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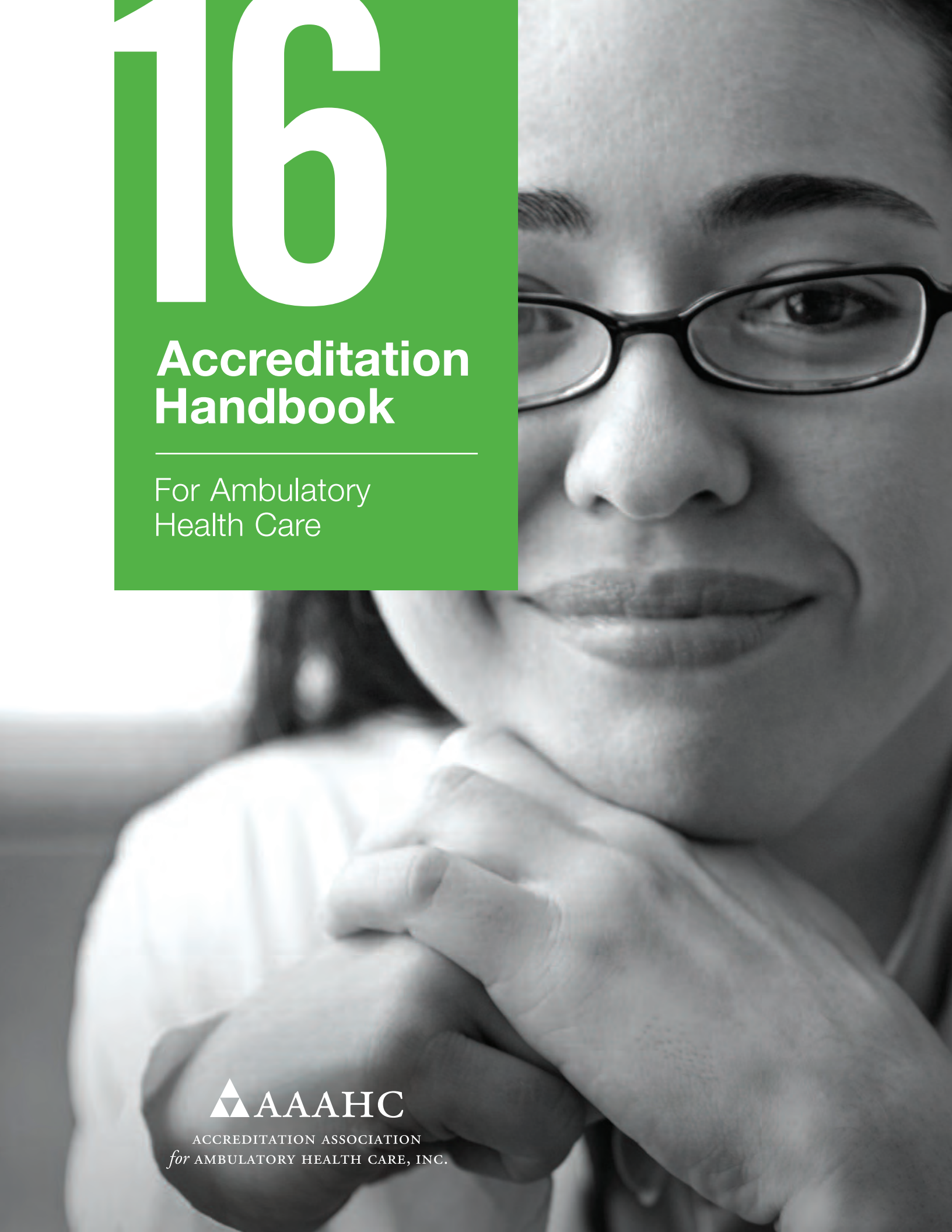
Accreditation Handbook

For Ambulatory Health Care



AAAHC

ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

OUR MISSION

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION

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References are made throughout this handbook to the NFPA 101® *Life Safety Code,*® 2000 Edition. Both are registered trademarks of the National Fire Protection Association, Quincy, Massachusetts.

The pronouns used in this handbook were chosen for ease of reading. They are not intended to exclude references to either gender.

Foreword

At AAAHC, our aim is to help improve the quality of care that accredited organizations provide to their patients, and the efficiency and effectiveness of how these organizations operate. We accomplish this with a consultative, educational approach to accreditation that centers on a triennial on-site survey and on resources that provide continuous opportunities for building performance excellence.

One such resource is the *Accreditation Handbook*. Each year we create versions of the handbook that are customized to reflect distinctions among the types of practices that our accreditation programs support. For 2016, the version you are holding (or reading electronically) is intended for primary medical or dental care organizations and for surgical/procedural care organizations that are not surveyed by AAAHC for Medicare Deemed Status. This is also the right publication for an organization that owns and operates at least 10 sites of (non-surgical) care, and seeks accreditation as a network. These organizations should begin review of our policies and procedures at the **Network Accreditation Program** tab.

For ASCs that do participate in the AAAHC Medicare Deemed Status Program, we have developed the *Accreditation Handbook for Medicare Deemed Status Surveys*. The content of the individual AAAHC Standards remains the same in both books, but our Standards and the CMS Conditions for Coverage have been interwoven and some policies and procedures are unique to Medicare Deemed Status Surveys.

For smaller surgical organizations, there is the *Accreditation Handbook for Office-Based Surgery*. While these organizations must meet the same AAAHC Standards, this publication includes surveyor review guidelines intended to offer additional support in understanding our expectations for how an organization with a smaller staff and a less complex organizational structure can demonstrate compliance with the Standards.

Each handbook is designed as a tool for self-assessment. Review the relevant Standards and evaluate how your organization puts them into practice. The worksheets—identical to those used by surveyors—can be useful in performing a mock survey. The self-assessment process may reveal best practices of which you were unaware or situations in which you are performing an important activity, but neglecting to document it or to evaluate its outcome. Remember that measurement drives improvement—but only if you review and compare the data and take corrective action when warranted.

When AAAHC surveyors visit your organization, they are not only evaluating your compliance with the Standards; they are bringing a collegial and consultative point of view to create a focused and helpful survey experience. But the on-site survey that serves as your organization's three year check-up is not the only time we want to hear from you. Your comments on proposed changes to the Standards, your questions about individual Standards, and your feedback on our process and resources is a valuable component of our own self-assessment.

Thank you for your support of our mission.

Frank Chapman, MBA
Board Chair

Stephen A. Martin, Jr., PhD, MPH
President and CEO

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Acknowledgments

We gratefully acknowledge the efforts of the AAAHC Board of Directors, the Standards and Survey Procedures Committee, and the Health Plan Advisory Committee.

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Note to Readers: Using this *Handbook*

The 2016 edition of the *Accreditation Handbook for Ambulatory Health Care* has been developed to communicate AAAHC policies and procedures, to assist organizations in realistically assessing their compliance with AAAHC Standards, and to provide tools and resources to help health care organizations improve.

The Standards are presented with rating checklists to provide an easy way to track the results of self-assessment. The compliance ratings are defined as:

SC — **Substantially Compliant** indicates that the organization's current operations are acceptable and meet the Standard.

PC — **Partially Compliant** indicates that a portion of the item is acceptable, but other areas should be addressed.

NC — **Non-Complaint** indicates that the organization's operations in the relevant area do not meet the Standard.

NA — **Not Applicable** indicates that the Standard does not apply to the organization (only present in adjunct chapters).

Following the chapters are tools that parallel those used by surveyors while on-site, and additional resources that may be helpful.

Note to Readers: Maintaining contact with AAAHC

From time to time, AAAHC uses e-mail to distribute important information affecting accredited organizations. We rely on each accredited organization to make sure that these communications get to the relevant individual by designating a Primary Contact. If your organization changes its Primary Contact for accreditation, please follow the instruction below to be sure your organization continues to receive important and timely information from us.

Send contact information changes on facility letterhead, signed by your organization's Administrator or Chief Medical Officer via e-mail, fax, or mail as follows:

E-mail: notify@aaahc.org

Fax: 847.853.9028

Mail: AAAHC Accreditation Services, 5250 Old Orchard Road, Suite 200, Skokie, IL 60077

Notice of a change should include the name of the new Primary Contact, his/her job title, phone number, and e-mail address. Changes to the Primary Contact are not accepted over the telephone.

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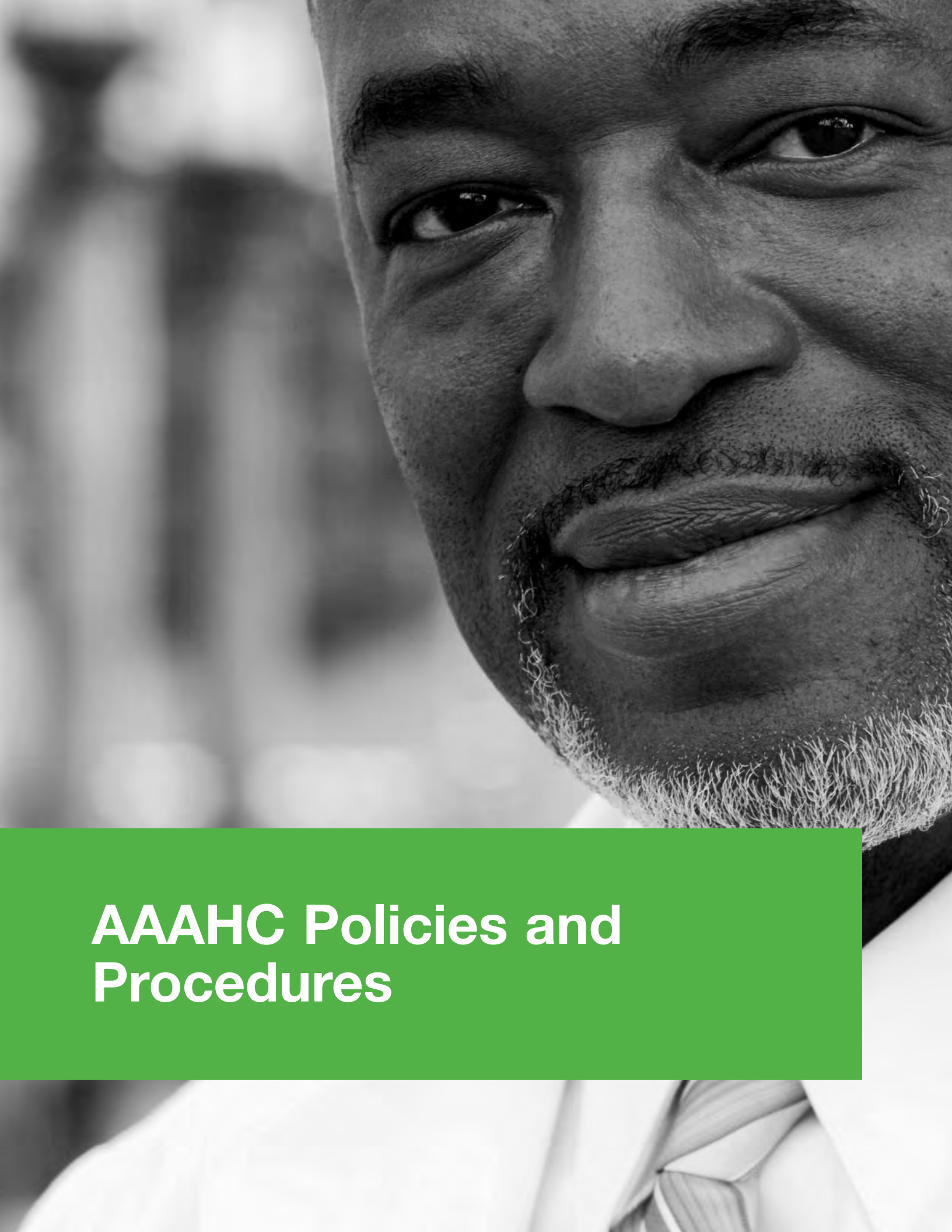

AAAHC Policies and Procedures

AAAHC Policies and Procedures

Introduction

Through its accreditation programs, AAAHC promotes safe, high-quality patient care, and measurement of performance in organizations providing health care services in ambulatory settings.

Many types of health care organizations have found AAAHC Standards and survey procedures appropriate and helpful in improving the quality of care they provide as well as the overall effectiveness and efficiency of their operations, including:

- Ambulatory health care clinics
- Ambulatory surgery centers
- College and university health centers
- Community health centers
- Dental practices — small and large
- Diagnostic and other imaging centers
- Endoscopy centers
- Indian health centers
- Lithotripsy centers
- Non-surgical network organizations
- Health plans/managed care organizations
- Military ambulatory health care facilities
- Multispecialty group practices
- 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 that function as Medical Homes
- Radiation oncology centers
- Single-specialty group practices
- Urgent or immediate care centers
- Women's health centers

The following lists setting-specific publications and content that may be appropriate for your organization:

For Medicare-certified ASCs:

Accreditation Handbook for Medicare Deemed Status Surveys

For small office-based surgery and procedure centers:

Accreditation Handbook for Office-Based Surgery

For non-surgical networks with 10 or more sites of service:

See **Network Accreditation Program** section in this handbook

For health plans, certified QHPs, and Federal Employee Health Benefit Plans:

Accreditation Handbook for Health Plans

Accreditation Handbook for FEHB Health Plans

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AAAHC Standards

The Standards in this handbook describe characteristics that we believe to be indicative of an accreditable ambulatory health care organization. Most AAAHC Standards are written in general terms to allow an organization to achieve compliance in a manner that is compatible with its specific situation and most conducive to high-quality patient care. Where the acceptable methods of achieving compliance with a Standard are limited, the Standard is written in specific terms. Whether a Standard is stated in general or specific terms, AAAHC is primarily concerned about compliance with the intent of the Standard.

Application of the Standards

The Standards contained in Chapters 1–8 will be applied to all organizations seeking an accreditation survey. AAAHC core Standards are interrelated and also relate to applicable adjunct Standards. See the back of the Core Chapters title page for further illustration and description of these relationships.

The Standards contained in Chapters 9–25 will be applied when relevant to the services provided by the organization. For example, immediate/urgent care centers, radiation oncology treatment centers, and occupational health centers must be in compliance with the respective adjunct chapters for these settings, as well as with core Standards and with other applicable adjunct Standards, such as those for pathology and medical laboratory services, and diagnostic and other imaging services. Review the adjunct chapter headings in order to assess applicability to your organization.

Similarly, organizations providing surgical/procedural services must meet the core Standards, plus the adjunct Standards for anesthesia care services and surgical and related services, as well as all other relevant adjunct Standards. Any questions about the applicability or non-applicability of this handbook, individual chapters or Standards should be directed to the AAAHC office prior to submitting an *Application for Survey*.

Throughout this handbook, reference is made to specific documents or standards published by other organizations. Subsequent editions of these publications become the authoritative reference for AAAHC only after they have been approved as such by the AAAHC Board of Directors.

Applicable version of the Standards

An organization will be surveyed according to the 2015 Standards if an *Application for Survey* is completed and received by AAAHC on or before February 29, 2016, AND the organization's survey begins on or before June 30, 2016.

An organization will be surveyed according to the 2016 Standards if an *Application for Survey* is completed and received by AAAHC on or after March 1, 2016, AND/OR the organization's survey begins on or after July 1, 2016.

Comments and suggestions about the Standards

All revisions, additions, or deletions to the Standards proposed by the Standards and Survey Procedures Committee for the next year are subject to a public comment period of 30 calendar days. Proposed changes are posted annually, usually in late August or early September, at www.aaahc.org. AAAHC solicits and invites comments regarding the proposed annual changes to the Standards from its member organizations and all other interested parties.

Following the period of public comment, the committee submits proposed revisions, additions, and deletions to the existing Standards, all relevant public comments received, and any recommendations in response to the comments to the AAAHC Board of Directors for review, and final approval.

We also welcome comments or suggestions at any time about the relevance or clarity of any of the Standards. Outside of the annual public comment period, these comments and suggestions should be sent to info@aaahc.org.

The following information is for California and New York, states that require formal reporting by accrediting organizations.

Please check www.aaahc.org/news/State-Laws-and-Regulations and your State Medical Board for regulations relevant to other states.

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.

(Continued, next page)

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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. In 2013, AAAHC received re-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 re-accreditation at least six months prior to their accreditation expiration date.

***California Health and Safety Code, Section 1248,* was amended effective January 1, 2012 to including, but not limited to:**

- Outpatient settings that have multiple service locations shall have all of the 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.
- 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.

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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 (see: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1275-1289.5), 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. The adverse event reporting form can be found at: http://www.mbc.ca.gov/Consumers/Outpatient_Surgery/outpatient_adverse_event_form.pdf

Patient Death or Transfer Reporting

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 (http://www.mbc.ca.gov/Forms/Reporting/patient_death.pdf) and send it to the Medical Board of California, Central Complaint Unit.

A physician or surgeon who performs or supervises a scheduled medical procedure that results in a transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours must send the facility a completed transfer report (Parts A & B) and must 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 at www.mbc.ca.gov/Forms/Reporting/enf-2240b.pdf or by calling the Medical Board of California at 916.263.2389.

Patient Transfer Plan

Health and Safety Code 1248.15(d): As of January 1, 2012, in addition to the requirements imposed at *1248.15(c)* (See AAAHC Standard 4.I), 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

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. 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.

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 have been 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 the AAAHC at 5250 Old Orchard Road, Suite #200, Skokie, IL 60077, by phone at 847.853.6060, or by fax at 847.853.9028.

