.30	CMC.130.20	CMC.190.20
	CMC.100.40	CMC.130.30	
	CMC.100.50		
	CMC.100.60		
CRD Clinical Records	CRD.140.10	CRD.200.10	CRD.250.20
	CRD.140.20	CRD.200.20	CRD.260.10
	CRD.140.30	CRD.200.30	CRD.260.20
	CRD.170.10	CRD.200.40	CRD.260.30
	CRD.170.20	CRD.210.20	CRD.260.40
	CRD.170.30	CRD.220	CRD.260.50
	CRD.170.40	CRD.230	CRD.260.50.1
	CRD.170.50	CRD.240.10	CRD.260.50.2
	CRD.180.10	CRD.240.20	CRD.330.10
	CRD.180.20	CRD.240.30	CRD.330.20
	CRD.180.30	CRD.250.10	CRD.330.30
	CRD.180.40	CRD.250.10.1	CRD.330.40
	CRD.180.50	CRD.250.10.2	CRD.330.50
	CRD.180.60	CRD.250.10.3	CRD.330.60
	CRD.180.70	CRD.250.10.4	
MHM Medical Home	MHM.100.50	MHM.120.10	MHM.160.10
		MHM.120.20	MHM.170.10
		MHM.120.30	MHM.180.50
		MHM.120.40	
OCS Other Clinical Services	OCS.100.10	OCS.100.20	OCS.130.30
PRR Patient Rights, Responsibilities and Protections	PRR.250	PRR.260.10	PRR.260.20
		PRR.260.10.1	PRR.310.30
		PRR.260.10.2	

Personnel Records Worksheet

Category	v43 Identifier	
ADM Administration	ADM.120.20	ADM.150.40
	ADM.140.10	ADM.150.50
	ADM.140.50	ADM.150.60
	ADM.140.60	ADM.150.70
	ADM.150.10	ADM.160.10
	ADM.150.20	ADM.160.20
	ADM.150.30	ADM.160.30
	ADM.150.30.1	
	ADM.150.30.2	
CPV Credentialing and Privileging	CPV.160.20	CPV.200.10
	CPV.180	CPV.200.20
	CPV.190.10	CPV.200.30
	CPV.190.20	CPV.200.40
	CPV.190.30	CPV.250.10
	CPV.190.40	CPV.250.20
		CPV.250.30
EMG Emergency Management	EMG.140.10	EMG.280.10
	EMG.140.20	EMG.290.10
	EMG.210.10	
	EMG.210.20	
	EMG.230.10	
	EMG.230.20	
	EMG.230.30	
SAF Safety	SAF.250.30	
	SAF.260.10	
	SAF.280.10	
	SAF.280.20	

Evaluation of Compliance to Standards

For Standards assigned to the organization, the AAAHC Surveyor will evaluate compliance through documentation review, interview, and observation.

Except as noted below, AAAHC uses a five-point rating scale to determine degree of compliance with Standards. The rating scale varies depending on the number of applicable elements. The grids below provide sample rating scales with consideration for the following:

- Standards components and terminology:
  - SOR: Statement of Requirement
  - EOC: Element of Compliance
  - SEOC: Sub Element of Compliance
  - NA: Not Applicable
- Standards without an EOC are rated either Fully Compliant (FC) or Non-Compliant (NC).
- Standards that have EOCs are assessed a compliance rating based on the total number of EOCs applicable and verified. For any given SOR with EOCs, there is a minimum of two and a maximum of seven EOCs associated. Some EOCs have an NA scoring option assessed based on the applicability to the organization.

Rating Grid Rule: Standards for which the SOR has no associated EOCs and NA is not an option

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
Standard is met		No rating option		Standard is not met

Rating Grid Rule: Standards for which the SOR has no associated EOCs *OR* the Standard does not apply to the organization

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant	☐ Not Applicable
Standard is met		No rating option		Standard is not met	Standard does not apply

Rating Grid Rule: Non-CfC Standards with multiple associated EOCs; zero or more EOCs apply

Rating Grid Rule: Standards with 7 elements for which all apply

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
All elements are present	6 of 7 elements are present	4 of 5 of 7 elements are present	2 or 3 of 7 elements are present	1 or no elements are present

Rating Grid Rule: Standards with 6 elements for which all apply *OR* Standards for which 6 elements apply and the remaining element is NA

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
All elements are present	5 of 6 elements are present	3 of 4 of 6 elements are present	2 of 6 elements are present	1 or no elements are present

Rating Grid Rule: Standards with 5 elements for which all apply *OR* Standards for which 5 elements apply and the remaining elements are NA

