AAAHC
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Moving Forward with Enhanced Standards v41
Webinar Q&A
July 15, 2020

Questions (v41 Standards Reference)	Response
1. Does the delegated entity responsible for recommending appointment or reappointment have to be a physician? Can the facility leadership (Administrator/Nurse Manager/Clinical Director) be responsible alone? (2.II.I)	The delegated entity (or members of the delegated entity, if the delegate is a committee) should have the appropriate clinical training to evaluate the application and make a recommendation regarding appointment or reappointment. At minimum, the person(s) making the recommendation should be qualified to provide peer review of the applicant.
2. Does this requirement also apply to obtaining the outside documents PRE-operatively? (6.L)	Standard 6.L of v41 refers to the records of established patients. An ASC may receive information, such as an H&P, before a record has been created. The prospective patient may or may not become a patient for whom a record is eventually created. If the patient never receives treatment and no record is created, such information is typically shredded.
3. Do we still need to keep a summary of past surgical visits at our center on the medical record? (6.K element 3)	Element 3 of v41 Standard 6.K maintains the following requirement: 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.
4. We are surveyed by the state for both CMS and state standards that include facility and environmental review of meeting all applicable codes. This is done every three years. Is having this documentation sufficient to meet this Standard? (8.A)	Standard 8.A simply states that "Documentation demonstrates that the facility complies with applicable building codes and regulations." 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. If CMS and the state are your relevant building approval authorities, then documentation from them is sufficient if it indicates that the building is in compliance.
5. Will the application be revised to eliminate the need for an Occupancy Permit or Fire Inspection due to 8.A?	The Application for Accreditation asks for documentation and includes help text that references Standard 8.A. The v41 Handbook contains a note at Standard 8.A (see question above) explaining the types of acceptable documentation.

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6. Construction/Renovation Risk Assessments: • **For 8.L regarding a renovation Safety/Risk assessment, is there a list of elements that need evaluation?** • **Are there any known resources for risk assessments related to construction other than Infection Prevention - ICRA reviews?**	Standard 7.II.B of v41 (former Standard 8.L) requires the risk assessment to: 1) Identify potential risks to occupant health and/or safety; 2) Identify actions necessary to eliminate or adequately mitigate such risks; and 3) Identify 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. The Facilities Guidelines Institute (FGI) offers a free Safety Risk Assessment Toolkit on its website. Note: This is just an example and may or may not suit all needs. https://fgiguidelines.org/resource/chd-safety-risk-assessment-toolkit/
7. Are there any changes for anesthesia or care in the PACU? (Chapters 9 and 10)	The few minor changes to Chapter 9, Anesthesia Care Services, are noted in the summary of revisions that begins on page 215 of the v41 Handbook. As discussed during the webinar, the major changes to Chapter 10.I are related to procedure verification and site marking. The summary of revisions in the Handbook lists the few other minor changes to Chapter 10.I, Surgical Services.
8. Site marking: • **If we determine that the circulating RN is part of the "surgical team," they can then mark the surgical site. Is this correct?** • **Clarifying that as long as the policy states it, Anesthesia can mark the surgery site?** • **If pre-op RNs mark the surgical site and are not in the OR when this is done, does the surgeon, anesthesia, circulating nurse have to mark the surgical site or just validate it when the patient is in the OR during the time-out with the surgeon and anesthesia?** • **Does the person marking the site need to be documented?**	Standard 10.I.O of v41 requires a site marking policy, and the policy needs to contain your definition of the "surgical team." The site must be marked by the person performing the procedure, OR by another member of the "surgical team" *who will be present during the time-out*. Site marking by a pre-op RN who is either *not* defined as part of the surgical team, and/or will *not* be present during the time-out, does not meet the Standard. The Standard also requires that clinical records contain documentation of site marking, to confirm that it was done and by whom, including that person's associated licensure. If your current policy requires that only the person performing the procedure may mark the site and you wish to maintain that policy, you may certainly do so, and have your definition of "surgical team" reflect that requirement.
9. What is the website that has a list of high-alert medications?	The Institute for Safe Medication practices, www.ismp.org, provides lists of both high-alert medications and medications with confused drug names (look-alike/sound-alike medications). These lists will be helpful for ensuring compliance with v41 Standards 11.F, G and H.