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Written Discharge Criteria

Health and Safety Code 1248.15(a)(1): 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. Complete information and a sample posting notice is available at http://www.mbc.ca.gov/Licensees/Notices/Notice_to_Consumers.aspx.

State of New York Office-Based Surgery Organization Accreditation

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 obtain and maintain full accredited status with a nationally-recognized accrediting agency, as determined by the New York State Commissioner of Health.

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 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. For more information about this law, please use the following link: http://www.health.state.ny.us.
- Effective January 14, 2008, all "adverse events," as defined by the New York law, occurring in these offices must be reported to the New York State Department of Health. The New York law defines "adverse events" to include a patient death within thirty days, an unplanned transfer to a hospital, an unscheduled hospital admission within 72 hours of the office-based surgery which lasts longer than 24 hours, or any other serious or life-threatening event. For the State of New York Adverse Event Report Form and Instructions, please visit: www.nyhealth.gov/forms/doh-4431.pdf.
- Effective February 17, 2014, 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 your organization is accredited by AAAHC, the following procedure applies to you: 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. For the AAAHC Adverse Event Report Form and Instructions, please visit: www.aaahc.org/news/Federal-and-State-Regulations.

Office-based surgical practices located in the State of New York might find it useful to visit the New York State Department of Health website regularly to review up-to-date requirements.

[1]*Organizations providing non-procedural health care through a network of at least ten sites of care may be eligible for the AAAHC Network Accreditation Program. Please refer to pages 19-30 for more information.*

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The Accreditation Process: Before the Survey

This handbook is intended for organizations seeking AAAHC accreditation and the following steps are specific to that process. Ambulatory surgery centers (ASCs) seeking a recommendation for Medicare Certification and AAAHC accreditation should use the 2016 edition of the *Accreditation Handbook for Medicare Deemed Status Surveys*. If you are unsure about which handbook to choose, please contact us for assistance.

1: Confirm that your organization meets survey eligibility criteria

Organizations are considered for survey by AAAHC on an individual basis. An organization is eligible for an accreditation survey if it meets all of the following criteria. The organization:

1. Has been providing health care services for at least six months before the on-site survey, excluding organizations seeking accreditation through an Early Option Survey (EOS); see page 7.
2. Is either a formally organized and legally constituted entity that primarily provides health care services, or a sub-unit that primarily provides such services within a formally organized and legally constituted entity that may be, but need not be, health related.
3. Is in compliance with applicable federal, state, and local laws and regulations, or, for organizations operating outside of the United States, all applicable laws and regulations.
4. Is licensed by the state in which it is located, if the state requires licensure for that organization, unless the organization is applying for a survey that will be used to obtain licensure in a state that recognizes AAAHC accreditation for this purpose.
5. 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):
    a. Doctor of medicine or osteopathy (MD/DO)
    b. Doctor of dental surgery or dental medicine (DDS/DMD)
    c. Doctor of podiatric medicine (DPM)
    d. Doctor of optometry (OD)
    e. Doctor of chiropractic (DC)
    f. Advanced practice registered nurse (APRN) practicing in compliance with state law and regulation
    g. Licensed clinical behavioral health professional in a behavioral health setting
6. Shares the facilities, equipment, business management, and records involved in patient care among the members of the organization.
7. Operates in compliance with the U.S. Equal Employment Opportunity Commission laws.
8. Submits the completed, signed *Application for Survey*, all supporting documents, and the non-refundable application fee in advance of the survey.
9. Pays the appropriate fees in accordance with AAAHC policies; see **Survey Fees**, page 9.
10. Acts in good faith in providing complete and accurate information to AAAHC during the accreditation process and throughout a term of accreditation.

2: Review the types of surveys available

Use the descriptions on the following page to identify what type of survey to request. If you are unsure about the appropriate survey type for your organization, contact AAAHC Accreditation Services at 847.853.6060 or via e-mail at info@aaahc.org.

Note: Interim, Random, and Discretionary Surveys are scheduled by AAAHC independently of the application process. See **Appendix B** for more information about these types of surveys and related policies.

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EARLY OPTION SURVEY (EOS)

This survey may be requested by an organization that is not accredited by AAAHC, meets Survey Eligibility Criteria, and has been providing services for fewer than six months before the on-site survey. Such organizations are (1) newly existing, operational, and require accreditation for third party reimbursement, and a six-month wait for a survey would entail financial hardship; or (2) require accreditation to meet laws or regulations before the facility can legally begin operations.

When an EOS is requested, the organization must meet the following requirements before a survey can be scheduled:

- 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 and state fire marshals, local or state health departments, or other code enforcement agencies.
- All governance and administrative structures are in place, including bylaws, policies, and procedures.
- Key executives are employed and medical staff have been credentialed and privileged by the governing body.
- All necessary equipment is in place and has been appropriately tested and/or calibrated with up-to-date maintenance logs in place.
- The date to begin operations has been identified.
- Licensure or provisional licensure has been obtained from the state licensing authority, unless the organization is applying for a survey in order to obtain licensure in a state that recognizes accreditation for this purpose (see **Survey Eligibility Criteria**, page 6). 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.

For organizations that perform surgery or procedures and are open and operational, the surveyors must observe a procedure while on-site.

Organizations undergoing an EOS will receive a three-year term of accreditation or be denied accreditation. See **Term of Accreditation**, page 14, for further information. Following a successful EOS survey, the organization may be subject to an Interim Survey to maintain the three-year term and an Interim Survey fee will be assessed. All applicable Standards will be applied during the Interim Survey. See **Appendix B** for additional information about an Interim Survey.

INITIAL ACCREDITATION 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 on-site survey.

RE-ACCREDITATION SURVEY

This survey is for a currently AAAHC-accredited organization seeking a continuation of its AAAHC accreditation.

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3: Apply for an On-site Survey

Any organization that meets **Survey Eligibility Criteria** (see page 6) may apply. The *Application for Survey* requires that the applicant organization attest to its compliance with these criteria.

Obtaining an *Application for Survey*

The electronic application available at www.aaahc.org is completed by each organization seeking a survey. Contact us if you need help.

By submitting its *Application for Survey*, the 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 survey process.
2. Agrees to comply with all applicable AAAHC policies and procedures.
3. Understands that AAAHC and its non-profit subsidiary, the AAAHC Institute for Quality Improvement, 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.

An organization's completed application, required supporting documents, and non-refundable application fee must be submitted before a survey will be scheduled. We recommend submitting the application five to six months prior to the desired survey date. AAAHC staff will review the application and may request clarification or additional information before it is accepted as complete.

After an organization submits its application and application fee, a letter of confirmation will be sent by e-mail.

A complete and accepted application is valid for six months from the date of its acceptance by AAAHC. If the application is incomplete when received, and is not considered complete by AAAHC within six months, or if the organization does not schedule a survey during the six-month period, the application will expire and the organization must submit a new *Application for Survey*, along with an additional non-refundable application fee.

AAAHC reserves the right to reject any application. If we determine that the Standards cannot be applied, a survey will not be conducted and we will inform the organization of the reason for this decision.

If a survey is conducted and we determine that the Standards cannot be appropriately applied in order to reach an accreditation decision, the survey will be deemed a consultation and the organization will receive a report of the survey findings. Fees for such a consultative survey will not be refunded.

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 an accreditation 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 this *Accreditation Handbook*; or (3) as otherwise required by law or agreement with a state or federal regulatory authority.

In submitting its signed *Application for Survey*, the organization either provides or authorizes AAAHC to obtain official records and reports of public or publicly-recognized licensing, examining, reviewing, or planning bodies.

In the event that 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.

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4: Payment and Survey Scheduling

Survey fees

The application fee is the same for any organization seeking accreditation. Survey fees vary.

Each survey is tailored to the type, size, and range of services offered by the organization seeking accreditation. The length of the on-site visit and the number of surveyors sent by AAAHC are based on review of the information in the organization's *Application for Survey* and supporting documents. These factors determine the survey fee.

Once the length and cost of the survey are determined, AAAHC staff will contact the applicant organization to schedule the survey and an invoice will be sent.

Questions regarding the scope of a survey or the estimated survey cost should be directed to the AAAHC office before the survey.

Except where prohibited by law, the survey fee must be paid no later than 20 calendar days before the survey start date, or 20 calendar days from receipt of the survey invoice, whichever is later. Failure to pay survey fees as outlined here and elsewhere in these policies will result in cancellation of the survey.

Scheduling

Survey dates are identified in cooperation with the organization being surveyed. The survey must be conducted when the organization is open for business and providing services. Every attempt is made to schedule the survey at a time that is convenient for the requesting organization.

Once a survey has been scheduled, we send written confirmation of the date(s) of the survey, a *Notice of Accreditation Survey* to be posted (see pages 10-11), the name(s) of the surveyor(s) who will be on-site, the survey agenda, and other information about what to expect prior to and during the survey. Contact us with questions about your scheduled survey.

Postponement

A request to postpone a scheduled survey must be received by the AAAHC office in writing.

- Application fees are non-refundable.
- For postponement due to any circumstance, the organization will be responsible for all direct and indirect non-refundable costs associated with delaying the survey, including, but not limited to, costs incurred for surveyor transportation and lodging.
- If an organization postpones a scheduled survey a second time, additional fees will be assessed at the discretion of AAAHC, and the fees must be paid prior to rescheduling the survey.
- If an organization requests a postponement more than twice, AAAHC will cancel the survey and organization will be required to submit a new application, including supporting documents, and pay another survey fee.

The following fee schedule applies to postponed surveys:

Occurrence	Fee
First (any time prior to the survey)	Any costs incurred by AAAHC due to the change
Second (any time prior to the survey)	Any costs incurred by AAAHC due to the change + $500 administrative fee
Third (survey will be cancelled)	Any costs incurred by AAAHC due to the change + $500 administrative fee

Cancellation policies

A request for cancellation of a scheduled survey must be received by the AAAHC office in writing.

- Application fees are non-refundable.
- If an organization cancels its survey 20 calendar days or more before the scheduled start date of the survey, the survey fee will be refunded, less all direct and indirect nonrefundable costs including, but not limited to, the cost of surveyor transportation and lodging.
- If the organization cancels its scheduled survey 10 to 19 calendar days before the scheduled survey start date, the survey fee will be refunded, less all direct and indirect nonrefundable costs including, but not limited to, the cost of surveyor transportation and lodging. AAAHC will also assess a $500 administrative fee.

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- If the organization cancels its survey fewer than ten calendar days before the start of the scheduled survey, no refunds or credits will be given.
- If an organization cancels a scheduled survey more than once, additional fees will be assessed at the discretion of the AAAHC, and the fees must be paid prior to scheduling the next survey.

All fees due must be paid prior to scheduling the next survey.

The following fee schedule applies to cancelled surveys:

Calendar Days Before Survey Start Date	Application Fee	Survey Fee	Administrative Fee
20 days or more	No refund	Full refund less costs incurred by AAAHC	None
10-19 days before survey	No refund	Full refund less costs incurred by AAAHC	$500
<10 days before survey	No refund	No refund	None

NOTE: Accreditation decisions and survey reports are not released to an organization with an outstanding invoice.

5: Pre-Survey Responsibilities and Preparation

Responsibilities of the applicant organization

The accuracy and veracity of information provided by an organization seeking accreditation or re-accreditation is critical to the integrity of AAAHC accreditation. 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.

An organization's duty to provide complete and accurate information continues during the entire accreditation experience. If an organization experiences significant changes after it submits an *Application for Survey*, but before an accreditation decision is reached, the organization must notify AAAHC in writing within five business days of this change. For a list of what may constitute a significant change, see **Continuation of accreditation following a significant change** on page 16. Failure to notify AAAHC promptly may result in immediate termination of an application or immediate revocation of accreditation.

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 status, 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.

In the event that an application or appeal is terminated, AAAHC is entitled to retain the application and survey fees or any other fees paid by the organization.

Responsibilities and preparation of the surveyor or survey chairperson

After the assigned surveyor or survey chairperson has reviewed the organization's application materials, and approximately one to two weeks prior to the survey start date, he or she will call or email 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, he or she may request that additional explanation or documentation be made available at the time of survey. Please direct questions regarding surveyor or survey chair responsibilities to the AAAHC office ahead of the survey.

Public posting of *Notice of Accreditation Survey*

Prior to the survey, the applicant organization's primary contact will receive a packet of information 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) the notice must be posted prominently throughout all organization sites for 30 calendar days prior to the scheduled survey start date. If you receive confirmation of the scheduled survey fewer than 30 calendar days before the start date, the notice must remain posted for a total of 30 calendar days.

You may photocopy the notice in order to achieve significant visibility.

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The goal of the notice is to provide an opportunity during the on-site survey for patients, staff, and members of the general public to present relevant information about the surveyed organization's provision of care or its compliance with AAAHC Standards. Alternatively, individuals may present such information in writing to the AAAHC office. All information received from individuals will be considered for relevance and accuracy during the accreditation process. The findings may be included in the survey report if applicable.

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

The opportunity for individuals to present information in person is usually scheduled during the morning of the first survey day and normally does 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 survey chairperson. 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/survey team.

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

The Accreditation Process: During the Survey

The survey team

Although an accreditation survey is evaluative, AAAHC emphasizes the educational and consultative benefits of accreditation. AAAHC uses health care professionals and administrators to conduct surveys. These dedicated individuals offer their time to train and work as surveyors and use their practical knowledge in the consistent application of the Standards.

A survey of an ambulatory care organization is conducted by surveyors selected by 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.

Specific 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 seeking accreditation. In the interest of objectivity, AAAHC cannot honor requests for specific surveyors.

Surveyor conduct during the survey

Surveyors are representatives of AAAHC. Their first priority when conducting surveys is to be ambassadors of AAAHC, objective fact finders, and educators.

A surveyor may not participate in surveys of organizations that may be in direct competition with that surveyor's business interests, or that bear any significant beneficial interest to the surveyor or the surveyor's 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, surveyed organizations should refrain from offering consultative or other types of business to their AAAHC surveyor(s), and/or to members of the surveyors' immediate families. Please immediately report a survey team conduct concern or question to us at 847.853.6060.

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 and ongoing quality improvement of the accreditation process. Observers do not participate in the on-site survey process in any manner.

- **Additional surveyors**

  AAAHC reserves the right to assign additional surveyors as part of ongoing surveyor education procedures. All surveyors may actively participate in the on-site survey process.

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.

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The on-site process

When arriving at the survey site, the surveyor/survey team will provide identification, introduce themselves, and conduct a brief orientation conference for the organization. The surveyor or the survey chair will provide an overview of the agenda, request needed documents, and ask that your team identify key personnel who will provide information and the access necessary to complete the survey. This is also a time for you to introduce leaders and staff and to ask questions about the anticipated survey events.

You will be asked in advance to have specific documents and other information available for surveyors during the on-site visit. This allows surveyors to gather and review information with minimal disruption to the daily activities of your organization. However, surveyors may ask to see additional documents or may request additional information during the on-site survey.

Organizations are asked to make a workspace available for surveyor use. This private or semi-private area may be used to review polices, conduct interviews, and hold survey team meetings to discuss findings.

Surveyors must observe a surgery or procedure at organizations that perform them. An organization's failure to provide information requested by AAAHC or its surveyors, or an organization's failure to allow surveyors to observe a surgery or procedure, may be grounds for termination of the survey or accreditation process.

Consultant participation in the AAAHC accreditation survey is limited to attendance at the survey opening conference and/or the summation conference. The AAAHC survey chairperson has the right to limit or exclude the participation of any individual(s) in any or all parts of AAAHC on-site accreditation survey activities.

Organizations with multiple service locations

For multi-site organizations seeking accreditation, the AAAHC office will determine which service sites will be visited during any survey.

If an organization indicates that a specific service location should not be reviewed, this site will not be eligible for accreditation and will not be listed on the *Certificate of Accreditation* or on the AAAHC website as a currently accredited organization.

Request to survey sub-units of an organization

Although in general, AAAHC surveys and accredits a single legal entity, it will review a sub-unit of an eligible legal entity, if requested, when the sub-unit 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 sub-unit.

When the applicant organization is a sub-unit 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. In addition, 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.

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

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Organizational or Functional Integration

Organizations that are determined to be functionally or organizationally integrated will be asked to describe the relationship in the *Application for Survey*. Additionally, an application for organizations with satellite locations will require certain supporting documentation and demographic information that may be requested and reviewed prior to or during the survey.

Organizational integration exists when the applicant organization's governing body, either directly or ultimately, controls the budgetary and resource allocation decisions for the related entity or service. Where separate corporate entities are involved, organizational integration also exists when there is greater than 50 percent of the same governing body membership on the board of the applicant organization and the board of the other entity.

Functional integration exists when the entity meets four of the following criteria, including items 1, 2, or 3:

1. The applicant organization occupies physically connected floor space and/or a geographic location with the related entity or service such that the related entity or service is represented or reasonably appears to the public as part of the applicant organization.
2. There is a common organized medical or professional staff for the applicant organization and the related entity.
3. The applicant organization's human resources function is responsible for all staffing of the related entity or service, and development and implementation of established personnel activities.
4. The applicant organization manages all operations of the related entity or service, i.e., the related entity has little or no management authority or autonomy independent of the applicant organization.
5. The applicant organization applies its quality improvement program to the related entity or service and has authority to implement actions intended to improve the performance at the related entity or service.
6. The applicant organization bills for services provided by the related entity or service under the name of the applicant organization.
7. The applicant organization's policies and procedures are applicable to the related entity or service, with few or no exceptions.
8. The related service or entity's patient records are integrated into the applicant organization's record system (or vice versa).

Concluding the survey experience

At the end of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. The surveyors are "fact finders" for AAAHC and do not render the final accreditation decision, so no information regarding an accreditation decision is provided during this 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.

