AAAHC
ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE

Moving Forward with Enhanced Standards v41

July 2020

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Today's Presenters

Meg Kerr, MPA
Vice President,
Standards Development

Frank Chapman, MBA
Chair, AAAHC Standards
Development Committee

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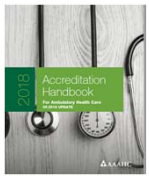
Version 41

- Past editions identified by calendar year



- Switching to version numbers
  - Separates release of new/revised Standards from a specific timeframe
  - Provides flexibility

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What's new in v41?

- More concise language, improved clarity
- More consistent / organized formatting
- Less repetition
- New Standards on current best practices, regulatory requirements

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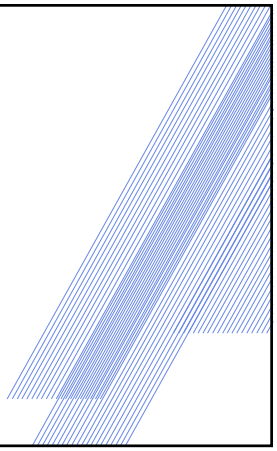
Version 41 Revisions



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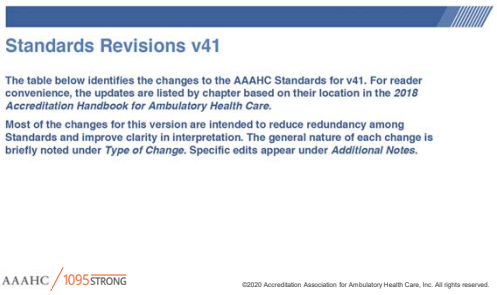
Guide to Version 41 Revisions

Handbook Pages 215-221



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Types of Revisions

- Reorganized / renumbered, without change in requirements
- Divided without change in requirements: max number of Elements of Compliance = 7
- Deleted for redundancy
- Edited for clarity and/or applicability
- Sub-elements of Compliance no longer rated individually; all must be present for Element to be rated "Yes"
- New and revised

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Standard 2.I.F

Ch. 2.I, Governance: General Requirements

New Statement of Requirement:

The governing body is responsible for ensuring appropriate communication within and on behalf of the organization.

- Elements of Compliance are not new; formerly present at 2018 Standards:
  - 2.I.B.7
  - 2.I.B.8
  - 2.I.B.11
  - 3.A.6
  - 3.A.8

No new or different actions are required

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Standard 2.II.I (former 2.II.G)

Ch. 2.II, Governance: Credentialing and Privileging

Revised:

- The governing body makes appointment and reappointment decisions following review of the applications or based on recommendations from a delegated entity.

New Element of Compliance:

- If the governing body delegates responsibility for reviewing the applications, documentation of the delegation is present. (May be NA)

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Standard 2.II.I (cont.)

References / Notes:

- In this context, “delegated entity” 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 Standard 2.II.K.4 requires review by an outside provider.

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Standard 3.A

Ch. 3: Administration

Administrative policies, procedures, and controls adopted by the governing body are implemented to ensure the orderly and efficient management of the organization.

- Formerly 8 elements, now reduced to 5
- Element 2 deleted:

~~2. There is evidence that policies in written manuals, handbooks, and/or standard operating procedure (SOPs):~~

~~a. Have been made available to staff.~~

~~b. Are enforced.~~

- Two other elements moved to Chapter 2.I

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Standard 5.I.D (formerly 5.I.C)

Ch.5.I: Quality Improvement Program

The organization demonstrates that continuous improvement is occurring by conducting quality improvement studies when the data collection processes described in Standard 5.I.C indicate that improvement is or may be warranted.

1. As evidenced by documentation of quality improvement studies conducted, the studies include the applicable components of the quality improvement process.
2. At least one current quality improvement study demonstrates that improvement occurred and has been sustained.
3. As documented in committee and/or staff meeting minutes, and/or in records of educational activities, the findings of quality improvement activities are communicated:
   a. To the governing body.
   b. Throughout the organization, as appropriate.

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Standard 5.II.A

Ch. 5.II: Risk Management

2018:

The organization has a written risk management program and/or policies.

V41:

The risk management program includes written policies.

Former Element 7 deleted as redundant with Chapter 2.II:

~~The identification of persons authorized to perform or assist in the procedure area~~.