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10. Vaccine Management: • **Regarding new Standard 11.N, is it acceptable to reference the CDC toolkit in policy/procedure and state that in the event of an excursion, guidance outlined in toolkit will be followed, OR does the specific detailed language from the tool kit need to be provided in the facility policy?** • **The CDC has a very detailed toolkit regarding storage and handling of vaccines--would it be acceptable for an ASCs P&P to refer to this document to meet the new Standard 11.N?**	• Yes, that would be acceptable. Keep in mind that a surveyor will expect you to follow whatever guidelines your policies and procedures indicate you have adopted. If you don't intend to adopt every item in a guideline, then your policies and procedures should be specific about what has and has not been adopted. • Yes, in fact, the CDC's guidelines are noted in the v41 Handbook as an example of nationally recognized guidelines for vaccine management.
11. Validation Testing: • **Re: Standard 12.I and the new elements 3 and 4, can you please repeat which CLIA group to which those elements do not apply?** • **Can you speak a little more on the validation testing needed for some testing equipment? I was told by a surveyor this needed to be done for my glucometers and INR machine, in addition to the regular quality tests we do daily on them.**	• For v41 Standard 12.I, elements 3 and 4 apply if moderate complexity or high complexity testing is conducted. These elements do not apply if only waived testing is conducted. • Refer to v41 Standard 8.J, which applies to all organizations regardless of CLIA certificate type, and regardless of the types of devices or equipment used. Testing, calibration and maintenance should always be conducted in accordance with the manufacturer's instructions.
12. Where can I find the recording of this webinar, and a copy of the slides?	Both the webinar recording and slides are located on the AAAHC website at: https://www.aaahc.org/education/standards-and-policy-updates/
13. What revisions to the ASC's Infection Prevention risk assessment regarding COVID-19 will surveyors be looking for?	Surveyors will determine whether an organization conducted a risk assessment specific to COVID-19 and updated the infection prevention and control program as needed to address infectious diseases. If your program already contained all of the appropriate provisions, the risk assessment may determine that the program may not need to be updated very much or at all. Refer to the Readiness Checklist for more information. Checklists are located here: https://www.aaahc.org/what-you-need-to-know/
14. Does completing the Readiness Checklist qualify as a COVID risk assessment?	We hope that the checklist provides a useful foundation for your risk assessment. However, each organization faces different risk factors depending on geographic location, services and procedures provided, patients served and other factors. Therefore, the checklist alone may not be sufficient for your particular situation.

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15. AAAHC Standards require quarterly drills. How will this be handled if we were closed for a quarter? How do we handle drills when working from home?	The Readiness Checklists for non-Medicare Deemed Status surgical organizations, and for Primary Care organizations, are located here: https://www.aaahc.org/what-you-need-to-know/. Both Checklists identify the requirement for quarterly drills as waived, i.e., during the period in which an organization was closed or operating at reduced capacity or altered functionality (e.g., seeing patients via telemedicine), could not be met. Organizations are not expected to make up for waived items but are expected to resume compliance as they return to normal operations.
16. Do you anticipate having any Standards in place for adequate ventilation in offices in light of COVID?	We continue to assess our Standards to ensure they address all aspects of events such as pandemics but have not identified any specific additional Standards at this time. v41 Standard 8.E.5 requires "adequate ventilation." Your risk assessment should determine whether changes are necessary to address pandemic situations.
17. Considering COVID, anything new to add or comment on relative to telehealth services as an originating site where the patient is located.	Although the Standards do not specifically address telehealth, a number of existing Standards are relevant to telehealth. The following document was developed for college health settings, but applies generally to primary or specialty care provided in an office setting: https://www.aaahc.org/wp-content/uploads/2020/05/AAAHC-ACHA-College-Health-Crosswalk-FINAL.pdf
18. During the COVID pandemic, are drivers/family members allowed to enter the ASC while the patient is having the procedure?	Allowing visitors to accompany patients into your ASC is a matter of ASC policy, as approved by your governing body. The policy should reference nationally accepted guidelines for the specific care being provided. Many specialty societies have published such guidelines.
19. Are there any changes to how onsite surveys are conducted while the pandemic continues? Is AAAHC exploring the option of virtual visits for accreditation during the pandemic?	AAAHC continues to conduct onsite surveys. As mentioned during the webinar, organizations are welcome to add virtual elements, such as for the opening and summation conferences when it may be desirable to limit a group size. Surveyors are expected to follow your policies with regard to PPE, social distancing, etc. Before they arrive, please let the surveyors (or AAAHC staff) know what to expect.
20. Do you know if surveys will continue to be delayed?	The situation changes continuously and is different in different locations, so predictions are difficult. For your particular circumstances, please contact your AAAHC Account Manager or info@aaahc.org.
21. If we have a new executive director starting this week, do we need to notify AAAHC?	Please notify AAAHC if the new director will become the primary contact between your organization and AAAHC. If that is not the case, we still recommend that you notify us so that we may update our approved contact list to include the new director. We are only able to discuss specific information about your accreditation with people on the approved contact list.

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22. Our expiration date is Dec. 2020. Because of the 6-month application process, do we need to immediately download v41?	The v41 Handbook is now available for download. Refer to the webinar slides for the website where it is located; you can find the slides here: https://www.aaahc.org/education/standards-and-policy-updates/ You may also contact info@aaahc.org to gain access to a complimentary electronic PDF version of the Handbook.
23. How do I determine whether my next survey will be conducted under v41?	Generally speaking, the effective date of version 41 is November 1, 2020. If your accreditation expiration date is on or after November 1, 2020, you will be surveyed against this set of Standards, including if your survey takes place *before* November 1st. (And, a reminder that even if your next survey is not due to occur until early 2021, the effective date for compliance with v41 Standards is November 1, 2020.) 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 additional questions, the AAAHC Accreditation Services team will help you determine the applicable version during the application and scheduling processes.
24. Will there be a v41 Handbook for Medicare Deemed Status? If so, when will it be available?	Yes, there will be a v41 for Medicare Deemed Status. We are working on it now and it is coming soon. We will notify all ASCs in the Deemed Status program as soon as it is available.
25. Will the September education program be virtual?	Yes, it will be! Keep an eye on this website for more information: https://www.aaahc.org/education/seminar-achieving-accreditation/