The Accreditation Process: After the Survey

AAAHC works with an external vendor to conduct on-going evaluation of our survey process and our surveyors. A representative from the calling center will contact the organization's designated primary contact approximately one week after the survey to discuss the survey experience. Obtaining this input by telephone provides AAAHC with a streamlined, efficient means of receiving feedback. An organization's feedback will have no bearing on the accreditation decision.

Accreditation decision and notification

Accreditation decisions are made by the AAAHC Accreditation Committee after review of the information gathered during the survey and documented in the surveyor's report, any other applicable supporting documents, and recommendations of surveyors and staff. All documents reflecting the opinions or deliberations of any AAAHC surveyor, staff member, committee member, or its officers or directors constitute peer review materials and will not be disclosed to the organization seeking accreditation or to any third party.

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AAAHC expects substantial compliance with the applicable Standards. Accreditation is awarded to organizations that demonstrate such compliance and adhere to AAAHC accreditation policies. Compliance with each requirement is assessed through at least one of the following means:

1. Documented evidence.
2. Answers to detailed questions concerning implementation.
3. On-site observations and interviews by surveyors.

A surveyor, staff member, or member of the AAAHC Board of Directors 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 be notified in writing of the accreditation decision and will receive a detailed report of the survey findings.

In the event that a decision is made to deny accreditation, the organization usually has an opportunity to provide additional information before a final denial 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, the organization will be notified of the revocation of accreditation, including the effective date. (See **Denial or Revocation of Accreditation**, page 15.)

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. (See **Denial or Revocation of Accreditation**).

AAAHC awards accreditation for three years when we conclude that an organization is in substantial compliance with the Standards, and there are no reservations about the organization's continuing commitment to provide high-quality patient care and services consistent with the Standards. Most organizations that have made a good faith effort to achieve and maintain accreditable status are successful in reaching this goal. AAAHC staff are available throughout an organization's term of accreditation to provide assistance and guidance.

Organizations may receive a three-year term with required intra-cycle activity–such as an Interim Survey (see **Appendix B**, page 167)—for continued assessment of ongoing compliance with the Standards. When deficiencies are cited during a survey, organizations must implement corrections in a timely manner. The organization's corrective actions should be documented and this documentation made available upon request by AAAHC and during subsequent surveys.

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.

Public Recognition of AAAHC Accreditation

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

AAAHC-accredited organizations are encouraged to publicly display their certificate. It is the responsibility of each organization to comply with any state regulations which may specify posting requirements. Please note that 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.

All certificates remain the property of AAAHC and must be returned if the organization loses its accreditation for any reason.

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Denial or Revocation of Accreditation

AAAHC denies accreditation to 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 we determine that an organization:

1. No longer satisfies AAAHC survey eligibility criteria.
2. Is no longer in compliance with AAAHC policies, 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, see **Continuation of Accreditation Following a Significant Change** on page 16.
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 reduce or revoke the term of accreditation of an organization when we determine 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 survey 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 **Appendix C**, **Organization's Right of Appeal Following Denial or Revocation of Accreditation** (page 168).

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 not granted accreditation, or that has its accreditation revoked based solely on failure to comply with AAAHC policies and procedures and/or Standards, may apply for another full survey at any time following the decision, as long as it has not exercised its right to appeal. The organization must submit a completed, signed *Application for Survey*, supporting documentation and the application fee when applying for a new survey.

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, accredited organizations are required to maintain their operations in compliance with the most current AAAHC Standards and policies throughout their accreditation term. This involves correcting any deficiencies cited during a survey in a timely manner and implementing continuous quality improvements to maintain ongoing compliance. AAAHC reserves the right to amend its Standards and policies so long as it provides all accredited organizations with notice of such amendments, or includes such amendments in the most recent edition of the handbook.

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Continuation of accreditation following a three-year term

Currently-accredited organizations must undergo full, regular surveys at least once every three years in order to retain accredited status. Such organizations must complete and submit an application, supporting documentation, and the non-refundable application fee for each Re-Accreditation Survey. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to AAAHC five to six months prior to its accreditation expiration date. In states where accreditation is mandated by law, an organization should submit the completed application and other required documentation a minimum of six months prior to its accreditation expiration date.

Submission of a late application, even if complete, fewer than 60 calendar days before the accreditation expiration date will result in a lapse of accreditation and an Initial Accreditation Survey will be scheduled for the organization.

Continuation of accreditation following a significant change

An accredited organization must notify AAAHC in writing within 15 calendar days of any significant organizational, ownership, operational, or quality of care events including, but not limited to:

- Merger or acquisition.
- Change in controlling interest/ownership.
- Consolidation.
- Name change.
- Relocation to another physical location.
- Additional services and specialties.
- Major renovations.
- Expansion.
- Any interruption in delivery of health care service that exceeds 30 calendar days.
- Adverse publicity or adverse media coverage related to the organization or its providers.
- Death or incapacitation of the health care provider or dentist in a solo provider organization.
- Changes in state license or other applicable license, (e.g., business license), federal certification, or qualifying status.
- Bankruptcy or other significant change in the financial viability of the organization.
- Any governmental investigation, including local, state, or federal authorities involving, directly or indirectly, the organization or any of its officers, administrators, medical staff, or other staff in their role within the organization.
- Criminal indictment, guilty plea, or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the organization or any of its officers, administrators, medical staff, or other staff in their role within the organization.

Notice can be made by email to notify@aaahc.org. Instructions for what to include with notification of specific changes can be found at http://www.aaahc.org/accreditation/General-information/policies/Notification-following-a-Change/Submitting-change-information.

It is an organization's duty to provide this information throughout the entire accreditation process and term of accreditation. In the event that 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 re-accreditation, or it is choosing to withdraw from the accreditation process prior to the expiration of its accreditation, the organization must:

- Return all copies of the AAAHC *Certificate of Accreditation* to AAAHC, Attn: Accreditation Services, 5250 Old Orchard Road, Suite 200, Skokie, Illinois 60077.
- Review internal information, e.g., letterhead, fax forms, and internal recorded phone messages, to ensure that the AAAHC name and/or logo has been removed.
- 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.

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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.

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Network Accreditation Program

The AAAHC Network Accreditation Program focuses on the ability and effectiveness of the corporate organization's system of centralized governance and administration to maintain its sites of care in an accreditable manner.

This section sets forth the specific policies and procedures for organizations seeking accreditation as a Network by AAAHC.

Network accreditation is granted to the corporate organization. Each individual site of care included in the network will receive a certificate identifying it as being operated by a network organization accredited by AAAHC. The following types of organizations have found the network accreditation survey process appropriate and helpful in improving the quality of care they provide:

- **Health care provider networks**
- **Onsite employer-based health centers**
- **Onsite employer-based dental clinics**
- **Convenient care clinics**
- **Occupational health centers**
- **Urgent or immediate care centers**
- **Primary care practices, including those that function as Medical Home practices**

Network Accreditation Program

Network Survey Eligibility Criteria

Organizations are considered for survey on an individual basis. A network organization must meet **all** of the following criteria to be eligible for this program. The organization:

1. Is a formally organized and legally constituted entity that provides health care services through a network of a minimum of ten health care sites for contracted parties' patient populations or the general public.[1] Organizations in business primarily to provide surgical services are not eligible for network accreditation.
2. Provides health care services under the direction of a doctor of medicine or osteopathy (MD/DO) or dentist (DDS or DMD).
3. Is in compliance with applicable federal, state, and local laws and regulations.
4. Submits the completed, signed *Application for Survey*, all supporting documents, and the application fee in advance of the survey. In addition, the organization must submit evidence of diligent and recent self-assessment and current attestation documents for each site to be included in the accreditation.
5. Pays the appropriate fees in accordance with AAAHC policies.
6. Acts in good faith in providing complete and accurate information to AAAHC during the accreditation process and throughout the term of accreditation.

AAAHC reserves the right to reject an application from an organization for any reason including a determination that the organization does not meet eligibility criteria.

AAAHC Standards

The Standards in this handbook describe characteristics that AAAHC believes to be indicative of an accreditable network organization and its service locations. Most AAAHC Standards are written in general terms to allow an organization to achieve compliance in the manner that is most compatible with its particular operations and most conducive to high-quality patient care.

Where the acceptable methods of achieving compliance with a Standard are limited, the Standard is written in specific terms. Whether a Standard is stated in general or specific terms, AAAHC is primarily concerned about compliance with the intent of the Standard.

The Standards contained in Chapters 1–8 will be applied to all organizations seeking an accreditation survey. AAAHC core Standards are interrelated and also relate to applicable adjunct Standards. See the back of the Core Chapters title page for further illustration of these relationships.

The Standards contained in Chapters 9–25 will be applied when relevant to the services provided by the organization. Organizations should review adjunct chapter headings in order to determine chapter applicability. For example, immediate/urgent care centers, radiation oncology treatment centers, and occupational health centers must be in compliance with the respective adjunct chapters for these settings, as well as with all core Standards. Any questions about the applicability or non-applicability of Standards and chapters should be directed to the AAAHC office prior to submitting an application.

Compliance Ratings

The following are the definitions of the compliance ratings for Standards which will appear in the organization's survey report and should be used in self-assessment activities.

SC — **Substantially Compliant** indicates that the organization's current operations are acceptable and meet the Standard.

PC — **Partially Compliant** indicates that a portion of the item is acceptable, but other areas should be addressed.

NC — **Non-Compliant** indicates that the organization's operations in this area do not meet the Standard.

NA — **Not Applicable** indicates that the Standard does not apply to the organization (only present in adjunct chapters).

[1]*The survey of a network organization may include separate legal entities if the network organization operates in states that limit the practice of medicine to medical professionals (commonly known as the Corporate Practice of Medicine Doctrine) and the network organization is able to demonstrate appropriate oversight and control of the separate legal entity(ies).*

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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 an accreditation 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 this handbook; or (3) as otherwise required by law or agreement with a state or federal regulatory authority.

In submitting its signed *Application for Survey*, the organization either provides or authorizes AAAHC to obtain official records and reports of public or publicly-recognized licensing, examining, reviewing, or planning bodies.

In the event that 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.

Pre-Application Materials

Memorandum of Agreement (MOA)

The MOA is a key element in establishing parameters for the partnership between AAAHC and the network applicant throughout the accreditation process and subsequently granted term of accreditation. The MOA describes the steps that will be followed to move forward with the process of accreditation. The MOA will be signed by the applicant organization after submitting an application to attest to understanding the accreditation process, roles, and responsibilities.

Business Associate Agreement (BAA)

AAAHC does not maintain, retain, store, or transmit any protected health information (PHI). During the AAAHC accreditation survey process, any documents containing PHI are reviewed by our on-site survey team only to determine compliance with applicable Standards.

We do, however, meet the description of a business associate as defined by HIPAA. As such, a Business Associates Agreement (BAA) that addresses AAAHC-specific use of PHI can be found on our website at: www.aaahc.org/news/Business-Associate-Agreement. Network organizations must review and sign a copy of the BAA before submitting an *Application for Survey*. Be advised that this agreement will only be effective upon full execution by your organization.

Accreditation plan

The accreditation plan is a blueprint for assuring that the organization meets AAAHC Standards. The organization is responsible for creating a comprehensive plan outlining what it will do to prepare for and maintain accreditation. The plan should include a description of how the two assessment documents described below, will be used. The plan must, at a minimum, describe how the organization will prepare for the survey, and identify responsible parties, timelines, findings from self assessments, Medical Home assessments (if applicable), quality data collection, etc. It should also address how the documents will be used in the implementation of Standards in new clinics.

The following documents are required as part of the organization's application materials:

- **Accreditation self-assessment**

  AAAHC views the accreditation process as an opportunity for a network organization to strengthen its operation of health care sites and employ a comprehensive performance/quality improvement process.

  The self assessment is a key component of the accreditation process and provides the first opportunity for a network to demonstrate how it implements and sustains performance within the AAAHC Standards. A self assessment template that includes all core and applicable adjunct Standards is available by contacting the Network Accreditation Specialist. Your organization will use it to rate your compliance with each Standard and to describe a plan of correction for any deficiencies identified.

  The self-assessment document must be submitted with the *Application for Survey*.

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- **Site worksheet**

  The network must provide an audit of each site to be included in the network accreditation. This audit will allow the network to assess each of its sites against all core and applicable adjunct Standards.

  If the organization is applying for Medical Home accreditation for any of its sites, a Medical Home Worksheet for each such site must be completed. This worksheet parallels the requirements of the Medical Home Chapter and requires the organization to evaluate compliance with each Standard and to provide descriptive detail.

  The site worksheets are submitted with the *Application for Survey*.

The Application

An organization interested in applying for the Network Accreditation Program should contact the AAAHC Network Accreditation Specialist at 847.853.6060. The *Application for Survey* is available online at www.aaahc.org.

The application requires the network organization to attest to its compliance with the **Network Survey Eligibility Criteria** (see page 19).

The online application is completed by all organizations applying for an Initial Accreditation Survey, as well as those network organizations seeking a renewal of accreditation following a three-year term. A non-refundable application fee is required and can be paid online when submitting the application.

An electronic application is valid for six months from the date of its acceptance by the AAAHC office. The application will expire and the organization must submit a new application and application fee if:

- The application is incomplete when received, and is not considered complete by AAAHC within six months, or
- The organization does not schedule a survey during the six-month period.

Submission of a completed application is not a guarantee that the network is eligible to undergo the accreditation process or that the network will be awarded accreditation by AAAHC. An applicant for network accreditation is prohibited from identifying itself as accredited prior to formal notification of the accreditation decision.

Applying for Re-Accreditation

Currently-accredited network organizations must undergo full, regular surveys at least once every three years in order to retain their accreditation status. Such organizations must complete and submit the application, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a Re-Accreditation Survey). To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to AAAHC five to six months prior to its accreditation expiration date. In states where accreditation is mandated by law, an organization should submit the completed application and other required documentation a minimum of six months prior to the expiration date.

Submission of a late application, even if complete, fewer than 60 calendar days prior to the accreditation expiration date will result in a lapse of accreditation and an Initial Accreditation Survey will be scheduled for the organization.

If AAAHC determines that the Standards cannot be applied, a survey will not be conducted and AAAHC will inform the organization of the reason for such a decision. If a survey is conducted and we determine that the Standards cannot be appropriately applied in order to reach an accreditation decision, the survey will be deemed a consultation and you will receive a report of the survey findings. Fees for such a consultation will not be refunded. **AAAHC reserves the right to reject any application.**

Survey Types

The Network Accreditation Program includes a variety of survey types. When completing an *Application for Survey*, network organizations select either an Initial Accreditation Survey or a Re-Accreditation Survey. If you are unsure about the right survey type for your organization, contact the Network Accreditation Specialist at 847.853.6060 or by email to info@aaahc.org.

Other survey types described below are elements of intra-cycle activities. Organizations in the Network Accreditation Program will be subject to Compliance Surveys as outlined in their MOA. Other intra-cycle surveys are at the discretion of AAAHC.

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INITIAL ACCREDITATION SURVEY

This survey is suitable for network organizations that are not currently accredited by AAAHC and have been providing services for at least six months before the on-site survey.

RE-ACCREDITATION SURVEY

This survey is suitable for organizations that are currently AAAHC-accredited and seek renewal of network accreditation.

COMPLIANCE SURVEY

Compliance Surveys are conducted at clinic sites that were not visited during the Initial Accreditation Survey. They are conducted as a quality check of the accredited organization's ability to maintain the Standards throughout the term of accreditation.

Compliance Surveys assess how the organization ensures its compliance and how accurately it self-assesses compliance. The minimum number of compliance surveys, as well as the nature of these surveys (focused or full) is determined during the application process and included in the Memorandum of Agreement (MOA) and sampling plan. The number of Compliance Surveys during a term of accreditation may be modified based on additional data from prior accreditation surveys and initial sampling rates.

Compliance Surveys may be announced or unannounced at the discretion of AAAHC. Fees for Compliance Surveys will be outlined in the MOA.

Following this survey, the organization will receive a decision letter and a survey report.

A network organization is not eligible for a new accreditation term as a result of a Compliance Survey. If, as a result of a Compliance Survey, AAAHC determines that the organization is not in substantial compliance with the Standards, the organization's accreditation term may be reduced, revoked, or it may be determined that an Interim Survey is necessary.

INTERIM SURVEY

This is a survey for organizations that are currently AAAHC-accredited and for which oversight is required to assess ongoing compliance with the accreditation Standards. Following an Interim Survey, the organization's three-year term of accreditation may be maintained or revoked. Organizations are not eligible for a new accreditation term as a result of an Interim Survey. A survey fee will be assessed.

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RANDOM SURVEY

To support ongoing quality improvement initiatives, an accredited organization may be selected by AAAHC for a Random Survey from 9 to 30 months after an accreditation survey. Random Surveys are unannounced. Organizations are selected on a proportionate basis across practice settings, geographic areas, and accreditation decision categories. These unannounced surveys, which are conducted by one surveyor and may last one full day, are a means by which AAAHC can evaluate the consistency and quality of its program, while also demonstrating to the public and regulators that accredited organizations remain committed to AAAHC Standards throughout the accreditation cycle. Random Surveys also provide AAAHC and its surveyors with opportunities to further consult with accredited organizations in the interval between regular surveys. No fee shall be charged to the organization when a Random Survey is conducted.

If, as a result of a Random Survey, AAAHC determines that the organization is not in substantial compliance with the Standards, the organization's accreditation term may be reduced, revoked, or it may be determined that an Interim Survey is necessary. Organizations are not eligible for a new accreditation term as a result of a Random Survey. (Refer to **Denial or Revocation of Accreditation**, page 27.) Following a Random Survey, the organization will receive an accreditation decision letter and a survey report.