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
All elements are present	4 of 5 elements are present	3 of 5 elements are present	2 of 5 elements are present	1 or no elements are present

Rating Grid Rule: Standards with 4 elements for which all apply *OR* Standards for which 4 elements apply and the remaining elements are NA

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
All elements are present	No rating option	2 or 3 of 4 elements are present	No rating option	1 or no elements are present

Rating Grid Rule: Standards with 3 elements for which all apply *OR* Standards for which 3 elements apply and the remaining elements are NA

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
All elements are present	No rating option	2 of 3 elements are present	No rating option	1 or no elements are present

Rating Grid Rule: Standards with 2 elements for which all apply *OR* Standards for which 2 elements apply and the remaining elements are NA

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
All elements are present	No rating option	1 of 2 elements are present	No rating option	Neither element is present

Rating Grid Rule: Standards with for which only 1 element applies and the remaining elements are NA

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant
Standard is met		No rating option		Standard is not met

Rating Grid Rule: Standards with for which only 1 element applies or no EOCs apply

☐ Fully Compliant	☐ Substantially Compliant	☐ Partially Compliant	☐ Minimally Compliant	☐ Non-Compliant	☐ Not Applicable
Standard is met		No rating option		Standard is not met	Standard does not apply

Glossary

Terms are defined for the purpose of facilitating interpretation of AAAHC Standards, policies and procedures.

Terms	Definition
Administrative controls	The use of administrative measures (e.g., policies, procedures, training, warning labels, and enforcement measures) to reduce risk.
Admission	The process of accepting someone into a hospital, clinic or other treatment facility.
Advance directives	A formal document or a set of documents that details a person's wishes about care before they become temporarily or permanently incapacitated. All 50 states and the District of Columbia have adopted laws to legalize the use of living wills, health care proxies, and/or a durable power of attorney.
Adverse Event also referred to as Adverse Incident	Any injury or harm to a patient resulting from the delivery of medical care or services. AAAHC expects an organization's definition of an adverse incident to include: a. An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition. b. Any process variation for which a recurrence carries a significant chance of a serious adverse outcome. c. Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient. d. Events involving reactions to drugs and materials.
Alcohol-Based Hand Rub (ABHR)	An alcohol containing preparation designed for application to the hands to reduce the number of viable microorganisms on the hands when no visible soil is present. In the United States, such preparations usually contain 60%-95% ethanol or isopropanol.
Allergies	Abnormal reactions of the immune system that occur in response to allergens. An allergic reaction may occur on contact with an otherwise harmless substance or subsequent to medication administration.
Allied health care professionals	Includes, but is not limited to, advance practice registered nurses and physician assistants. Accredited and/or certified organizations may wish to include additional categories of health care professionals (e.g., dental assistants and orthopedics technicians), who are employed by a credentialed dentist or physician and assist in surgical procedures.
Alternate power source	An additional power source that maintains function when the primary power source fails.
American Society of Anesthesiologists (ASA)	A professional organization providing well- recognized anesthesia, analgesia, and sedation-related standards and guidelines.
Americans with Disabilities Act (ADA)	A federal civil rights law that prohibits discrimination against people with disabilities in defined areas of public life.
Anesthesia	Utilized for pain control during a procedure/surgery. The Accreditation Handbook defines six levels: a. local or topical b. minimal sedation c. moderate sedation/analgesia (conscious sedation) d. regional anesthesia e. deep sedation/analgesia f. general anesthesia
Antimicrobial soap	A soap (e.g., detergent) containing an antiseptic agent.