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Standard 6.L (former 6.K.1)

Ch. 6: Clinical Records

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.

1. Summaries or records are obtained from the external provider(s) or organization. (Yes, No)
2. Summaries or records are incorporated into the clinical record. (Yes, No, NA)
3. Summaries or records are provided to the external health care professional as appropriate and in accordance with Standard 6.D. (Yes, No)

References / Notes

Surgical organizations may choose to maintain such records in a file other than the clinical record. Therefore, Element 2 has an NA rating option.

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Standards 7.I.F and G (former 7.I.G)

Ch. 7.I: Infection Prevention and Control

Safeguards are in place to protect patients and others from cross-infection.

New Element 4:

Written policies identify people authorized to be in patient care areas.

Former Element 4 is now 7.I.G:

Resources are sufficient to protect patients and others from cross-infection.

1. Space is sufficient.
2. Equipment is sufficient.
3. Supplies are sufficient.
4. Personnel are sufficient.

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2018 Standard 8.L

If the facility will undergo a demolition, construction, or renovation project while occupied, a proactive and ongoing risk assessment for existing or potential environmental hazards is documented.

1. If such a project is planned or has occurred, documentation of the proactive and ongoing risk assessment is present. (Yes/No/NA)
2. The assessment includes the steps taken to mitigate identified risks. (Yes/No/NA)
3. If no such project is planned or has occurred, staff demonstrates knowledge of procedures in place to ensure the risk assessment would occur when needed. (Yes/No/NA)

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Standard 7.II.B (former 8.L; revised)

Ch. 7.II: Safety

The safety program requires performance of a proactive, documented risk assessment before commencing demolition, construction or renovation while the facility is occupied.

1. The risk assessment identifies potential risks to occupant health and/or safety.
2. The risk assessment identifies actions necessary to eliminate or adequately mitigate such risks.
3. 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.

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Standard 7.II.C (former 8.L; revised)

Ch. 7.II: Safety

Documentation demonstrates that the risk assessment was conducted or is underway in accordance with the requirements of the organization's safety program.

References / Notes

- For initial surveys, apply the NA rating. May also be rated NA on reaccreditation surveys if none of the types of projects described in Standard 7.II.B have occurred in the last three years, or no such project is anticipated.

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Standard 7.II.I

Ch. 7.II: Safety

A written policy requires documentation of the pre-cleaning, transport, and handling of medical devices intended for external vendor reprocessing, inspection, or repair.

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Standard 8.A (Revised)

Ch. 8: Facilities and Environment

~~The facility is in compliance with all applicable building codes and regulations~~. Documentation demonstrates that the facility complies with applicable building codes and regulations.

1. ~~An approved occupancy permit demonstrates compliance with applicable state and local building codes and regulations.~~
2. ~~Documentation of periodic inspection by the local or state fire authority is present, if this service is available in the community.~~

References / Notes

- 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.

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2018 Standard 9.G

Ch. 9: Anesthesia Care Services

Deleted; redundant with Core Standard in Ch.7.II:

~~As demonstrated by documentation in training or personnel records, all clinical support personnel with direct patient contact maintain, at a minimum, skills in basic life support (BLS).~~

BLS requirements at the following 2018 Standards also deleted for redundancy:

- 10.I.C.1.b (Surgical Services)
- 14.H (Dental Services)
- 22.B (Immediate/Urgent Care Services)
- 23.D (Emergency Services)

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Standards 10.I.N and 10.I.O (former 10.I.M)

Ch. 10.I: Surgical Services – General Requirements

- 2018 Standard 10.I.M combines requirements for procedure verification and site marking
- Revised Standards address topics separately

10.I.N

Prior to the surgery or procedure, the intended procedure is verified.

1. A written verification policy is present.
2. The patient or their authorized representative is involved in the verification process.
3. Clinical records contain documentation of procedure verification.

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Standards 10.I.N and 10.I.O (former 10.I.M)

Ch. 10.I: Surgical Services – General Requirements

10.I.O

Prior to a surgery or procedure involving level or laterality, the site is marked.

1. A written site marking policy is present.
2. The policy includes the organization's definition of "surgical team."
3. The patient or their authorized representative is involved in the site marking process prior to the administration of anesthesia.
4. 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.
5. Clinical records contain documentation of site marking.