DISCRETIONARY SURVEY

A Discretionary Survey is conducted "for cause," when concerns have been raised about 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. A fee may be charged to the organization when a Discretionary Survey is conducted.

If, as a result of a Discretionary Survey, AAAHC determines that the organization is not in substantial compliance with the Standards, the organization's accreditation term may be reduced, revoked, or it may be determined that an Interim Survey is necessary. Organizations are not eligible for a new accreditation term as a result of a Discretionary Survey. (Refer to **Denial or Revocation of Accreditation**, page 27.) Following a Discretionary Survey, the organization will receive an accreditation decision letter and a survey report.

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Survey Process

Site visit

Survey dates are determined by AAAHC in cooperation with the organization being surveyed. Every attempt is made to schedule the survey at a time convenient for the requesting network organization and its sites.

The survey must be conducted when the organization is open for business and providing services. Once a survey has been scheduled, AAAHC sends the organization a written confirmation of the date(s) of the survey, the name(s) of the surveyor(s) who will conduct the survey, the survey schedule, and other information about what to expect during the on-site visit.

Each network survey is tailored to the type, size, and range of services offered by the organization seeking accreditation. The length of the on-site visit and the number of surveyors sent by AAAHC are based on a careful review of the information provided in the Memorandum of Agreement (MOA), in the *Application for Survey*, and in supporting documents submitted by the organization. Questions regarding the scope of a survey should be directed to the AAAHC office before the survey.

Survey team

Although the accreditation survey is evaluative, AAAHC emphasizes the educational and consultative benefits of accreditation. AAAHC uses health care professionals and administrators who are actively involved in primary care settings to conduct Network Accreditation Program surveys. These dedicated individuals offer their time to train and work as surveyors and use their practical knowledge in the consistent application of the Standards.

Specific 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 network seeking an accreditation survey. In the interest of objectivity, AAAHC cannot honor requests for specific surveyors.

Surveyors are representatives of AAAHC. Their first priority when conducting surveys is to be ambassadors of AAAHC, objective fact finders, and educators.

Surveyors do 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 surveyor or the surveyor's immediate family.

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 any of their personal, entrepreneurial endeavors. In support of these policies, AAAHC requests that surveyed organizations refrain from offering consultative or other types of business to their AAAHC surveyor(s), and/or to members of the surveyors' immediate families.

An organization that applies for a network survey accepts 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 and ongoing quality improvement of the accreditation process. Observers do not participate in the on-site survey process in any manner.

- **Additional surveyors**

  AAAHC reserves the right to assign additional AAAHC surveyors as part of ongoing surveyor education procedures. All surveyors may actively participate in the on-site survey process. The presence of observers or additional surveyor(s) does not result in any additional charge to the organization, nor may it serve as grounds for any challenge to the accreditation survey outcome.

Site visit activities

AAAHC will determine which service sites will be visited during any survey.

If an organization indicates on its application that a site location should not be reviewed, this site will not be eligible for network accreditation and will not be listed in the MOA, nor will it receive a certificate or be listed on the AAAHC website as part of an accredited network.

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On-site process

At the start of the on-site survey, the survey team conducts an orientation conference for the organization. The members of the survey team will introduce themselves, review the survey format, confirm written documentation for which they anticipate a need, and ask that the organization identify the key personnel who will provide the information and access necessary to complete the survey. This is also a time for the organization to ask questions. Network organizations should anticipate one corporate orientation and additional introductory meetings at each site of care selected for the survey. Network organizations are notified in advance to have specific documents and other information available for surveyors during the on-site visit at the corporate office and at the sites of service. This allows surveyors to gather and review information with minimal disruption to the daily activities of the organization being surveyed. Surveyors may, however, ask to see additional documents or may request additional information during the on-site survey.

Organizations are asked to make a workspace available for surveyor use. This private or semi-private area may be used to review polices, conduct interviews, and hold survey team meetings to discuss findings.

Surveyors must observe patient care at each site visit where care is rendered. Surveyors may ask the network or sites visited to observe care provided to one or more patients while on-site, with appropriate patient consent.

An organization's failure to provide information requested by AAAHC or by its surveyors, or an organization's failure to allow surveyors to observe patient management may be grounds for exclusion of the site from accreditation, or termination of the survey or network accreditation process.

Consultant participation in an on-site AAAHC accreditation survey is limited to the consultant's attendance at the survey opening conference and/or the summation conference. The AAAHC Survey Chairperson has the right to limit or exclude the participation of any individual(s) in any or all parts of the AAAHC on-site accreditation survey activities.

Concluding the survey experience

At the end of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. The surveyors are "fact finders" for AAAHC and do not render the final accreditation decision, so no information regarding an accreditation decision is provided during this 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 express their perceptions of the survey. Network summation may be scheduled via teleconference after the conclusion of all site surveys.

Organization responsibilities regarding the summation conference:

- Coordinate the specific time with the survey chair and network staff, and designate staff that are to attend.
- Ensure adequate room for all in attendance.
- Inform surveyors prior to the conference if you intend to record (audio or video) the summation conference.
- Capture information provided by the survey team.
- Ask questions to clarify any information that is not well understood.
- Confirm understanding of the difference between the factual findings and consultative comments provided by surveyors.
- Before the summation concludes, provide any documents/items requested by the survey team that they did not receive during the survey.
- Before the summation concludes, let the surveyors know if they have described any findings with which the organization disagrees.

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Post-Survey Process

Providing feedback

AAAHC works with an external vendor to conduct on-going evaluation of our survey process and our surveyors. A representative from the calling center will contact the organization's designated primary contact approximately one week after the last site survey to discuss the network survey experience. Obtaining this input by telephone provides AAAHC with a streamlined, efficient means of receiving feedback. An organization's feedback will have no bearing on the accreditation decision.

Accreditation decisions

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 surveyors and staff. All documents reflecting the opinions or deliberations of any AAAHC surveyor, staff member, committee member, or its officers or directors constitute peer review materials and will not be disclosed to the organization seeking accreditation or to any third party.

AAAHC expects substantial compliance with the applicable Standards. Accreditation is awarded to organizations that demonstrate substantial compliance with the Standards and adhere to AAAHC accreditation policies. Compliance is assessed through at least one of the following means:

1. Documented evidence.
2. Answers to detailed questions concerning implementation.
3. On-site observations and interviews by surveyors.

A surveyor, staff member, or member of the AAAHC Board of Directors who is in any way affiliated with an organization, or whose participation represents a conflict of interest, is not allowed to participate in deliberations or voting relative to the accreditation status of that organization. The organization will be notified in writing of the accreditation decision and will receive a detailed report of the survey findings.

In the event that a decision is made to deny accreditation, the organization usually has an opportunity to provide additional information before a final denial decision is rendered, and the denial decision is subject to an 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, the organization will be notified of the revocation of accreditation, including the effective date of the revocation. (See **Denial or Revocation of Accreditation**, page 27.)

Term of accreditation

AAAHC awards accreditation for three years when it concludes that the network organization is in substantial compliance with the Standards, and has no reservations about the organization's continuing commitment to provide high-quality patient care and services consistent with the Standards at all of its sites.

Following a network accreditation survey, an organization may be awarded a three-year term of accreditation or it may be denied accreditation. See **Denial or Revocation of Accreditation**.

Network organizations may also receive a three-year term with required intra-cycle activities—such as Interim Surveys—for continued assessment of ongoing compliance with the Standards. Organizations are expected to maintain compliance at all times with the current AAAHC Standards. When deficiencies are cited during a survey at the corporate office or any of its sites, a network organization must implement corrections in a timely manner. The organization's corrective actions are documented and these documents are available upon AAAHC request and during subsequent surveys.

Accreditation certificates

The focus of the Network Accreditation Program is how the network is operated and managed. Surveyor(s) focus their evaluation on the network organization and how the individual sites are operated.

After a successful survey an organization will receive one certificate for the network organization. The sites will receive additional certificates. The site-specific certificates clearly identify that the network organization has achieved accreditation and that the site is recognized as part of the network.

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Network marketing

As long as a network organization is currently accredited by AAAHC, that organization may advertise or use "accredited by AAAHC" marks to inform its clients and the general public of the accreditation status. For purposes of this policy, "marks" means a party's trade names, service marks and symbols, commercial symbols, and trademarks. AAAHC will include the accredited organization's name on the AAAHC web site in the section "Search for Accredited Organizations."

When the network accreditation term has expired, been revoked, or the network organization is choosing to withdraw from the accreditation process, the network organization must:

- Return all AAAHC Certificates of Network Accreditation to AAAHC, Attn: Accreditation Services, 5250 Old Orchard Road, Suite 200, Skokie, IL 60077
- Review internal information, e.g., letterhead, fax forms, and internal recorded phone messages at the corporate headquarters and all sites of care, to ensure that the AAAHC name and/or logo has been removed.
- Review marketing materials, website, radio or television advertisements, telephone directory advertisements, and all other similar types of materials to ensure removal of references to the AAAHC name, logo, and accreditation status.

Report monitoring

AAAHC requires an accredited network organization to maintain continuous compliance with AAAHC Standards throughout its accreditation cycle as detailed in this handbook and in the Memorandum of Agreement (MOA). Responsibilities of an accredited network include:

- Self-reporting of critical incidents, significant occurrences, and changes.
- Completion, as applicable, of progress reports on Standards compliance for new acquisitions.
- Participation in accreditation cycle monitoring processes, accreditation compliance surveys and/or third-party complaint review, as specified by AAAHC.

Networks are encouraged to contact AAAHC with any questions about self-reporting.

Non-transferability of accreditation

Network accreditation is not transferable. An accredited network must notify AAAHC at least 30 business days prior to the network's expected legal date to merge with, acquire, or be acquired by another organization or entity.

Network/clinic site closure

Networks organizations must contact AAAHC at least 15 business days prior to closure of the network or any site of care that is included in accreditation. Notification should include:

- Closure/discontinuation date of the network or site of care.
- Reason for closing (bankruptcy, loss of funding).
- Transition plan(s) for consumers, if applicable.

Denial or Revocation of Accreditation

AAAHC denies accreditation to an organization when it concludes that the organization is not in substantial compliance with AAAHC Standards and/or AAAHC policies or procedures. We reserve 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 it is determined that an organization:

1. No longer satisfies AAAHC Network Survey Eligibility Criteria.
2. Is no longer in compliance with AAAHC policies, 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, see **Continuation of accreditation following a significant change** on page 28.
6. Fails to notify AAAHC within 15 calendar days of an imposed sanction, changes 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.

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In addition, AAAHC may revoke or reduce the term of accreditation when 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 the AAAHC Survey 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 of denial or revocation of accreditation by AAAHC may be appealed. The appeal of any decision is governed by AAAHC appeal procedures which are in effect at the time of the appeal. Refer to **Appendix C**, **Organization's Right of Appeal Following Denial or Revocation of Accreditation**.

In the unlikely event that an applicant organization, after exercising its right to appeal and upon final decision by the AAAHC Board of Directors, seeks further appeal, the applicant shall have the right to submit such decision for settlement by arbitration administered by the American Arbitration Association in Chicago, Illinois, 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 not granted accreditation or that has its accreditation revoked based solely on failure to comply with AAAHC policies and procedures and/or Standards, may apply for another survey at any time following the decision, as long as it has not exercised its right to appeal. After receiving a denial of accreditation or having its accreditation revoked, the organization must submit a completed, signed *Application for Survey* and application fee when applying for another survey.

Continuation of Accreditation

An accredited organization acts as an advocate for its patients and the community through the provision of quality patient care. Therefore, accredited organizations are required to maintain operations in compliance with the most current AAAHC Standards and policies throughout their term of accreditation. This involves correcting any deficiencies cited during a survey in a timely manner and implementing continuous quality improvements so as to maintain ongoing compliance. AAAHC reserves the right to amend Standards and policies so long as it provides all accredited organizations with notice of such amendments, or includes such amendments in the most recent edition of the handbook.

Continuation of accreditation following a significant change

Accredited network organizations must notify AAAHC in writing within 15 calendar days of any significant organizational, operational, or financial changes including, but not limited to:

- Merger or acquisition.
- Change in controlling interest/ownership.
- Consolidation.
- Name change.
- Organization relocation to another physical location.
- Additional services or locations.
- Major renovations.
- Expansion.
- Any interruption in delivery of health care service that exceeds 30 calendar days.
- Adverse publicity or adverse media coverage related to the organization or its providers.
- Death or incapacitation of the health care provider or dentist in solo provider organizations.
- Changes in state license or other applicable license, (e.g., business license), federal certification, or qualifying status.
- Bankruptcy or other significant change in the financial viability of the organization.
- Any governmental investigation, including local, state, or federal authorities involving, directly or indirectly, the organization or any of its officers, administrators, medical staff, or other staff, in their role within the organization.
- Criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) involving, directly or indirectly, the organization or any of its officers, administrators, medical staff, or other staff in their role within the organization.

Notice can be made by email to notify@aaahc.org. Instructions for what to include with notification of specific changes can be found at http://www.aaahc.org/accreditation/General-information/policies/Notification-following-a-Change/Submitting-change-information.

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An organization's duty to provide this information continues throughout the entire accreditation process and term. In the event that the organization is exercising its right to 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 establish any such conditions.

Public Disclosure of Accreditation Decisions

The AAAHC Certificate of Accreditation is recognized as a symbol of quality by the organization's most valuable contacts: its patients, third-party payers, managed care companies, medical organizations, insurance companies, state and federal agencies, and the general public. AAAHC maintains a searchable list of currently-accredited organizations at www.aaahc.org. AAAHC-accredited organizations are encouraged to publicly display their Certificate of Accreditation. Such posting may be regulated by state law. It is the responsibility of each organization to comply with any state regulations that may specify posting requirements.

Please note that 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 AAAHC accreditation to the public must accurately reflect the AAAHC-accredited organization. All certificates remain the property of AAAHC and must be returned if the organization loses its accreditation for any cause.

Accreditation Fees

All network accreditation survey fees are determined by reviewing information from the organization's Business Associate Agreement (BAA), Memorandum of Agreement (MOA), *Application for Survey*, and supporting documentation. Factors considered in determining survey fees include the size, type, geographic locations, and range of services provided by the network organization and its sites of service. Network survey fees cover all costs and expenses of the on-site survey, including, but not limited to, travel, hotel, meals, and incidentals.

Upon submission of the fully-executed BAA, MOA, *Application for Survey,* and supporting documents, the organization will receive an invoice for the requested services.

Application fee

There is a non-refundable application fee for new network applicants. A network should contact the AAAHC Accreditation Specialist regarding the application fee.

Survey fee

Survey fees must be paid no later than 20 days prior to the survey date or 20 days from receipt of the invoice, whichever is later. Failure to pay the survey fee at least 20 days prior to the survey will result in cancellation of the survey.

Fees for postponement or cancellation

A request for postponement or cancellation of a scheduled survey must be received by the AAAHC office in writing.

- Application fees are non-refundable.
- If an organization cancels or postpones its survey 20 calendar days or more before the scheduled start date of the survey, the survey fee will be refunded, less all direct and indirect nonrefundable costs including, but not limited to, the cost of surveyor transportation and lodging.
- If an organization cancels or postpones its survey 10 to 19 calendar days before the scheduled start date of the survey, the survey fee will be refunded, less all direct and indirect nonrefundable costs including, but not limited to, the cost of surveyor transportation and lodging. AAAHC will also assess a $1000.00 administrative fee.
- If an organization cancels or postpones its survey fewer than 10 calendar days before the scheduled start date of the survey, no refunds or credits will be given.
- If an organization cancels or postpones a scheduled survey more than one time, additional fees will be assessed at the discretion of the AAAHC, and all fees due must be paid prior to scheduling the next survey.
- All fees due must be paid prior to scheduling the next survey. Accreditation decisions are not released to organizations with unpaid fees.

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Calendar Days Before Survey Start Date	Application Fee	Survey Fee	Administrative Fee
20 days or more	No refund	Full refund, less incurred costs	None
10-19 days	No refund	Full survey fee refund less incurred costs plus $1,000 admin fee	$1,000
<10 days	No refund	No refund	None
Cancel or postpone more than once per cycle	No refund	Must pay survey fee before scheduling next survey	Admin. fee at the discretion of AAAHC

Additional fees

Compliance Surveys will be conducted at a sample of sites of care included in the MOA that were not surveyed during the Initial Accreditation Survey. The number of Compliance Surveys will be based on complexity of the services provided, uniformity of the services, and target patient populations. Fees for Compliance Surveys are detailed in the MOA.

If an Interim or Discretionary Survey is deemed necessary, the organization will be assessed a fee for the survey at the then-current AAAHC survey fee schedule. Factors considered in determining survey fees for Interim and Discretionary Surveys include the size, type, and range of services provided by the organization, as well as the extent of the deficiencies found at the time of the last survey. See **Interim** and **Discretionary Surveys** on pages 22, 23.