Terms	Definition
Antiseptic	A germicide used on skin or living tissue for the purpose of inhibiting or destroying microorganisms. Examples include alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol (PCMX), quaternary ammonium compounds, and triclosan.
Antiseptic hand rub	The process of applying an alcohol-based antiseptic hand rub product to all surfaces of the hands to reduce the number of microorganisms present.
Antiseptic hand wash	Washing hands with water and soap or detergents containing an antiseptic agent.
Appeal	A request to a health insurance issuer to review a decision that denies a benefit or payment. A member or authorized representative of a member may appeal any adverse decision.
Advanced Practice Registered Nurse (APRN), also APN	Includes clinical nurse specialist, nurse midwife, nurse practitioner, and nurse anesthetist. Educational and certification requirements and the legal scopes of practices are determined at the state level and vary considerably. Physician assistant (PA) is not included in the definition of APRN (see physician assistant).
ASA physical status classification system	Adopted by the American Society of Anesthesiologists (ASA) as an assessment tool for classifying patients before surgery. The classification tool consists of 6 categories: ASAI: a normal healthy patient; ASA II: a patient with mild systemic disease; ASA III: a patient with severe systemic disease; ASA IV: a patient with severe systemic disease that is a constant life threat to life; ASA V: a moribund patient who is not expected to survive without an operation; ASA VI: a declared brain-dead patient whose organs are being removed for the donor purposes.
Asepsis	The state of being free of living pathogenic microorganisms; also, the process of removing pathogenic microorganisms and protecting against infection by such organisms.
Audit	An examination of records (e.g., clinical, financial, personnel) to verify contents and/or check accuracy. When the result of an audit reveals missing or inaccurate information, appropriate quality improvement activities should be undertaken to ensure that improvement occurs.
Benchmark	A reference point against which other, similar things can be evaluated or measured.
Benchmarking	A systematic comparison of similar products, services, or work processes to identify the best practices known to date for the purpose of continuous quality improvement. When the results of benchmarking indicate that performance improvement is needed, appropriate quality improvement activities should be undertaken to ensure that improvement occurs. Recognized and reliable sources of benchmarking data may be available from professional organizations and societies, and from agencies such as the CDC and AHRQ.
Benchmarking, external	The comparison of the performance of one organization with another's similar processes outside the organization, or with a group of organizations that have similar process.
Benchmarking, internal	The comparison of performance within an organization, such as by physician or department, or over time.
Biological indicator	A device to monitor the sterilization process by monitoring a standardized population of bacterial spores known to be resistant to the mode of sterilization. Biological indicators do not indicate an item is sterile. Use of a biological indicator indicates that all the parameters necessary for sterilization were present.
Bloodborne pathogen standard	A standard developed, promulgated, and enforced by the Occupational Safety and Health Administration (OSHA) directing employers to protect employees from occupational exposure to blood and other potentially infectious material.
Bloodborne pathogens	Disease-producing microorganisms spread by contact with blood, or other body fluids contaminated with blood.
Body Mass Index (BMI)	BMI is a person's weight (kilograms) divided by the square of height (meters). This tool is used to help determine weight categories that can lead to possible health issues.

Terms	Definition
Business Unit (BU)	Owner of the AAAHC Client record and accountable for the accreditation and/or certification. Within *1095 Engage*, BU is used as a generic term for a single site or PBU during profile and application completion.
Case management	A collaborative process of activities including, but not limited to assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost effective outcomes.
Centers for Medicare & Medicaid Services (CMS)	Part of the Department of Health and Human Services that oversees several federal health care programs.
Certified Neuroscience Registered Nurse (CNRN)	A nurse with specialized knowledge and experience in the care of patients with neurological trauma and illness.
Chemical indicator	A device or product to monitor the sterilization process that changes color or form with exposure to one or more of the physical conditions within the sterilizing chamber (e.g., temperature, steam). Chemical indicators are intended to detect potential sterilization failures that could result from incorrect packaging, incorrect loading of the sterilizer, or malfunctions of the sterilizer. A "pass" response does not verify that the processed items are sterile.
Chemical sterilant	Chemicals used for the purpose of destroying all forms of microbial life, including bacterial spores.
Child Business Unit (CBU)	Lowest level of a business structure. Physical site or location (including mobile) that may be surveyed. CBUs must be part of a PBU; cannot stand alone.
Chronic care management	Encompasses the oversight of and education activities conducted by health care professionals to help patients with chronic diseases and health conditions, such as diabetes, high blood pressure, lupus, multiple sclerosis and sleep apnea, learn to understand their condition and live successfully with it.
Cleaning	The removal of visible soil and organic and inorganic contamination from a device or surface, using either the physical action of scrubbing with a surfactant or detergent and water, or an energy-based process (e.g., ultrasonic cleaners) with appropriate chemical agents.
Clinical Laboratory Improvement Amendments (CLIA)	Regulates laboratory testing and requires clinical laboratories to be certified by the Centers for Medicare & Medicaid Services (CMS) before they can accept human samples for diagnostic testing. Laboratories can obtain multiple types of CLIA certificates, based on the kinds of diagnostic tests they conduct.
Clinical support staff	Work under the direct supervision or order of a licensed health care professional. Provide vital assistance in treating and caring for patients or performing diagnostic tests. In some cases, they are involved in looking after the general well-being and comfort of patients. These roles have a direct impact on patients' lives. The professionals may be licensed or certified. Examples: Registered nurses (RN), licensed practical nurses (LPN), licensed vocational nurses (LVN), certified nurse assistants (CNA), medical assistants, dental assistants, pharmacy technician, ultrasound technicians, radiation therapists, surgical technicians. An organization determines whether a registered nurse is considered an allied health care professional or clinical support staff.
Communicable disease	A disease the causative agents of which may pass or be carried from one person to another directly or indirectly.
Community	Refers to the population of various individuals in a common location. The needs of a community can assist in developing a target population.
Comorbidity	The presence of two or more chronic diseases or conditions in a patient.
Compliance	Refers to the act or process to ensure set guidelines, specifications, or requirements are met or exceeded.