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New Standard 11.F

Ch. 11: Pharmaceutical Services

The medication inventory is monitored to track the presence or absence of high-alert medications and medications with confused drug names.

1. A written policy describes the monitoring process and responsibility(ies) for its implementation.
2. Documentation demonstrates that relevant staff have been trained on the policy.
3. Monitoring activities are documented.

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Standards 11.G and 11.H (former 11.F)

Ch. 11: Pharmaceutical Services

G: Procedures are in place to prevent errors from high-alert medications.

H: Procedures are in place to prevent errors from medications with confused drug names.

Same elements of compliance for both:

1. A list of high-alert medications currently present in the facility is maintained.
2. Processes are in place to prevent errors from administration of these medications, in accordance with nationally recognized guidelines.

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New Standard 11.N

Ch. 11: Pharmaceutical Services

Nationally recognized guidelines for vaccine storage and handling are followed.

1. Guidelines adopted by the governing body.
2. Written P&Ps for routine storage and handling.
3. Written P&Ps for storage, handling and transport in case of emergency.
4. Documentation of training of relevant staff.
5. Vaccine storage unit is equipped with a temperature monitoring device per adopted guidelines.
6. Staff knowledge of procedures if vaccines are exposed to a temperature excursion.

References / Notes

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.

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Standards 12.A - 12.E

Ch. 12: Pathology and Medical Laboratory Services

Expanded to address additional types of laboratory certificates, both CLIA and state

- Standards 12.A and 12.C address requirements for CLIA and/or state certificates based on lab services provided
  - State laboratory programs in New York and Washington are currently exempt from CLIA requirements
  - Other states require both CLIA and state certificates
- Standards 12.B, 12.D and 12.E address the qualifications of persons directing lab services, based on required certificates
- Some may not apply, depending on state and services provided

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Standard 12.I (former 12.H)

Ch. 12: Pathology and Medical Laboratory Services

Laboratory quality control procedures are performed.

1. Quality controls are performed in accordance with manufacturer instructions.
2. The results of quality control procedures are documented.
3. Equipment is calibrated in accordance with manufacturer instructions.
4. Validation tests for new equipment are performed in accordance with manufacturer instructions.

References / Notes

- Elements 3 and 4 apply only if moderate complexity and/or high complexity testing are conducted.

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New Standard 12.J

Ch. 12: Pathology and Medical Laboratory Services

Proficiency testing is performed if required by CLIA, the CLIA accrediting body, the state, and/or the organization's policies.

- May be NA
- Check requirements for your CLIA and/or state certificate type
- To learn more about proficiency testing, see:
  https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/CLIAbrochure8.pdf

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Standard 12.M (former 12.K)

Ch. 12: Pathology and Medical Laboratory Services

Laboratory work is performed with optimal accuracy, precision, efficiency, and safety.

1. All test kits, laboratory devices and supporting supplies are FDA approved for use under the type of CLIA or state certificate obtained.
2. Observation and interviews confirm that the following are sufficient:
   a. Space.
   b. Equipment.
   c. Supplies.

References / Notes

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

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Chapters 13 - 25

No significant revisions

13. Diagnostic and Other Imaging Services
14. Dental Services
15. Travel Medicine
16. Health Education and Health Promotion
17. Behavioral Health Services
18. Teaching and Publication Activities
19. Research Activities
20. Overnight Care and Services
21. Occupational Health Services
22. Immediate/Urgent Care Services
23. Emergency Services
24. Radiation Oncology Treatment Services
25. Medical Home

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A note about the rating process

Some Elements of Compliance have sub-elements, *e.g.*:

Standard 1.A

Patients are treated with respect, consideration and dignity.

1. Patients are provided appropriate privacy:
   a. At check-in
   b. In evaluation and treatment areas

- Sub-elements are no longer rated separately
- **Both** must be assessed as "Yes" for the Element to be rated "Yes"

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Guide to Version 41 Revisions

Pages 215-221 in the Handbook

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When does v41 take effect?

November 1, 2020

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When does v41 take effect?

Surveys that have been delayed

If your accreditation expiration date is:

- *Prior to* November 1, but…
- Your survey takes place *on or after* November 1, 2020 due to delays caused by the COVID-19 pandemic

Then your survey will be conducted using v41.

If you have questions:

During the application and scheduling process, the AAAHC Accreditation Services team will help you determine the applicable version.

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