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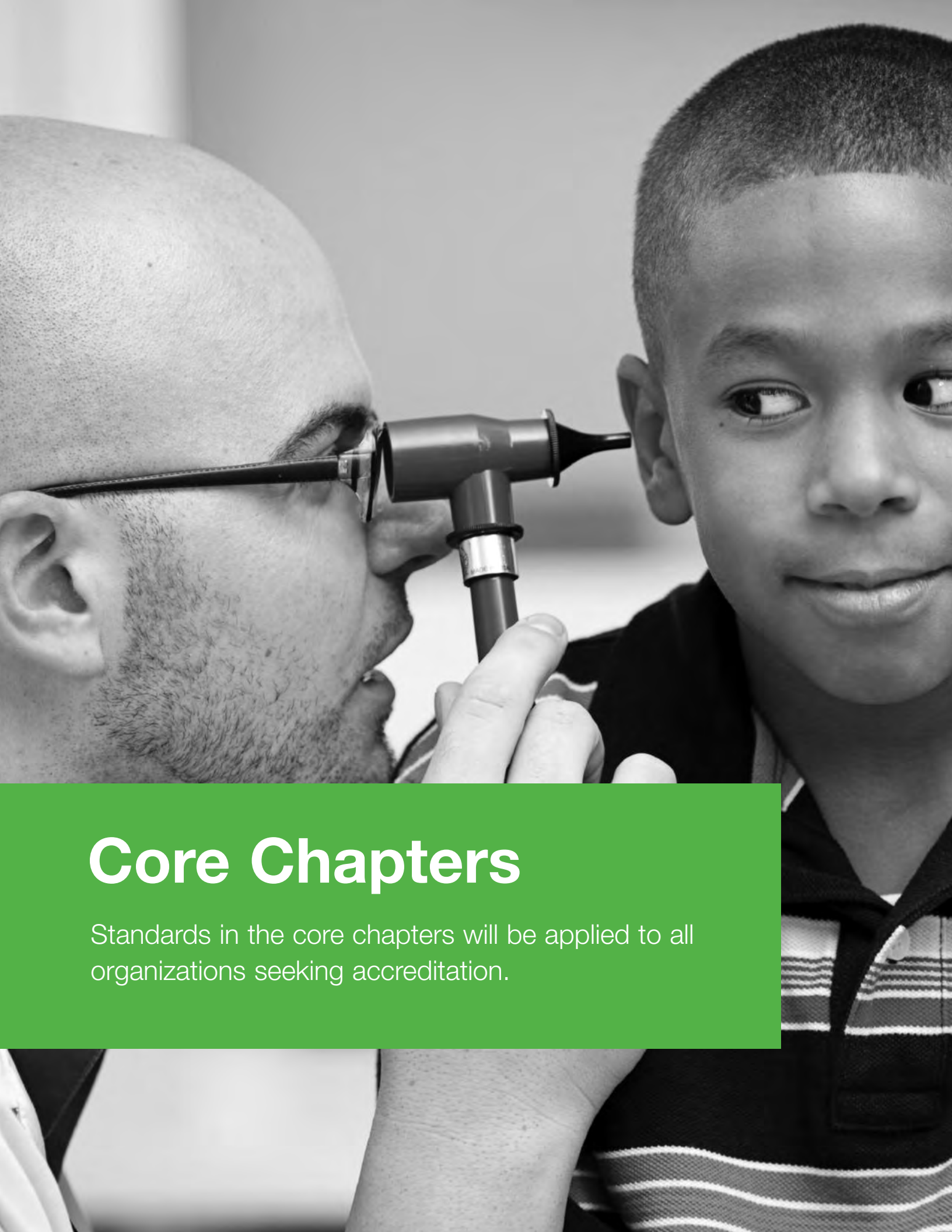
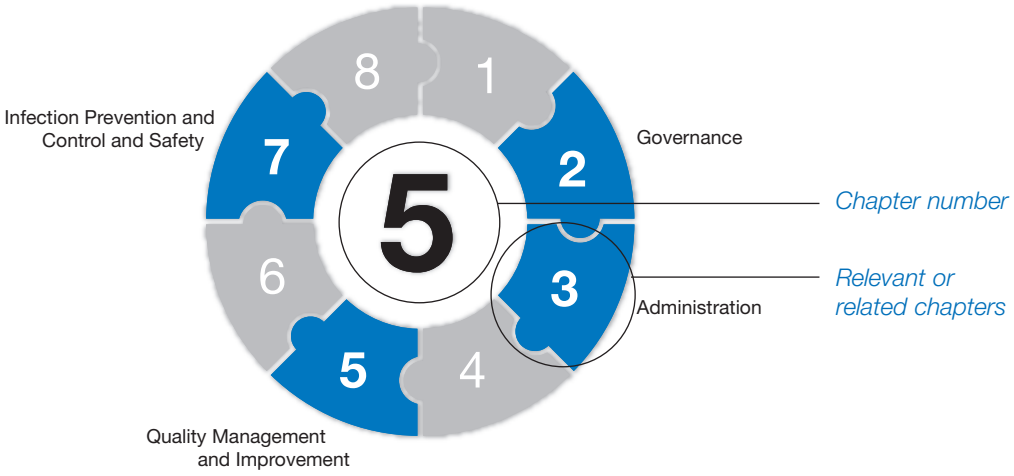


Core Chapters

Standards in the core chapters will be applied to all organizations seeking accreditation.

All AAAHC Standards are developed and designed to help organizations improve. Individually and collectively, they help organizations drive toward one mission: patient safety through the provision of high-quality care. For this reason, Standards are both inextricably interrelated, and appropriately located in different chapters.



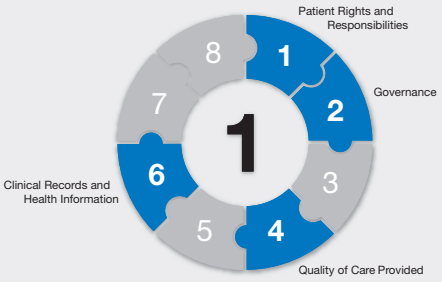
AAAHC Standards represent a system of connected principles, rather than a list of discrete requirements. At the beginning of each core chapter, you will see the symbol above. The current chapter number is in the center, surrounded by eight connected segments, representing the core chapters:

1. Patient Rights and Responsibilities
2. Governance
3. Administration
4. Quality of Care Provided
5. Quality Management and Improvement
6. Clinical Records and Health Information
7. Infection Prevention and Control and Safety
8. Facilities and Environment

All of these chapters are linked, and one or more of them also may be highlighted in color. The highlights represent topics that may be especially relevant to the current chapter and should be consulted for Standards that are closely related.

01

Patient Rights and Responsibilities



An accreditable organization recognizes the basic human rights of patients. Such an organization has the following characteristics.

Standard		Compliance		
		SC	PC	NC
A.	Patients are treated with respect, consideration, and dignity.	☐	☐	☐
B.	Patients are provided appropriate privacy.	☐	☐	☐
C.	When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.	☐	☐	☐
D.	Patients are provided, to the degree known, 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.	☐	☐	☐
E.	Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.	☐	☐	☐
F.	Information is available to patients and staff concerning:	☐	☐	☐
	1. Patient rights, including those specified in A, B, C, D, and E above.	☐	☐	☐
	2. Patient conduct, responsibilities, and participation.	☐	☐	☐
	3. Services available at the organization.	☐	☐	☐
	4. Provisions for after-hours and emergency care.	☐	☐	☐
	5. Fees for services.	☐	☐	☐
	6. Payment policies.	☐	☐	☐
	7. Advance directives, as required by state or federal law and regulations.	☐	☐	☐
	8. The credentials of health care professionals.	☐	☐	☐
	9. The absence of malpractice coverage, if applicable.	☐	☐	☐
	10. How to voice grievances regarding treatment or care.	☐	☐	☐
	11. Methods for providing feedback, including complaints.	☐	☐	☐

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		SC	PC	NC
G.	Prior to receiving care, patients are informed of their responsibilities. These responsibilities require the patient to:	☐	☐	☐
	1. Provide complete and accurate information to the best of his/her ability about his/her health, any medications taken, including over-the-counter products and dietary supplements, and any allergies or sensitivities.	☐	☐	☐
	2. Follow the treatment plan prescribed by his/her provider and participate in his/her care.	☐	☐	☐
	3. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by the provider.	☐	☐	☐
	4. Accept personal financial responsibility for any charges not covered by insurance.	☐	☐	☐
	5. Behave respectfully toward all the health care professionals and staff, as well as other patients.	☐	☐	☐
H.	Patients are informed of their right to change providers if other qualified providers are available.	☐	☐	☐

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02

Governance

An accreditable organization has a governing body that sets policy and is responsible for the organization. Such an organization has the following characteristics.

Standard	Compliance		
	SC	PC	NC
Subchapter I – General Requirements: This subchapter describes general requirements for an organization and its governing body.	☐	☐	☐
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.	☐	☐	☐
1. The legally constituted entity is 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.	☐	☐	☐
B. The names and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies, or subdivisions of other bodies, such as public agencies or religious, fraternal, or other philanthropic organizations) are available upon request and furnished to AAAHC.	☐	☐	☐
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. Governing body responsibilities include, but are not limited to:	☐	☐	☐
1. Determining the mission, goals, and objectives of the organization.	☐	☐	☐
2. Ensuring that facilities and personnel are adequate and appropriate to carry out the mission.	☐	☐	☐
3. Establishing an organizational structure and specifying functional relationships among various components of the organization.	☐	☐	☐
4. Adopting bylaws or similar rules and regulations for the orderly development and management of the organization.	☐	☐	☐
5. Adopting policies and procedures necessary for the orderly conduct of the organization, including the organization's scope of clinical activities.	☐	☐	☐
6. Developing and maintaining a written policy regarding the care of pediatric patients, if relevant. (Specific components of pediatric perioperative care are listed in Standard 10.I.BB.)	☐	☐	☐
7. Ensuring that the quality of care is evaluated and that identified problems are appropriately addressed.	☐	☐	☐

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	SC	PC	NC
8. Reviewing all legal and ethical matters concerning the organization and its staff and, when necessary, responding appropriately.	☐	☐	☐
9. Maintaining effective communication throughout the organization, including ensuring links between quality management and improvement activities and other management functions of the organization.	☐	☐	☐
10. Establishing a system of financial management and accountability appropriate to the organization.	☐	☐	☐
11. Determining a policy on the rights and responsibilities of patients.	☐	☐	☐
12. Approving and ensuring compliance of all major contracts or arrangements affecting the medical and dental care provided under its auspices and ensuring that services are provided in a safe and effective manner, including, but not limited to, those concerning:	☐	☐	☐
a. The employment or contracting of health care professionals.	☐	☐	☐
b. The provision of external services for radiology, pathology, medical laboratory, and housekeeping services.	☐	☐	☐
c. The provision of care by other health care organizations, such as hospitals.	☐	☐	☐
d. The provision of education to students and postgraduate trainees.	☐	☐	☐
e. The provision of after-hours patient information or telephone triage services, including the review of protocols.	☐	☐	☐
f. The Centers for Medicare & Medicaid Services (CMS) requirements, if the organization participates in the Medicare/Medicaid program.	☐	☐	☐
g. The activities or services delegated to another entity.	☐	☐	☐
13. Formulating long-range plans in accordance with the mission, goals, and objectives of the organization.	☐	☐	☐
14. Fulfilling all applicable obligations under local, state, and federal laws and regulations, such as those addressing disabilities, medical privacy, grievances, fraud and abuse, self-referral, anti-trust, and reporting to the National Practitioner Data Bank (NPDB)*, etc.	☐	☐	☐
15. Ensuring that none of the marketing and/or advertising regarding the competence and capabilities of the organization is misleading.	☐	☐	☐
16. Developing a program of risk management appropriate to the organization that includes review of risk management activities.	☐	☐	☐
17. Determining a policy on continuing education for personnel and/or patient education, if applicable.	☐	☐	☐
18. Development, implementation, and oversight of the organization's infection control and safety programs to ensure a safe environment of care.	☐	☐	☐

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		SC	PC	NC
D.	Accredited organizations must notify AAAHC in writing within 15 calendar days of significant organizational, ownership, operational, or quality of care events, including 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 continues during the entire accreditation term.	☐	☐	☐
E.	Representation of accreditation to the public must accurately reflect the AAAHC-accredited entity.	☐	☐	☐
F.	The governing body meets at least annually, or more frequently as determined by the governing body, and keeps such minutes or other records as may be necessary for the orderly conduct of the organization.	☐	☐	☐
G.	Items to be reviewed at least annually by the governing body should include, but are not limited to:	☐	☐	☐
	1. Rights of patients.	☐	☐	☐
	2. Delegated administrative responsibilities.	☐	☐	☐
	3. Quality of care.	☐	☐	☐
	4. The quality management and improvement program.	☐	☐	☐
	5. The organization's policies and procedures.	☐	☐	☐
	6. The appointment/reappointment process.	☐	☐	☐
	7. The infection control program.	☐	☐	☐
	8. The safety program.	☐	☐	☐
	9. Compliance with all other applicable Standards.	☐	☐	☐
H.	If the governing body elects, appoints, or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions are defined.	☐	☐	☐

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	SC	PC	NC
Subchapter II — Credentialing and Privileging: This subchapter describes the requirements for credentialing and privileging of health care professionals to provide patient care in an accreditable organization. Organizations may find the **Tools and Resources** sections located in the back of this handbook helpful in creating medical staff applications and in measuring compliance with credentials verification processes. ***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 he or she claims and that the position requires. An accreditable organization: 1) establishes minimum training, experience, and other requirements (i.e., credentials) for physicians and other health care professionals; 2) establishes 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) carries out the review, assessment, and validation as outlined in the organization's description of the process.	☐	☐	☐
A. The medical staff must be accountable to the governing body. The governing body establishes and is responsible for a credentialing and reappointment process, applying criteria in a uniform manner to appoint individuals to provide patient care for the organization. The governing body approves mechanisms for credentialing, reappointment, the granting of privileges, and suspending or terminating clinical privileges, including provisions for appeal of such decisions.	☐	☐	☐
B. The governing body, either directly or by delegation, makes initial appointment, reappointment, and assignment or curtailment of clinical privileges of medical staff members based on professional peer evaluation (and consistent with state law). This process has the following characteristics:	☐	☐	☐
1. The governing body has specific criteria for the initial appointment and reappointment of physicians and dentists.	☐	☐	☐
2. Provisions are made for the expeditious processing of applications for clinical privileges.	☐	☐	☐
3. On a formal application for initial medical or dental 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. At a minimum, the following credentialing and privileging information shall be provided or obtained for evaluation of the candidate:	☐	☐	☐
a. Education, training, and experience: Relevant education and training are verified at the time of appointment and initial granting of clinical privileges; the applicant's experience is reviewed for continuity, relevance, and documentation of any interruptions in that experience.	☐	☐	☐
b. Peer evaluation: Current competence is verified and documented.	☐	☐	☐
c. Current state license: Current licensure is verified and documented at the time of appointment.	☐	☐	☐
d. Drug Enforcement Administration (DEA) registration, if applicable.	☐	☐	☐
e. Proof of current medical liability coverage meeting governing body requirements, if any.	☐	☐	☐

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		SC	PC	NC
f.	Information obtained from the National Practitioner Data Bank (NPDB)* **Note:** NPDB Continuous Query is an acceptable service for meeting this requirement (see Resources).	☐	☐	☐
g.	Written attestation from the applicant addressing other pertinent information including, at a minimum:	☐	☐	☐
i.	Professional liability claims history.	☐	☐	☐
ii.	Information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations.	☐	☐	☐
iii.	Complaints or adverse action reports filed against the applicant with a local, state, or national professional society or licensure board.	☐	☐	☐
iv.	Refusal or cancellation of professional liability coverage.	☐	☐	☐
v.	Denial, suspension, limitation, termination, or nonrenewal of professional privileges at any hospital, health plan, medical group, or other health care entity.	☐	☐	☐
vi.	DEA and state license action.	☐	☐	☐
vii.	Any Medicare/Medicaid sanctions.	☐	☐	☐
viii.	Conviction of a criminal offense (other than minor traffic violations).	☐	☐	☐
ix.	Current physical, mental health, or chemical dependency problems that would interfere with his/her ability to provide high-quality patient care and professional services.	☐	☐	☐
h.	The initial staff appointment application is signed and dated, includes a formal statement releasing the organization from any liability in connection with credentialing decisions, and includes the applicant's attestation to the accuracy and completeness of the application and additional information provided.	☐	☐	☐
4.	Upon receipt of a completed and signed initial application, the credentials are verified according to procedures established in the organization's bylaws, rules and regulations, or policies. The organization has established procedures to obtain information necessary for primary or secondary source verification of the credentials and is responsible for obtaining this information. An accreditable organization may use information provided by a Credentials Verification Organization (CVO) after proper assessment of the capability and quality of the CVO. Alternatively, a CVO may demonstrate such capability and quality by becoming accredited or certified by a nationally recognized accreditation organization. Primary or acceptable secondary source verification is required for items listed in 2.II.B.3.a-f, unless a CVO or an organization performing primary source verification that is accredited or certified by a nationally recognized body is used. If the organization utilizes 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.	☐	☐	☐

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	SC	PC	NC
5. Members of the medical or dental staff must apply for reappointment every three years, or more frequently if state law or organizational policies so stipulate. The reappointment process includes:	☐	☐	☐
a. Completion of a formal reappointment application which includes, at a minimum:	☐	☐	☐
i. Updated personal information.	☐	☐	☐
ii. Completed attestation questions found in 2.II.B.3.g.	☐	☐	☐
iii. A formal statement releasing the organization from any liability in connection with credentialing decisions.	☐	☐	☐
iv. A formal statement confirming the information submitted is accurate and complete.	☐	☐	☐
v. Applicant signature and date.	☐	☐	☐
b. Upon receipt of the completed reappointment application, the organization will conduct primary or secondary source verification of items listed in Standard 2.II.B.3.c-f. At the time of reappointment consideration by the governing body, the entire reappointment application and peer review results and activities, completed in accordance with Chapter 2.III, will be considered.	☐	☐	☐
6. The organization shall monitor and document the currency of date-sensitive information such as licensure, professional liability insurance (if required), certifications, DEA registrations, and other such items, where applicable, on an ongoing basis (at expiration, appointment, and re-appointment, at minimum).	☐	☐	☐
7. In a solo medical or dental practice, the provider's credentials file shall be 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, to ensure currency, accuracy, and completeness of credentials. The provider is required to complete an application or reapplication, and the documentation identified in Standard 2.II.B.3 must be present in the credentials file, including a list of procedures that will be performed by the provider in the organization/practice setting and evidence of appropriate education, training, and experience to perform the privileged procedures. Applications are available for other providers requesting credentialing and privileges to perform procedures in the solo provider's organization, including any anesthesia providers. In a solo provider's practice, the granting of privileges shall be reviewed by an outside physician (for medical practices) or dentist (for dental practices) with documentation provided to the organization.	☐	☐	☐

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. An accreditable organization: 1) determines the clinical procedures and treatments that are offered to patients; 2) determines the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege; and 3) establishes a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non-arbitrary manner.