Terms	Definition
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	A set of standardized surveys that measure patient satisfaction with the experience of care. CAHPS is sponsored by the Agency for Health Care Research and Quality (AHRQ).
Consumer engagement	Activities to encourage patients to engage in their care.
Continuing Education Unit (CEU)	A measure used in continuing education programs to assist a professional to maintain professional licensure.
Continuing Medical Education (CME)	Activities to help maintain, develop, or increase knowledge for practicing physicians.
Continuity of care	Concerned with quality of care over time; the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care.
Control biological indicator	A biological indicator from the same lot as a test indicator that is left unexposed to the sterilization cycle and then incubated to verify the viability of the test indicator. The control indicator should yield positive results for bacterial growth.
Core leaders	Medical director and clinical resource person appointed to lead and support the specialty program.
Credentialing	A process through which an organization reviews and validates the professional qualifications of applicants (e.g., physicians, allied health professionals) requesting clinical privileges.
Credentials	Evidence of qualifications (i.e., licenses, certifications, education, and experience).
Credentials Verification Organization (CVO)	A service company providing primary source verification of practitioners' credentials on behalf of an accredited and/or certified organization.
Certified Registered Nurse Anesthetist (CRNA)	An advanced practice nurse who administers anesthesia for surgery or other medical procedures.
Decontamination	A process or treatment that renders a medical device, instrument, or environmental surface safe to handle. According to OSHA, "the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal" [29 CFR 1910.1030].
Deep Vein Thrombosis (DVT)	A blood clot that forms in one or more of the deep veins in the body. Most commonly occurs in the lower leg or thigh but can occur in other areas.
Delegation	The transfer or assignment of responsibility for the performance of an activity from one entity to another while retaining full accountability for the outcome.
Discharge, medical	Occurs when a patient is determined to be medically stable but not yet ready to physically leave (i.e., physical discharge) from a health care facility. Before medical discharge, a patient must be medically evaluated by the appropriate professional.
Discharge, physical	The actual physical departure of a patient from a health care facility.
Disease management	An approach to health care that teaches patients how to manage a chronic disease. Patients learn to take responsibility for understanding how to take care of themselves. They learn to avoid potential problems and exacerbation, or worsening, of their health problem.
Disinfectant	A chemical agent used on inanimate objects (nonliving objects such as floors or sinks) to destroy virtually all recognized pathogenic microorganisms, but not necessarily all microbial forms (e.g., bacterial endospores). The Environmental Protection Agency (EPA) groups disinfectants according to whether the product label claims to be a "limited," "general" or "hospital" disinfectant. Always follow manufacturer's instructions and recommendations for use of a product.
Disinfection	The destruction of pathogenic and other kinds of microorganisms by physical or chemical means. Disinfection is less lethal than sterilization, because it destroys most recognized pathogenic microorganisms, but not necessarily all microbial forms, such as bacterial spores. Disinfection does not ensure the margin of safety associated with sterilization processes. Also see high-level disinfection, intermediate disinfection, and low-level disinfection.

Terms	Definition
Durable Medical Equipment (DME)	Any medical equipment used in the home to aid in a better quality of living.
Engineering controls	Controls that isolate or remove the bloodborne pathogens hazard from the workplace (e.g., sharps disposal containers, self-sheathing needles, and medical devices such as sharps with engineered injury protections and needleless systems).
Epidemiology	The study of medicine that focuses on cause, incidence, and control of disease or health outcomes.
Evidence based guidelines	Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances. The guidelines are intended to identify generally recommended interventions to be considered by a knowledgeable health care provider.
External review	A request for a third-party independent review of an organization's adverse determination.
Food and Drug Administration (FDA)	An agency within the U.S. Department of Health and Human Services that Administration (FDA) is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable, and by helping the public get the accurate, science-based information they need to use medicines and foods to improve their health.
Germicide	An agent that destroys microorganisms, especially pathogenic organisms. Other terms with the suffix "–cide" (e.g., virucide, fungicide, bactericide, tuberculocide, sporicide) indicate an agent that destroys the microorganism identified by the prefix. Germicides may be used to inactivate microorganisms in or on living tissue (antiseptic) or on environmental surfaces (disinfectants). Always follow manufacturer's instructions and recommendations for use.
Hand hygiene	A general term that applies to hand washing, antiseptic hand wash, antiseptic hand rub, and surgical hand antisepsis.
Health care professional	An individual who provides health services to a patient.
Healthcare-Acquired Infection (HAI)	Any infection associated with a medical or surgical intervention. The term "health care-acquired" replaces the outdated term "nosocomial."
High-Level Disinfection (HLD)	A disinfection process that inactivates vegetative bacteria, mycobacteria, fungi, and viruses, but not necessarily high numbers of bacterial spores. The FDA further defines a high-level disinfectant as a sterilant used under the same contact conditions except for a shorter contact time.
Immunization	The process by which a person becomes immune or protected against a disease. Although not identical in meaning, this term is often used interchangeably with "vaccination" or "inoculation."
Implant or Implantable device	Device placed into a surgically or naturally formed cavity of the human body and intended to remain there for more than 30 days.
Incident	Any clinical or non-clinical occurrence that is not consistent with the routine care or operation of the organization. Incidents may involve patients, visitors, employees, and medical or dental staff members.
Intermediate-level disinfectant	A liquid chemical germicide registered by the EPA as a hospital disinfectant and with a label claim of potency as a tuberculocidal.
Intermediate-level disinfection	A disinfection process that inactivates vegetative bacteria, most fungi, mycobacteria, and most viruses (particularly the enveloped viruses), but not bacterial spores.
Intervention	A planned and defined action taken to increase the probability of a desired outcome.
Low-level disinfectant	A liquid chemical germicide registered by the EPA as a hospital disinfectant. OSHA requires low-level disinfectants also to have a label claim for potency against HIV and HBV if used for disinfecting clinical contact surfaces.

Terms	Definition
Low-level disinfection	A process that will inactivate most vegetative bacteria, some fungi, and some viruses, but cannot be relied on to inactivate resistant microorganisms such as mycobacteria or bacterial spores.
Malignant hyperthermia (MH)	A biochemical chain reaction response triggered by commonly used general anesthetic gases and the paralyzing agent succinylcholine within the skeletal muscles of susceptible individuals. The general signs of the MH crisis include tachycardia (a rise in heart rate), a greatly increased body metabolism, muscle rigidity and/or fever that may exceed 110° F. Severe complications include: cardiac arrest, brain damage, internal bleeding, failure of other body systems, and death.
Medical staff	All credentialed and privileged health care professionals.
Medication reconciliation	Medication reconciliation includes completing a list of medications, vitamins, nutritional supplements, and over-the-counter drugs at the start of care (ASC admission/hospital admission/start of an office visit), at the transfer of care (within a hospital setting) and at the end of care (ASC discharge/hospital discharge/office visit plan or summary). Reasonable efforts are made to verify dosages and frequency. Adapted from: Medication Reconciliation - Patient Safety and Quality - NCBI Bookshelf (nih.gov)
Member	A person covered under a health plan, either the enrollee or eligible dependent.
National Institute for Occupational Safety and Health (NIOSH)	The federal agency responsible for conducting research and making recommendations for the prevention of work-related disease and injury. The Institute is part of the Centers for Disease Control and Prevention.
National Practitioner Data Bank (NPBD)	A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.
Nationally recognized guidelines	Clinical practice recommendations developed by panels of experts based on systematic review of research evidence that are defined for practitioner use as general guidelines for clinical implementation. Examples include guidelines disseminated by the CDC, OSHA, WHO, or the FDA.
Obstructive Sleep Apnea (OSA)	A common type of sleep apnea characterized by repetitive episodes of shallow or paused breathing during sleep. OSA is caused by a complete or partial obstruction of the upper airway and can result in a decreased oxygen saturation.
Occupational exposure/workplace exposure	A reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.
Operating room	A room equipped for performing surgery; typically maintained as a sterile environment.
Organization Chart	A graphic representation of the structure of an organization. This structure displays the relationships of the positions within an organization.
Orthopaedic Nurses Certification (ONC)	Represents specialized knowledge and experience in the care of orthopaedic patients.
Orthotics	A custom molded, individually designed insert to enhance accurate positioning and support.
Other Potentially Infectious Materials (OPIM)	An OSHA term that refers to (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV (human immunodeficiency virus)-containing or HBV (hepatitis B virus)-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.
Other qualified health care professionals	Professionals qualified by virtue of education, experience, competence, professional licensure, and state laws, rules, and regulations. Includes advanced practice registered nurses, registered nurses, physical therapists, and social workers.