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		SC	PC	NC
C.	The scope of procedures is periodically reviewed by the governing body and amended as appropriate.	☐	☐	☐
D.	Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specified period of time. The health care professional must be legally and professionally qualified for the privileges granted. These privileges are granted based on an applicant's written request for privileges, qualifications within the services provided by the organization and recommendations from qualified medical or dental personnel.	☐	☐	☐
E.	The organization has its own independent process of credentialing and privileging. The approval of credentials or the granting of privileges requires review and approval by the organization's governing body. Credentials may not be approved, nor privileges granted without further review, solely on the basis that another organization, such as a hospital, has approved credentials or granted privileges. Such status at another organization may be included in the governing body's consideration of the application.	☐	☐	☐
F.	The governing body provides a process for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for allied health care professionals.	☐	☐	☐
	1. The process is consistent with state law.	☐	☐	☐
	2. The process includes verification of education, training, experience, and current competence, and primary or secondary source verification of licensure or certification, as applicable.	☐	☐	☐

Subchapter III — Peer Review: An accreditable organization maintains an active and organized process for peer review that is integrated into the quality management and improvement program and is evidenced by the following characteristics: ☐ ☐ ☐

A.	The health care professionals understand, support, and participate in a peer review program through organized processes consistent with the organization's policies and procedures and responsible to the governing body. The peer review activities are evidenced in the quality improvement program.	☐	☐	☐
B.	Each physician or dentist receives peer-based review from at least one similarly-licensed peer.	☐	☐	☐
C.	In solo physician or dental organizations, an outside physician or dentist is involved to provide peer-based review.	☐	☐	☐
D.	In settings where no physician or dentist is a member of the provider staff, a physician or dentist is not required to be part of the peer review process. When led by an advanced practice registered nurse practicing in compliance with state law and regulation, or when led by a licensed clinical behavioral health professional in a behavioral health setting, peer review is provided by a similarly-licensed peer or an outside physician or dentist.	☐	☐	☐
E.	The organization provides ongoing monitoring of important aspects of the care provided by physicians, dentists, and other health care professionals. Monitoring important aspects of care is necessary for monitoring performance and establishing internal benchmarks.	☐	☐	☐

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		SC	PC	NC
F.	Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.	☐	☐	☐
G.	Data related to established criteria are collected in an ongoing manner and periodically evaluated to identify trends or occurrences that affect patient outcomes.	☐	☐	☐
H.	The results of peer review activities are reported to the governing body.	☐	☐	☐
I.	The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in Chapter 2.II.	☐	☐	☐
J.	To improve the professional competence and skill—as well as the quality of performance—of the health care professionals and other professional personnel it employs, the organization:	☐	☐	☐
	1. Provides convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization.	☐	☐	☐
	2. Encourages health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures. These educational programs may be internal or external, and are consistent with the organization's mission, goals, and objectives.	☐	☐	☐

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03

Administration

An accreditable organization is administered in a manner that ensures the provision of high-quality health services and that fulfills the organization's mission, goals, and objectives. Organizations may find it helpful to use the *Personnel Records Worksheet*, found in the **Tools** section, to evaluate compliance with some Standards found in this chapter.

Standard	Compliance		
	SC	PC	NC
A. Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to:	☐	☐	☐
1. Enforcing policies delegated by the governing body.	☐	☐	☐
2 Employing qualified management personnel.	☐	☐	☐
3. Taking all reasonable steps to comply with applicable laws and regulations.	☐	☐	☐
4. Protecting the assets of the organization.	☐	☐	☐
5. Implementing fiscal controls, including, but not limited to:	☐	☐	☐
a. Authorization and record procedures that are adequate to provide accounting controls over assets, liabilities, revenues, and expenses.	☐	☐	☐
b. Policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements.	☐	☐	☐
c. Rates and charges for services provided by the organization.	☐	☐	☐
d. Methods of collection of unpaid accounts that are reviewed before referral to a collection agency.	☐	☐	☐
6. Using methods of communicating and reporting designed to ensure the orderly flow of information within the organization.	☐	☐	☐
7. Controlling the purchase, maintenance, and distribution of the equipment, materials, and facilities of the organization.	☐	☐	☐
8. Operating based on established lines of authority.	☐	☐	☐
9. Establishing controls relating to the custody of the official documents of the organization.	☐	☐	☐
10. Maintaining the confidentiality, security, and physical safety of data on patients and staff.	☐	☐	☐

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		SC	PC	NC
	11. Maintaining a health information system that supports the collection, integration, and analysis of data and allows reporting as necessary.	☐	☐	☐
	12. Dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, and the media.	☐	☐	☐
B.	Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies:	☐	☐	☐
	1. Define and delineate functional responsibilities and authority.	☐	☐	☐
	2. Require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification.	☐	☐	☐
	3. Specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system, as described in Standard 5.II.E.2-4.	☐	☐	☐
	4. Reflect the requirement for documentation of initial orientation and training according to position description. Orientation and training shall be:	☐	☐	☐
	a. Completed within 30 days of beginning employment.	☐	☐	☐
	b. Provided annually thereafter and when there is an identified need.	☐	☐	☐
	5. Require periodic appraisal of each person's job performance, including current competence.	☐	☐	☐
	6. Describe incentives and rewards, if any exist.	☐	☐	☐
	7. Are made known to employees at the time of employment.	☐	☐	☐
	8. Comply with federal and state laws and regulations regarding verification of eligibility for employment, such as I-9 (Immigration and Naturalization form) and visas, as required.	☐	☐	☐
C.	Health care workers are protected from biologic hazards, consistent with state, federal, and CDC guidelines. The organization has:	☐	☐	☐
	1. Approved and implemented policies that comply with all applicable occupational health and safety regulations for health care workers, such as the Occupational Safety and Health Administration (OSHA) rules on Occupational Exposure to Bloodborne Pathogens (Title 29 CFR 1910.1030) designed to eliminate and/or minimize employee exposures.	☐	☐	☐
	2. The organization has a written exposure control plan that is reviewed and updated at least annually, including an evaluation of the availability of safer medical devices and changes in technology.	☐	☐	☐
	3. The exposure control plan is made a part of employee initial orientation and retraining that is conducted within one year of the employee's last training.	☐	☐	☐

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		SC	PC	NC
4.	The organization has an effective program addressing bloodborne pathogens, including:	☐	☐	☐
a.	Hepatitis B vaccination program.	☐	☐	☐
b.	Post-exposure evaluation and treatment.	☐	☐	☐
c.	Appropriate training in and communication of hazards to employees.	☐	☐	☐
d.	Appropriate record keeping and management.	☐	☐	☐
5.	An immunization program for other infectious agents of risk to health care workers and their patients.	☐	☐	☐
6.	A tuberculosis respiratory protection program.	☐	☐	☐
7.	Programs that address other relevant biological hazards, such as bioterrorism, as needed for employee safety and health.	☐	☐	☐
D.	A program is maintained to assess and reduce risks associated with occupational chemical exposures, including:	☐	☐	☐
1.	Hazard assessment of chemicals used in the workplace.	☐	☐	☐
2.	Engineering measures to reduce the risk of chemical exposure.	☐	☐	☐
3.	Worker training programs.	☐	☐	☐
E.	A program is maintained to assess and, where necessary, reduce risks associated with physical hazards, such as ergonomic exposures, violence at the workplace, and external physical threats such as terrorism.	☐	☐	☐
F.	Records of work injuries and illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately.	☐	☐	☐
G.	The organization periodically assesses patient satisfaction with services and facilities provided. The findings are reviewed by the governing body and, when appropriate, corrective actions are taken.	☐	☐	☐
H.	When students and postgraduate trainees are present, their status is defined in the organization's written policies and procedures.	☐	☐	☐

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04

Quality of Care Provided

An accreditable organization provides high-quality health care services in accordance with the principles of professional practice and ethical conduct, and with concern for the costs of care and for improving the community's health status. Such an organization has the following characteristics.

Standard	Compliance		
	SC	PC	NC
A. All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.	☐	☐	☐
B. Health care professionals practice their professions in an ethical and legal manner.	☐	☐	☐
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.	☐	☐	☐
D. The organization has a current and comprehensive written quality management and improvement program.	☐	☐	☐
E. The organization facilitates the provision of high-quality health care by:	☐	☐	☐
1. Providing health care consistent with the current standard of care.	☐	☐	☐
2. Educating and effectively communicating with patients regarding the diagnosis and treatment of their conditions, appropriate preventive measures, and use of the health care system.	☐	☐	☐
3. Making appropriate and timely diagnosis based on findings of the current history and physical examination.	☐	☐	☐
4. Performing medication reconciliation.	☐	☐	☐
5. Providing treatment consistent with clinical impression or working diagnosis.	☐	☐	☐
6. Making appropriate and timely consultation and referrals.	☐	☐	☐
7. When clinically indicated, contacting patients as quickly as possible for follow-up regarding significant problems and/or abnormal findings.	☐	☐	☐
8. Continuity of care and patient follow-up.	☐	☐	☐
9. Assessing patient satisfaction and taking corrective actions, when indicated.	☐	☐	☐
10. Using performance measures to improve outcomes.	☐	☐	☐

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		SC	PC	NC
F.	Health services available at the organization are accessible to patients and ensure patient safety by at least the following:	☐	☐	☐
	1. Providing for and informing patients about access to services when the organization's facilities are not open.	☐	☐	☐
	2. Providing adequate and timely transfer of information when patients are transferred to other health care professionals.	☐	☐	☐
G.	The organization has policies and procedures for identifying, storing, and transporting laboratory specimens and biological products. The policies and procedures include logging and tracking to ensure that results for each specimen are obtained and reported to the ordering physician in a timely manner.	☐	☐	☐
H.	When the need arises, the organization assists patients with the transfer of their care from one health care professional to another.	☐	☐	☐
	1. Adequate specialty consultation services are available by prior arrangement.	☐	☐	☐
	2. Referral to another health care professional is clearly outlined to the patient and arranged with the accepting health care professional.	☐	☐	☐
I.	When emergencies or unplanned outcomes occur, and hospitalization is indicated for the evaluation and stabilization of the patient, the organization shall have **one** of the following in place:	☐	☐	☐
	1. A written transfer agreement for transferring patients to a nearby hospital.	☐	☐	☐
	2. A written policy of credentialing and privileging physicians and dentists who have admitting and similar privileges at a nearby hospital.	☐	☐	☐
	3. Written agreement with a physician or provider group with admitting privileges at a nearby hospital.	☐	☐	☐
	4. A detailed written procedural plan for handling medical emergencies.	☐	☐	☐
J.	Concern for the costs of care is present throughout the organization.	☐	☐	☐

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05

Quality Management and Improvement

In striving to improve the quality of care and to promote more effective and efficient utilization of facilities and services, an accreditable organization maintains an active, integrated, organized, ongoing, data-driven, peer-based program of quality management and improvement that links peer review, quality improvement activities, and risk management in an organized, systematic way.

Organizations may also find it useful to refer to *Developing Meaningful Quality Improvement Studies* in the **Tools** section of this handbook.

Note: The intent of this chapter is that administrative and clinical personnel be involved in the quality management and improvement activities of the organization.

Standard	Compliance		
	SC	PC	NC
Subchapter I — Quality Improvement Program: An accreditable organization maintains an active, integrated, organized, and peer-based quality improvement (QI) program as evidenced by the following characteristics:	☐	☐	☐
A. The organization has a written quality improvement program for ensuring ongoing quality and improving performance when needed. The program is broad in scope in order to address clinical, administrative, and cost-of-care performance issues, as well as actual patient outcomes, i.e., results of care, including safety of patients. At a minimum, the written program:	☐	☐	☐
1. Addresses the full scope of the organization's health care delivery services and describes how these services are assessed for quality.	☐	☐	☐
2. Identifies the specific committee(s) or individual(s) responsible for development, implementation, and oversight of the program.	☐	☐	☐
3. Ensures participation by health care professionals, one or more of whom is a physician or dentist. 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.	☐	☐	☐
4. Includes program purposes, as well as specific objectives that the program intends to achieve.	☐	☐	☐
5. Specifies the data collection processes used to ensure ongoing quality and identify quality-related problems or concerns (see Standard 5.I.B).	☐	☐	☐
6. Implements activities to improve performance when opportunities for improvement are identified (see Standard 5.I.C).	☐	☐	☐

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		SC	PC	NC
	7. Describes how the organization integrates quality improvement activities, peer review, and the risk management program.	☐	☐	☐
	8. Is evaluated at least annually for effectiveness and to determine if the program's purposes and objectives continue to be met.	☐	☐	☐
	9. Describes processes used to ensure that the results of quality improvement activities, including the annual program evaluation, are reported to the governing body and throughout the organization, as appropriate.	☐	☐	☐
B.	The organization implements data collection processes to ensure ongoing quality and to identify quality-related problems or concerns. Such processes include, but are not limited to:	☐	☐	☐
	1. Analysis of the results of peer review activities.	☐	☐	☐
	2. Periodic audits of critical processes, as appropriate for the services provided. (See "Audit" in the Glossary.)	☐	☐	☐
	3. Ongoing monitoring of important processes and outcomes of care, as appropriate for the services provided. (See "Quality monitoring" in the Glossary.)	☐	☐	☐
	4. Comparison of the organization's performance to internal and external benchmarks.	☐	☐	☐
	5. Methods to systematically collect information from other sources such as, but not limited to, patient satisfaction surveys, financial data, medical/legal issues, and outcomes data.	☐	☐	☐
	6. Evaluation of the information and data obtained through the data collection activities noted above to identify the existence of unacceptable variation or results that require improvement.	☐	☐	☐
C	The organization demonstrates that ongoing improvement is occurring by conducting quality improvement studies when the data collection processes described in Standard 5.I.B indicate that improvement is or may be warranted. Written descriptions of QI studies document each of the following elements, as applicable[1]:	☐	☐	☐
	1. A statement of the purpose of the QI study that includes a description of the problem and an explanation of why it is significant to the organization. (See *Developing Meaningful Quality Improvement Studies* in the **Tools** section of this handbook.)	☐	☐	☐
	2. Identification of the measurable performance goal against which the organization will compare its current performance in the area of study. The goal must be stated in quantitative terms. (Note: See the QI study template on page 110 for more information on numerically stated goals.)	☐	☐	☐
	3. A description of the data that will be collected in order to determine the organization's current performance (i.e., the study methodology).	☐	☐	☐

[1] *At least one completed quality improvement study demonstrating that improvement has occurred, i.e., including Standards 5.I.C.1–8, 9 (if applicable) and 10, must be present in order for Standard 5.I.C. to be considered for a rating of Substantially Compliant (SC). This does not imply that conducting only one complete study per accreditation cycle is adequate or appropriate for all organizations, nor does conducting one complete study automatically result in a rating of SC for Standard 5.I.C.*

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		SC	PC	NC
4.	Evidence of data collection.	☐	☐	☐
5.	Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).	☐	☐	☐
6.	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	☐	☐	☐
7.	Implementation of corrective action(s) to resolve identified problem(s).	☐	☐	☐
8.	Re-measurement (a second round of data collection and analysis as described in Standard 5.I.C.4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.	☐	☐	☐
9.	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved or is no longer relevant.	☐	☐	☐
10.	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").	☐	☐	☐
D.	The organization participates in external benchmarking activities that compare key performance measures with other similar organizations, with recognized best practices, or with national or professional targets or goals.	☐	☐	☐
1.	The organization's benchmarking activities include, but are not limited to:	☐	☐	☐
a.	The use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served.	☐	☐	☐
b.	Systematically collecting and analyzing data related to the selected performance measures.	☐	☐	☐
c.	Using benchmarks that are based on valid and reliable local, state, national, or published data.	☐	☐	☐
d.	Measuring changes in the organization's performance on the selected performance measures.	☐	☐	☐
e.	Demonstrating sustained performance improvement over time.	☐	☐	☐
2.	Results of benchmarking activities must be incorporated into other quality improvement activities of the organization.	☐	☐	☐
3.	Results of benchmarking activities must be reported to the organization's governing body and throughout the organization, as appropriate.	☐	☐	☐

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	SC	PC	NC
Subchapter II — Risk Management: An accreditable organization develops and maintains a program of risk management appropriate to the organization, designed to protect the life and welfare of the organization's patients and employees. Such an organization has the following characteristics:	☐	☐	☐
A. The organization's governing body approves a written risk management program and/or policies that address:	☐	☐	☐
1. Methods by which a patient may be dismissed from care or refused care.	☐	☐	☐
2. Methods for managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure.	☐	☐	☐
3. Methods for communicating concerns regarding an impaired health care professional.	☐	☐	☐
4. Establishment of responsibility for, and documentation of, coverage after normal working hours.	☐	☐	☐
5. Restricting observers in patient care areas.	☐	☐	☐
6. Persons authorized to perform or assist in the procedure area.	☐	☐	☐
7. Requirements for evidence of patient consent for all persons permitted in patient care areas who are not authorized staff. Examples of unauthorized persons include students, interested physicians, health care industry representatives, surveyors, etc.	☐	☐	☐
B. The governing body designates a person or committee to be responsible for implementation, ongoing management, and consistent application of the risk management program and/or policies throughout the organization, including all departments and service locations.	☐	☐	☐
C. The risk management program and/or policies include ongoing processes that address patient safety and other important issues including:	☐	☐	☐
1. The definition of an adverse incident, that includes, at a minimum, the events defined in Standard 5.II.D.2.	☐	☐	☐
2. The identification, reporting, and appropriate analysis of all adverse incidents. The analysis identifies the basic or causal factors underlying the incident, and identifies potential improvements in processes or systems, if any exist, to reduce the likelihood of such incidents in the future.	☐	☐	☐
3. Encouraging the reporting of near-miss events.	☐	☐	☐
4. The communication of reportable events as required by law and regulation.	☐	☐	☐
5. Periodic review of all litigation involving the organization and its staff and health care professionals.	☐	☐	☐
6. An ongoing review of patient complaints and grievances that includes defined response times, as required by law and regulation.	☐	☐	☐
7. Documentation of timely notification to the professional liability insurance carrier when adverse or reportable events occur.	☐	☐	☐
8. Periodic review of clinical records and clinical record policies.	☐	☐	☐

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		SC	PC	NC
	9. Other state or federal risk management requirements.	☐	☐	☐
D.	The organization's risk management program and/or policies include the definitions of an incident and an adverse incident. At a minimum:	☐	☐	☐
	1. The definition of an **incident** includes any 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. All incidents are reviewed and, when appropriate, acted upon.	☐	☐	☐
	2. The definition of an **adverse incident** incorporates:	☐	☐	☐
	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. All events involving reactions to drugs and materials.	☐	☐	☐
	e. Circumstances or events that could have resulted in an adverse event (near-miss events).	☐	☐	☐
E.	Documented education regarding the risk management program, policies, and activities including adverse incident reporting, is provided to all staff within 30 days of beginning employment, annually thereafter, and when there is an identified need.	☐	☐	☐

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Got QI?