Terms	Definition
Over-Utilization	Providing clinical services that are not clearly indicated; treatment given without medical justification.
PBU	Owner of the AAAHC Client record and accountable for the accreditation and/or certification. Used the same way as BU; A PBU has at least one CBU.
Peer evaluation	Formal documentation received during the initial application for staff privileges. Peer evaluations may come from other professionals acquainted with the applicant's performance, training program mentors, or past professional associates.
Peer review	A participatory process that monitors important aspects of care provided by an organization's individual practitioners, as well as by the organization's practitioners in the aggregate. The results of peer review at the individual level are used in the medical staff reappointment process. When the results of peer review indicate a need for performance improvement at the individual and/or aggregate levels, appropriate quality improvement activities should be undertaken to ensure that improvement occurs.
Performance goal	A statement of a desired level of performance, expressed quantitatively (numerically, e.g., "zero patient falls" or "zero medication errors" or as a percentage, e.g., "greater than 95% compliance"). A performance goal is set when a QI study is begun, so that after corrective action has been taken and re-measurement of performance has occurred, the organization may compare its new performance level against its stated goal and determine whether the corrective actions have enabled the organization to reach the performance goal. Whenever possible, performance goals should be based on established benchmarks of best practice performance.
Performance measure	A clearly defined statement or question describing information to be collected for purposes of improving processes and outcomes of care. Two examples are: (1) Percentage of cases in which each cataract surgeon in the ASC starts (makes the incision for) cataract surgery on or before the time the procedure is scheduled to start. (2) Percentage of visits for which each provider documents a recommendation for chlamydia screening for sexually active non-pregnant female patients age 24 years and younger who have a scheduled (not drop-in) visit.
Performance review	A periodic and systematic process whereby the job performance of an employee is documented and evaluated. Also referred to as a performance review, performance evaluation, development discussion, or employee appraisal, sometimes shortened to "PA".
Personal Protective Equipment (PPE)	Specialized clothing or equipment (e.g., equipment (PPE) gloves, masks, protective eyewear, gowns) worn by an individual for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts, or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.
Physician	A person who has been educated, trained, and licensed to practice the art and science of medicine. The term "physician" includes professionals who have earned MD, DO, DDS, DMD, or DPM degrees.
Physician Assistant (PA)	A licensed health professional who practices medicine as a member of a team with his/her supervising physician.
Post-exposure evaluation	The evaluation and appropriate treatment of a health care worker following an occupational exposure to suspected or confirmed bloodborne pathogens.
Practitioner	A licensed or certified professional who provides medical care or behavioral health care services, or one of the allied health care professions.
Pre-screening	A process of assessing a patient and her/his health status prior to a procedure or surgery. This process is important in determining patients at greater risk and for improving outcomes.

Terms	Definition
Primary source verification	Documented verification by an entity that issued a credential indicating that an individual's statement of possession of that credential is true. Verification may be provided by mail, fax, telephone, or electronically, provided that the method by which it is obtained is documented and measures are taken to demonstrate that there was no interference in the communication by an outside party.
Privileging	An organization's formal process for the assessment of an applicant's qualifications in a specific area or aspect of patient care using appropriate criteria. Approval, modification, or denial of an applicant using appropriate criteria and approving, modifying, or denying any or all requested privileges in a non-arbitrary manner.
Procedure/treatment room	A room, as designated by the organization, in which various treatments or procedures are performed.
Proctored specialty case	An objective evaluation of a physician's clinical competence by a like privileged surgeon at the ASC.
Prosthesis	An artificial device to replace or augment a missing or impaired part of the body.
Quality Assurance (QA)	Systematic monitoring and evaluation of the various aspects of a project, service, or facility to maximize the probability that minimum standards of quality are being attained. The term "quality improvement" is more reflective of ongoing, measurable, and sustained improvements to the care and safety of patients. Throughout its Standards and processes, AAAHC uses the terms "quality improvement" and "QI."
Quality Improvement (QI) program	A systematic, ongoing process to achieve and sustain measurable improvements in performance. A QI program includes various activities to measure and improve performance. Examples of measurement activities include (but are not limited to) benchmarking, monitoring, auditing, and QI studies. Performance improvement activities include corrective actions taken or other types of interventions implemented to improve performance.
Quality Improvement (QI) study	A type of QI activity that includes corrective actions and/or other interventions to improve performance and demonstrates, through measurement, that performance improvement has occurred and is sustained.
Quality monitoring	The ongoing collection of data about a specific aspect of performance. The data is usually collected for a defined interval of time, and then compared to the same data collected for previous intervals to identify desirable and undesirable changes. When undesirable changes are identified, appropriate quality improvement activities should be undertaken to ensure that improvement occurs. Examples of aspects of performance that an organization might monitor include complications, infections, patient falls, adverse incidents, building safety issues such as exit lighting and fire equipment, review of medical record documentation, on-time starts, no-shows, near misses, patient satisfaction, and access to care.
Reappointment	Renewal of membership in a health care service, such as a medical staff or medical group.
Recredentialing	A process through which an organization periodically reviews and validates the professional qualifications of providers (e.g., physicians, dentists, allied health care professionals) requesting reappointment of clinical privileges.
Registered Nurse (RN)	A nurse who has graduated from a program at a college or university and has successfully passed a national licensing exam. Accredited organizations determine whether a registered nurse is considered an allied health care professional or clinical support staff.
Restricted area	A designated space contained within the semi-restricted area and accessible only through a semi-restricted area. Includes the operating and other rooms in which operative or other invasive procedures are performed. Restricted areas have specific HVAC design requirements associated with the intended use of the space. Personnel in the restricted area should wear surgical attire and cover head and facial hair. Masks should be worn when the wearer is in the presence of open sterile supplies or of persons who are completing or have completed a surgical hand scrub. Only authorized personnel and patients accompanied by authorized personnel should be admitted to this area. (Source: AORN)