Achieving Accreditation does.

Your organization is already doing lots of monitoring and measuring, from adverse events to patient satisfaction scores to the cost of supplies. But do you know how to fit the data into a comprehensive quality improvement program? Do you know how to construct and write up a meaningful QI study?

At *Achieving Accreditation*, we'll teach you. And you'll leave with a tool that will help you teach others in your organization.

For the schedule of upcoming conferences, visit www.aaahc.org/education.

AAAHC

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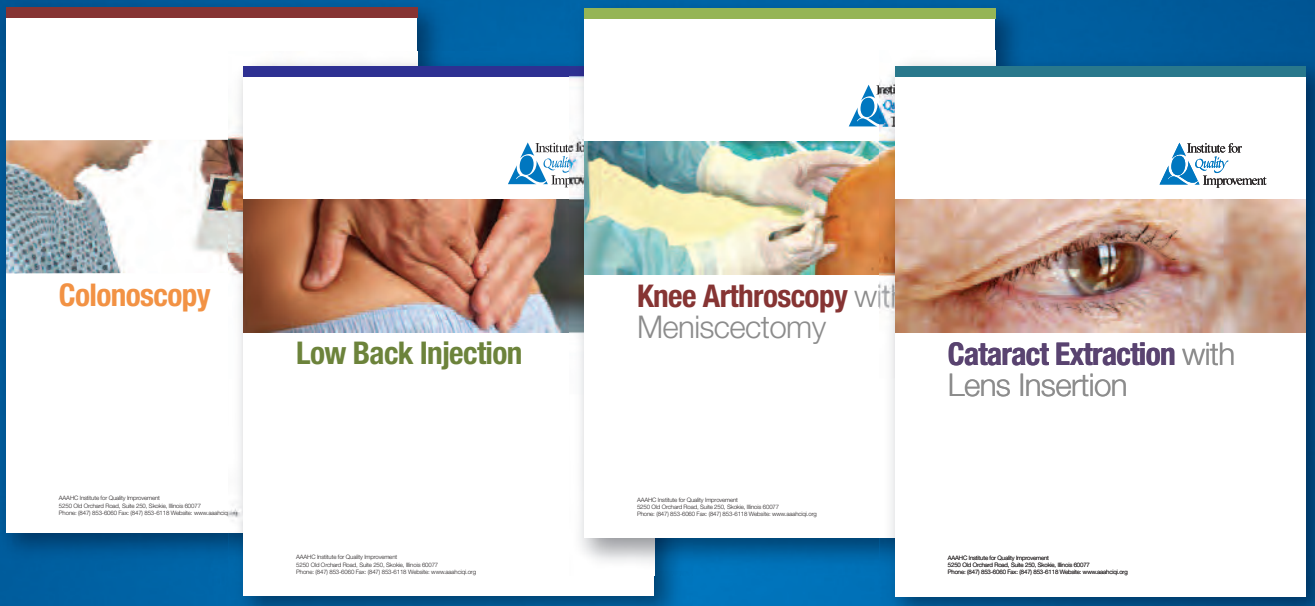
Got benchmarking?

The AAAHC Institute for Quality Improvement does.



(Studies like these help you continue delivering quality care)

How long do your patients wait for an appointment? How many post-procedure ER visits occur each month? How long does it take to get lab results back? How many medication errors happen in a quarter?

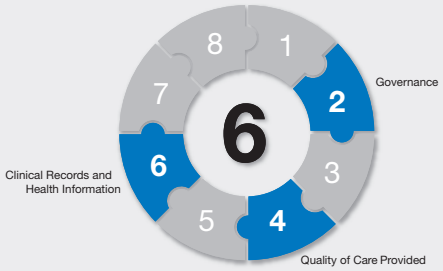
You may be able to answer these questions, but what do the answers mean? If your patients wait an average of 20 minutes to see a provider for an appointment, is that good or bad? That's where benchmarking comes in. The AAAHC Institute for Quality Improvement is your go-to resource for benchmarking studies. Institute studies cover topics from the procedure-specific to general patient satisfaction. You'll submit data reflecting a six-month period, and receive a comprehensive report that includes charts and graphs showing comparative results at a glance. Plus, AAAHC-accredited organizations are entitled to participate in one benchmarking study free of charge during a three-year term of accreditation.

For more information on all the ways the Institute can help you, visit **http://www.aaahc.org/en/institute**.

Institute for Quality Improvement

06

Clinical Records and Health Information



An accreditable organization maintains electronic and/or paper clinical records and a health information system from which information can be retrieved promptly. Clinical records are complete, comprehensive, legible, documented accurately in a timely manner, and readily accessible to health care professionals.

The *Clinical Records Worksheet*, found in the **Tools** section of this handbook, may be useful in assessing your organization's compliance with Chapter 6 Standards.

Standard	Compliance		
	SC	PC	NC
A. The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of clinical records.	☐	☐	☐
B. A designated person is in charge of clinical records. This person's responsibilities include, but are not limited to:	☐	☐	☐
1. The confidentiality, security, and physical safety of records.	☐	☐	☐
2. The timely retrieval of individual records upon request.	☐	☐	☐
3. The supervision of the collection, processing, maintenance, storage, and appropriate access to and usage of records.	☐	☐	☐
4. Security of the clinical record including:	☐	☐	☐
a. A method of tracking who accesses the record in order to block unauthorized access for electronic records.	☐	☐	☐
b. A method of identifying designated locations of paper records throughout the organization in order to avoid unauthorized access.	☐	☐	☐
C. An individual clinical record is established for each person receiving care. Each record includes, but is not limited to:	☐	☐	☐
1. Name.	☐	☐	☐
2. Identification number (if appropriate).	☐	☐	☐
3. Date of birth.	☐	☐	☐
4. Gender.	☐	☐	☐
5. Responsible party, if applicable.	☐	☐	☐
D. Clinical record entries are legible and easily accessible within the record by the organization's personnel.	☐	☐	☐

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		SC	PC	NC
E.	If a patient has had three or more visits/admissions, or the clinical record is complex and lengthy, a summary of past and current diagnoses or problems, including past procedures, is documented in the patient's record to facilitate the continuity of care.	☐	☐	☐
F.	The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistently defined location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.	☐	☐	☐
G.	Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.	☐	☐	☐
H	Documentation regarding missed and canceled appointments is added to the patient's record.	☐	☐	☐
I.	Entries in a patient's clinical record for each visit include, at a minimum:	☐	☐	☐
	1. Date (and department, if departmentalized).	☐	☐	☐
	2. Chief complaint or purpose of visit.	☐	☐	☐
	3. Clinical findings.	☐	☐	☐
	4. Studies ordered, such as laboratory or x-ray studies.	☐	☐	☐
	5. Care rendered and therapies administered.	☐	☐	☐
	6. Any changes in prescription and non-prescription medication with name and dosage, when available.	☐	☐	☐
	7. Discharge diagnosis or impression.	☐	☐	☐
	8. Disposition, recommendations, and instructions given to the patient.	☐	☐	☐
	9. Verification of contents by health care professionals	☐	☐	☐
	10. Signature of, or authentication by, the health care professional on the clinical record entries.	☐	☐	☐
J.	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.	☐	☐	☐
K.	The date of entry into the clinical record (with or without time of entry) of reports, histories and physicals, progress notes, and other patient information is documented in the patient's record.	☐	☐	☐
L.	Significant medical advice given to a patient by text, e-mail, or telephone, including medical advice provided after-hours, is permanently entered in the patient's clinical record and appropriately signed or initialed.	☐	☐	☐
M.	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.	☐	☐	☐

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		SC	PC	NC
N.	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, are incorporated into the patient's clinical record.	☐	☐	☐
O.	The organization ensures continuity of care for its patients. If a patient's primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are:	☐	☐	☐
	1. Obtained from the other (external) provider(s) or organization and incorporated into the patient's clinical record.	☐	☐	☐
	2. Provided to the other (external) health care professional(s) and, as appropriate, to the organization where future care will be provided.	☐	☐	☐
P.	Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. Patients are given the opportunity to approve or refuse release of records, except when release is permitted or required by law.	☐	☐	☐
Q.	All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients.	☐	☐	☐
R.	Written policies concerning clinical records address, at a minimum:	☐	☐	☐
	1. The retention of active records.	☐	☐	☐
	2. The retirement of inactive records.	☐	☐	☐
	3. Clear definition for the release and security of information, including accountability for editing, deletion, and access of clinical record content.	☐	☐	☐

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07

Infection Prevention and Control and Safety

An accreditable organization provides health care services while adhering to safe practices for patients, staff, and all others. The organization maintains ongoing programs designed to (1) prevent and control infections and communicable diseases, and (2) provide a safe and sanitary environment of care.

Standard	Compliance		
	SC	PC	NC
Subchapter I — Infection Prevention and Control: An accreditable organization maintains an active and ongoing infection prevention and control program as evidenced by the following characteristics:	☐	☐	☐
A. The organization has established a written program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to the governing body and other health authorities, if appropriate.	☐	☐	☐
B. The written infection prevention and control program is:	☐	☐	☐
1. Approved by the governing body.	☐	☐	☐
2. Based on nationally-recognized infection prevention and control guidelines considered and selected by the governing body.	☐	☐	☐
3. An integral part of the organization's quality improvement program.	☐	☐	☐
4. The result of a formal, documented infection prevention risk assessment to ensure that the program is relevant to the organization.	☐	☐	☐
5. In compliance with all applicable state and federal requirements.	☐	☐	☐
6. A plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.	☐	☐	☐
7. Focused on direct intervention to prevent infection, as needed.	☐	☐	☐
C. The infection prevention and control program is under the direction of a designated and qualified health care professional who has training and current competence in infection control.	☐	☐	☐
D. The infection prevention and control program reduces the risk of health care-acquired infection as evidenced by education and active surveillance, consistent with:	☐	☐	☐
1. WHO, CDC, or other nationally-recognized guidelines for hand hygiene.	☐	☐	☐
2. CDC or other nationally-recognized guidelines for safe injection practices.	☐	☐	☐
E. Medical and dental staff members, allied health practitioners, employees, volunteers, and others receive infection prevention education and training and comply with requirements.	☐	☐	☐

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		SC	PC	NC
F.	Processes for the cleaning, disinfection, and sterilization of instruments, equipment, supplies, and implants adhere to:	☐	☐	☐
	1. Nationally recognized guidelines.	☐	☐	☐
	2. Manufacturer's instructions for use.	☐	☐	☐
	3. State and federal guidelines.	☐	☐	☐
G.	A written sharps injury prevention program must be present in the organization. Such a program will include:	☐	☐	☐
	1. Documentation of new employee orientation, annual staff education, and additional education as needed.	☐	☐	☐
	2. Disposal of intact needles and syringes into appropriate puncture-resistant sharps containers, in accordance with current state and federal guidelines.	☐	☐	☐
	3. Placement of sharps containers in appropriate care areas, secured from tampering.	☐	☐	☐
	4. Replacement of sharps containers when the fill line is reached.	☐	☐	☐
	5. Handling, storage, and disposal of filled sharps containers in accordance with applicable regulations.	☐	☐	☐
H.	The organization provides safeguards to protect the patient from cross-infection through the provision of adequate space, equipment, supplies, and personnel.	☐	☐	☐
I.	Policies are in place for the isolation or immediate transfer of patients with a communicable disease.	☐	☐	☐
J.	A mechanism is in place to notify public health authorities of reportable conditions.	☐	☐	☐
K.	Procedures must be available to minimize the sources and transmission of infections, including adequate surveillance techniques.	☐	☐	☐
L.	A written process is in place for monitoring and documenting the cleaning, high-level disinfection, and sterilization of medical equipment, accessories, instruments, and implants.	☐	☐	☐
M.	A written policy addresses the identification and processing of medical equipment and instruments that fail to meet high-level disinfection or sterilization parameters.	☐	☐	☐
N.	Sterile packs of equipment and instruments are handled and stored to maintain their sterility.	☐	☐	☐
O.	The organization's written policies address cleaning of patient treatment and care areas which, at a minimum, include:	☐	☐	☐
	1. Cleaning before use.	☐	☐	☐
	2. Cleaning between patients.	☐	☐	☐
	3. Terminal cleaning at the end of the day.	☐	☐	☐
	4. Requirements that cleaning products are used according to the manufacturer's instructions for use.	☐	☐	☐

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		SC	PC	NC
P.	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.	☐	☐	☐
Q.	A written policy outlines appropriate hand hygiene using products according to the product manufacturer's instructions for use.	☐	☐	☐
R.	Documented education regarding the infection control program and applicable policies and processes is provided to all staff within 30 days of beginning employment, annually thereafter, and when there is an identified need.	☐	☐	☐
	Subchapter II — Safety: An accreditable organization adheres to safe practices for patients, staff, and others as evidenced by the following characteristics:	☐	☐	☐
A.	Elements of an organization's written safety program address the environment of care and the safety of patients, staff, and others, and must meet or exceed local, state, or federal safety requirements. Elements of the safety program include, at a minimum:	☐	☐	☐
	1. Processes for managing identified hazards, potential threats, near misses, and other safety concerns.	☐	☐	☐
	2. Processes to reduce and avoid medication errors.	☐	☐	☐
	3. Policies addressing manufacturer or regulatory agency recalls related to medications, medical equipment and devices, and food products.	☐	☐	☐
	4. Prevention of falls or physical injuries involving patients, staff, and others. As required by regulation or contract, reporting falls or physical injuries is accurate and timely.	☐	☐	☐
B.	The governing body designates responsibility for the organization's safety program to an identified individual or committee.	☐	☐	☐
C.	Medical staff members, allied health providers, employees, volunteers, and others receive safety program education and training and comply with the requirements.	☐	☐	☐
D.	Unique patient identifiers are consistently used throughout care.	☐	☐	☐
E.	The organization has a comprehensive written emergency and disaster preparedness plan to address internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The written plan must include a provision for the safe evacuation of individuals during an emergency, especially individuals who are at greater risk.	☐	☐	☐
F.	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.	☐	☐	☐
G.	The organization has adopted appropriate policies and procedures to educate medical staff members, employees, volunteers, and other providers and personnel in fire prevention and fire hazard reduction.	☐	☐	☐
H.	Fire safety, fire prevention, and fire drills are included in the surveillance activities of personnel responsible for safety and risk management.	☐	☐	☐
I.	Environmental hazards associated with safety are identified and safe practices are implemented.	☐	☐	☐

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		SC	PC	NC
J.	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposure.	☐	☐	☐
K.	Food and drink for patient use is stored, prepared, served, and disposed of in compliance with local, state, and federal guidelines.	☐	☐	☐
L.	When a medical device is provided to a patient:	☐	☐	☐
	1. The patient is educated about the use of the device.	☐	☐	☐
	2. Patient understanding of how to use the device is verified before independent use.	☐	☐	☐
M.	Written policies clearly require documentation of the pre-cleaning, transport, and handling of medical devices intended for external vendor reprocessing, inspection, or repair.	☐	☐	☐
N.	Reprocessing of manufacturer-labeled single-use devices must comply with FDA regulation and is limited to devices approved for reprocessing in accordance with FDA 510(k) clearance.	☐	☐	☐
O.	The organization has a written policy and process that address the recall of items including drugs and vaccines, blood and blood products, medical devices, equipment and supplies, and food products. At a minimum, the policy addresses documentation of:	☐	☐	☐
	1. Sources of recall information (FDA, CDC, manufacturers, and other local, state, or federal sources).	☐	☐	☐
	2. How applicable staff members are notified.	☐	☐	☐
	3. How the organization determines if a recalled product is present or has been given or administered to patients.	☐	☐	☐
	4. Response to recalled products.	☐	☐	☐
	5. Disposition or return of recalled items.	☐	☐	☐
	6. Patient notification, as appropriate.	☐	☐	☐
P.	The organization has a policy for disposal or return of expired medications and supplies that complies with local, state, and federal guidelines.	☐	☐	☐
Q.	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 manufacturer's guidelines.	☐	☐	☐
R.	Prior to use, appropriate education is provided to intended operators of newly-acquired devices or products to be used in the care of patients.	☐	☐	☐
	1. A designated a person is responsible for ensuring that clinical education occurs prior to the use of the devices or products.	☐	☐	☐
	2. Vendor representatives are not used as the sole source for clinical education.	☐	☐	☐
S.	Documented education in the safety program, policies, and activities is provided to all staff within 30 days of beginning employment, annually thereafter, and when there is an identified need.	☐	☐	☐

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08

Facilities and Environment

An accreditable organization provides a functionally safe and sanitary environment for its patients, personnel, and visitors.