Terms	Definition
Risk Management	Clinical and administrative activities undertaken by an organization to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself. Risk management considers such factors as patient safety, quality assurance and patient rights.
Safe injection practices	A set of measures taken to perform injections in an optimally safe manner for patients, health care personnel, and others.
Secondary source verification	Documented verification of a credential through a verification report from an entity that has performed primary source verification of that credential. Information received from any such source must meet the same transmission and documentation requirements as defined under primary source verification.
Sterile	Free from all living microorganisms; aseptic.
Sterilization	The physical or chemical process that eliminates all microorganisms. This may be achieved by heat, chemicals, irradiation, high pressure and filtration, or a combination of these methods.
Strategic partner	The entities with which the organization has a contract or agreement relating to the patient service (e.g., home health, care coordinators, vendors). Such relationships have the capacity to bridge gaps in care and directly impact patient outcomes. Factors to consider when selecting strategic partners include outcomes, reputation, and training requirements for licensed personnel.
Surgical hand scrub	An antiseptic-containing preparation that substantially reduces the number of microorganisms on intact skin; it is broad-spectrum, fast-acting, and exists or endures over a prolonged period.
Survey	The physical onsite evaluation or virtual desk review of a single Business Unit (BU), including vehicles, that contributes to or is the sole source of input for an accreditation or certification decision.
Survey Event	Two or more surveys that contribute to a single Parent Business Unit (PBU) accreditation/certification decision for which a single scope is determined composed of the combined work effort necessary to conduct all surveys included in the event and for assignment of one or more Surveyors. MDS survey events are the combination of a Health and Life Safety Code (LSC) survey which combined result in a single accreditation decision.
Survey Tour	A combination of two or more survey events for which the combined survey results are used for the determination of a single Parent Business Unit (PBU) accreditation or certification decision that covers all sites.
Target population	A defined group of patients that a specialty service is designed to serve.
Telehealth	Telehealth (including teledental and telebehavioral health) involves a broader definition of remote healthcare that does not always involve direct clinical services. Telehealth includes the use of telecommunication technologies for patient education, health promotion and wellness outreach and distance learning, program planning, administrative services, and other diverse aspects of a healthcare delivery system. Telehealth can be both synchronous and asynchronous, and does not require the direct, real-time participation of a licensed and credentialed healthcare provider. *Adapted from the Center for Connected Health Policy (CCHP) definition.*
Telemedicine	Telemedicine is the use of medical/behavioral/dental information exchange from one site to another via electronic communication to improve a patient's/client's health status. It is the use of two-way, synchronous, real time interactive communication equipment by a licensed and credentialed healthcare provider and a patient/client. Telemedicine is a segment of telehealth. This includes audio, virtual/video communications equipment, or live chat platforms. *Adapted from the Center for Connected Health Policy (CCHP) definition.*
Time-out	A universal protocol performed immediately before a surgery or procedure to verify the correct patient, procedure, and site. This process should include the entire surgical team and the patient.

Terms	Definition
Transition of care	The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Travel medicine	A branch of medicine that specializes in diseases and conditions that are acquired during travel. Travelers to different countries should be aware of the potential for acquiring diseases and injuries that are not common in their own country. Immunizations, preventive medications, and general precautions are encouraged prior to trips to different parts of the world.
Under-utilization	Failure to provide medical intervention when it is likely to produce a favorable outcome.
Unique Device Identification (UDI)	A number used to identify a medical device throughout its distribution and use.
Utilization Management (UM)	The evaluation of medical necessity against nationally recognized, evidence-based standards and decision support.
Utilization Management (UM) Criteria	The application of objective and quantifiable guidelines to assess health care decision making.
Utilization review	Critical examination of health care services provided to patients (e.g., identifying unnecessary medical procedures) and monitoring the quality of care.
Vaccine	A product that improves immunity to a specific disease.
Venous Thromboembolism (VTE)	The formation of a blood clot in a vein.
Worker compensation laws	Regulations regarding employer requirements when employees are injured or disabled on the job. These laws are regulated by each state.

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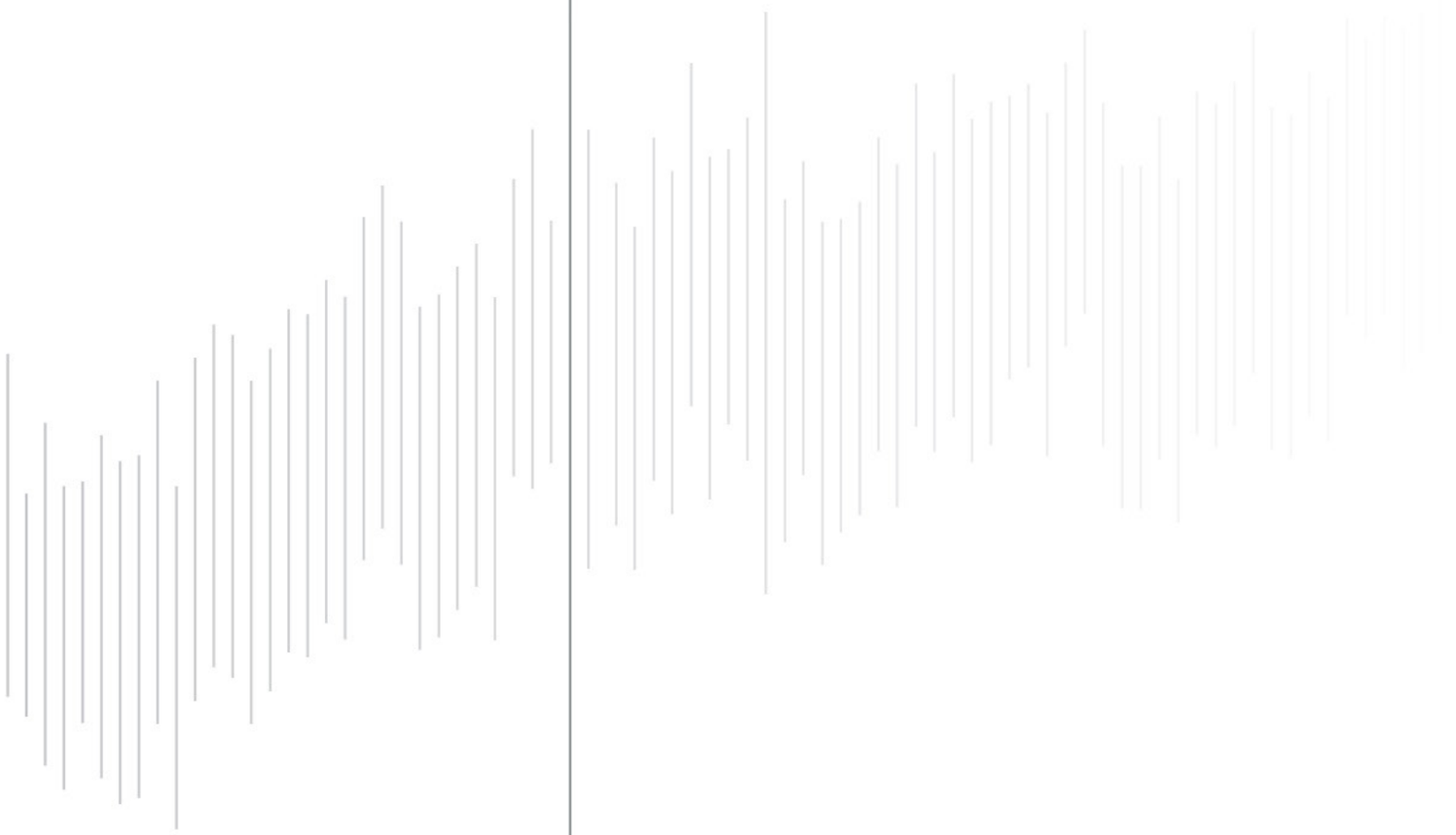

The 1095 Strong, quality every day philosophy provides ongoing client engagement through valuable and meaningful tools, resources, and education that help organizations improve the quality and safety of care.

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Note: Page references followed by n, indicate footnotes.

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