Standard	Compliance		
	SC	PC	NC
A. The organization provides evidence of compliance with the following:	☐	☐	☐
1. Applicable state and local building codes and regulations.	☐	☐	☐
2. Applicable state and local fire prevention regulations.	☐	☐	☐
3. Applicable federal regulations.	☐	☐	☐
4. Periodic inspection by the local or state fire control agency, if this service is available in the community.	☐	☐	☐
B. The organization ensures that its facilities:	☐	☐	☐
1. Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire.	☐	☐	☐
2. Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall.	☐	☐	☐
3. Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of patients and staff, in case of an emergency.	☐	☐	☐
4. Have stairwells protected by fire doors, when applicable.	☐	☐	☐
5. Provide reception areas and toilets appropriate for patient and visitor volume.	☐	☐	☐
6. Provide examination rooms, dressing rooms, and reception areas that are constructed and maintained to ensure patient privacy during interviews, examinations, treatment, and consultation.	☐	☐	☐
7. Are operated in a safe and secure manner, with written policy(ies) addressing safety and security practices.	☐	☐	☐
C. The organization has the necessary personnel, equipment, and procedures to deliver safe care, and to handle medical and other emergencies that may arise.	☐	☐	☐
D. The organization documents its periodic instruction to all personnel in the proper use of safety, emergency, and fire-extinguishing equipment.	☐	☐	☐

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		SC	PC	NC
E.	The organization conducts scenario-based drills of the internal emergency and disaster preparedness plan.*	☐	☐	☐
	1. At least one drill is conducted each calendar quarter.	☐	☐	☐
	2. One of the quarterly drills is a cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization.	☐	☐	☐
	3. A written evaluation of each drill is completed.	☐	☐	☐
	4. Any needed corrections or modifications to the plan are implemented promptly.	☐	☐	☐
F.	Smoking is prohibited within the facility.	☐	☐	☐
G.	Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are identified and addressed.	☐	☐	☐
H.	Provisions are made to reasonably accommodate disabled individuals.	☐	☐	☐
I.	Adequate lighting and ventilation are provided in all areas.	☐	☐	☐
J.	Facilities are clean and properly maintained.	☐	☐	☐
K.	A system exists for the proper identification, management, handling, transport, treatment, and disposal of hazardous materials and wastes, whether solid, liquid, or gas.	☐	☐	☐
L.	The space allocated for a particular function or service is adequate for the activities performed therein.	☐	☐	☐
M.	Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of each patient care service site.	☐	☐	☐
N.	Policies and procedures regarding medical equipment include its standardized use, and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer's specifications.	☐	☐	☐
O.	Testing and inspection of fire alarm and suppression systems, including verification of signal transmission, are performed and documented.	☐	☐	☐
P.	When an organization undergoes demolition, construction, or renovation projects, the organization performs a proactive and ongoing risk assessment for existing or potential environmental hazards.	☐	☐	☐
Q	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. Recommended temperature ranges are readily available to staff performing the monitoring function.	☐	☐	☐

**Drills should be appropriate to the facility's activities and environment. Examples include medical emergencies, building fires, surgical fires, tornados, hurricanes, earthquakes, bomb threats, violence, and chemical, biological, or nuclear threats.*

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Adjunct Chapters

The adjunct chapters will be applied based on the services provided by the organization seeking accreditation.

09

Anesthesia Care Services

Anesthesia care services in an accreditable organization are provided in a safe and sanitary environment by qualified health care professionals who have been granted privileges to provide those services by the governing body.

The provisions of this chapter apply to all care involving administration of sedation and anesthesia in all ambulatory settings, including office-based settings. The following definitions are used in determining how the Standards of this chapter are applied based on the level of anesthesia and sedation administered by an organization:

Standards A through J of this chapter will be applied to organizations in which only local or topical anesthesia or only minimal sedation is administered.

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.

Standards A through Z of this chapter will be applied to organizations that administer moderate sedation/analgesia, deep sedation/analgesia, or regional anesthesia. Standard AA will apply only if general anesthesia is administered.

Moderate sedation/analgesia (conscious sedation) is a drug-induced depression of consciousness during which patients respond purposefully[1] to verbal commands, either alone or accompanied by light tactile stimulation. 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. 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.

Note: *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.*

**Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.*

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	SC	PC	NC	NA
Standards A through J will be applied at organizations involved in the administration of sedation and anesthesia as defined on page 61, including those where only local or topical anesthesia or only minimal sedation is administered.				
A. Anesthesia services provided by the organization are limited to those techniques that are approved by the governing body upon the recommendation of qualified professional personnel.	☐	☐	☐	☐
B Anesthesia is only administered by anesthesiologists, other qualified physicians, dentists, certified registered nurse anesthetists, or other qualified* health care professionals approved by the governing body pursuant to Chapter 2.II.	☐	☐	☐	☐
C. The organization ensures the appropriate supervision of anesthesia services.	☐	☐	☐	☐
1. The governing body has approved one or more qualified physicians or dentists as responsible for the supervision of anesthesia services, and has granted privileges for supervision to those responsible for it.	☐	☐	☐	☐
2. Other qualified* health care professionals must be directly supervised by a physician or dentist who has been granted privileges for supervision.	☐	☐	☐	☐
D. Written policies and procedures are developed for anesthesia services, which include, but are not limited to:	☐	☐	☐	☐
1. Education, training, and supervision of personnel.	☐	☐	☐	☐
2. Responsibilities of non-physician anesthetists.	☐	☐	☐	☐
3. Responsibilities of supervising physicians and dentists.	☐	☐	☐	☐
E. Patients are examined immediately prior to the administration of an anesthetic to evaluate the risks of anesthesia relative to the procedure to be performed.	☐	☐	☐	☐
1. The examination is conducted by a health care professional privileged to administer anesthesia in accordance with Standard 9.B.	☐	☐	☐	☐
2. Based on the results of the examination, the health care professional develops and documents a plan of anesthesia.	☐	☐	☐	☐
F. The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed. One consent form may be used to satisfy the requirements of this Standard and Standard 10.I.I.	☐	☐	☐	☐
G. The facility must be established, constructed, equipped, and operated in accordance with applicable local, state, and federal laws and regulations.	☐	☐	☐	☐
H. At a minimum, all settings in which sedation or anesthesia is administered should have the following equipment for resuscitation purposes:	☐	☐	☐	☐
1. Reliable and adequate source of oxygen delivery.	☐	☐	☐	☐
2. A device such as a self-inflating hand resuscitator bag capable of administering at least 90% oxygen.	☐	☐	☐	☐
3. Appropriate emergency drugs, supplies, and equipment.	☐	☐	☐	☐

**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 Chapter 2.II.*

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		SC	PC	NC	NA
	4. Appropriate monitoring equipment for the intended anesthesia care.	☐	☐	☐	☐
	5. Reliable suction source and appropriate equipment to ensure a clear airway.	☐	☐	☐	☐
I.	All clinical support personnel with direct patient contact maintain, at a minimum, skills in basic life support (BLS).	☐	☐	☐	☐
J.	If local or topical anesthesia or minimal sedation is administered, clinical records include entries that, at a minimum, address patient evaluation and the administration plan.	☐	☐	☐	☐

Standards A through AA will be applied at organizations that administer moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia.

K.	If moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia is administered, clinical records include entries that, at minimum, address:	☐	☐	☐	☐
	1. Pre-anesthesia evaluation.	☐	☐	☐	☐
	2. Intra-anesthesia administration, monitoring, and evaluation.	☐	☐	☐	☐
	3. Post-anesthesia recovery evaluation.	☐	☐	☐	☐
L.	A patient's oxygenation, ventilation, and circulation must be continually evaluated and documented. Intra-operative physiologic monitoring must include: continuous use of a pulse oximeter, blood pressure determination at frequent intervals, and electrocardiogram (EKG) monitoring for patients during moderate sedation, deep sedation/analgesia, or general anesthesia. Monitoring for the presence of exhaled CO_2 is required during the administration of deep sedation/analgesia. Monitoring for end tidal CO_2 is required during the administration of general anesthesia.	☐	☐	☐	☐
M.	The organization maintains a written policy with regard to assessment and management of acute pain.	☐	☐	☐	☐
N.	The patient is observed and monitored in a post-anesthesia care unit or in an area that provides equivalent care by methods appropriate to the patient's medical condition and sedation or anesthesia.	☐	☐	☐	☐
O.	A physician or dentist is present until the medical discharge of the patient following clinical recovery from the surgery/procedure and anesthesia.	☐	☐	☐	☐
P.	Before medical discharge from the facility, each patient must be evaluated by a physician, dentist, or delegated, qualified* health care professional, supervised by a physician or dentist and approved by the governing body, to assess recovery. If medical discharge criteria have previously been set by the treating physician or dentist, and approved by the governing body, a delegated, qualified* health care professional may determine if the patient meets such discharge criteria, and if so, may discharge the patient when those criteria are met.	☐	☐	☐	☐

**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 Chapter 2.II.*

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		SC	PC	NC	NA
Q.	Health care professionals, with documentation of current training in advanced cardiac life support (ACLS) are present to provide advanced resuscitative techniques until all patients operated on that day have been physically discharged. When pediatric patients are served, health care professionals with documentation of current training in PALS and age- and size-appropriate resuscitative equipment must be available at all times until pediatric patients operated on that day have been physically discharged. Initial ACLS and PALS training and subsequent retraining shall be 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.	☐	☐	☐	☐
R.	Patients who have received moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia are discharged in the company of a responsible adult.	☐	☐	☐	☐
S.	A safe environment for providing anesthesia services is ensured through the provision of adequate space, equipment, supplies, medications, and appropriately trained personnel. Written policies must be in place for safe use of injectables and single-use syringes and needles. All equipment should be maintained, tested, and inspected according to the manufacturer's specifications. A log is kept of regular preventive maintenance.	☐	☐	☐	☐
T.	Alternate power adequate for the type of surgery/service being performed is available in operative and recovery areas.	☐	☐	☐	☐
U.	Organizations that have anesthetic and resuscitative agents available that are known to trigger malignant hyperthermia must:	☐	☐	☐	☐
	1. Adopt current nationally-recognized* written treatment protocols that include:	☐	☐	☐	☐
	a. The use of dantrolene and other medications.	☐	☐	☐	☐
	b. Readily-available methods of continuous cooling and temperature monitoring of the patient.	☐	☐	☐	☐
	c. Initiation of an emergency transfer protocol.	☐	☐	☐	☐
	2. Provide relevant staff with education and training in the recognition and treatment of malignant hyperthermia.	☐	☐	☐	☐
	a. An accredited organization that begins to use triggering agents for the first time must document that relevant staff were provided with such education and training before the agents were made available for use within the organization.	☐	☐	☐	☐
	b. Organizations using triggering agents and seeking first-time accreditation must document that relevant staff have been provided with such education and training.	☐	☐	☐	☐
	c. All accredited organizations using triggering agents must document that new staff are provided with such education and training as part of their initial orientation, as appropriate to their roles.	☐	☐	☐	☐
	3. Post the treatment protocols so that they are immediately available in each area within the organization where triggering agents might be used.	☐	☐	☐	☐

An example is the Malignant Hyperthermia Association of the United States (MHAUS) protocol. See* ***Resources**,* Malignant Hyperthermia Guidelines.

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	SC	PC	NC	NA
4. Conduct documented malignant hyperthermia drills at least annually when triggering agents are present within the organization.	☐	☐	☐	☐
V. The organization has a written protocol in place for the safe and timely transfer of patients to a predetermined alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. Standard 4.I addresses medical emergencies that arise in connection with surgical procedures.	☐	☐	☐	☐
Standard W will be applied to organizations that provide anesthesia services to children.	☐	☐	☐	☐
W. If anesthesia services are provided to infants and children, the required equipment, medication, and resuscitative capabilities appropriate to pediatric patients are on site.	☐	☐	☐	☐
X. No patient shall receive 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. The operating physician or dentist may be the supervising physician or dentist. During moderate sedation, the additional individual may assist with minor, interruptible tasks.	☐	☐	☐	☐
Y. In settings where anesthesia may be provided by other than an anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an anesthesiologist assistant within his/her scope of practice:	☐	☐	☐	☐
1. Such personnel must be privileged by the governing body to administer sedative, hypnotic, or analgesic drugs that do not have an antagonist medication (for example, propofol) if these drugs are used.	☐	☐	☐	☐
2. A written protocol defines how the organization will respond in the event that a deeper-than-intended level of sedation occurs.	☐	☐	☐	☐
Standards Z and AA will be applied to organizations that administer deep sedation and/or general anesthesia.	☐	☐	☐	☐
Z. The administration of deep sedation requires monitoring for the presence of exhaled CO_2.	☐	☐	☐	☐
AA. The administration of general anesthesia requires:	☐	☐	☐	☐
1. Monitoring for end-tidal CO_2.	☐	☐	☐	☐
2. A readily available means of measuring body temperature.	☐	☐	☐	☐

**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 Chapter 2.II.*

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10

Surgical and Related Services

Surgical and related services in an accreditable organization are performed in a safe and sanitary environment by qualified health care professionals who have been granted privileges to perform those procedures by the governing body. The Standards in this chapter apply to organizations that provide any invasive procedures, such as pain management, endoscopy procedures, cardiac catheterization, lithotripsy, and in-vitro fertilization, as well as surgery.

In this chapter 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, laser, or otherwise physically entering or changing body tissues and organs, including invasive pain management procedures.

Note: Some Standards may not apply to organizations that only perform minor, superficial procedures without anesthesia or under local or topical anesthesia.

Standard	Compliance			
	SC	PC	NC	NA
Subchapter I — General Requirements: This subchapter describes general requirements for an organization that provides surgical and related services.	☐	☐	☐	☐
A. Surgical procedures must be performed in a functional and sanitary environment and are limited to those procedures that are approved by the governing body upon the recommendation of qualified medical staff.	☐	☐	☐	☐
B. Adequate supervision of surgery conducted by the organization is a responsibility of the governing body. It is recommended that supervision of surgical services be provided by a physician or dentist.	☐	☐	☐	☐
C. Surgical procedures must be performed in a safe manner only by qualified providers who:	☐	☐	☐	☐
1. Are licensed to perform such procedures within the state in which the organization is located.	☐	☐	☐	☐
2. Have been granted clinical privileges to perform those procedures by the governing body in accordance with Chapter 2.II.	☐	☐	☐	☐
D. An appropriate and current health history must be completed and incorporated into the patient's clinical record no more than 30 days prior to the scheduled surgery/procedure (or according to local, state, or federal requirement), with a list of current prescription and non-prescription medications and dosages, when available; physical examination; and pertinent pre-operative diagnostic studies.	☐	☐	☐	☐
1. The organization has written policies regarding the procedures and treatments that are offered to patients, which include criteria for patient selection, the need for anesthesia support, and post-procedural care.	☐	☐	☐	☐
E. When pre-operative antibiotics are ordered, the use and time of administration are documented in the patient's clinical record.	☐	☐	☐	☐

		SC	PC	NC	NA
F.	A written policy is in place for the risk assessment and prevention practices relating to deep vein thrombosis, when appropriate.	☐	☐	☐	☐
G.	Specific instructions for discontinuation or resumption of medications prior to and after a procedure are provided to the patient with corresponding documentation in the patient's clinical record.	☐	☐	☐	☐
H.	Informed consent for the proposed procedure is obtained.	☐	☐	☐	☐
1.	There is documentation that the necessity or appropriateness of the proposed procedure or surgery, as well as alternative treatment techniques, have been discussed with the patient.	☐	☐	☐	☐
2.	The organization obtains written informed consent from the patient or the patient's representative before the procedure or surgery is performed.	☐	☐	☐	☐
I.	Registered nurse(s) and other health care professionals assisting in the provision of surgical services are appropriately trained and supervised, and are available in sufficient numbers for the surgical and emergency care provided.	☐	☐	☐	☐
J.	Each operating room is designed, constructed, and equipped to support the types of surgery conducted.	☐	☐	☐	☐
1.	The design and equipment facilitate the physical safety of all persons in the area.	☐	☐	☐	☐
2.	The design, construction, and equipment comply with applicable state and local codes.	☐	☐	☐	☐
K.	Whenever patients are present in the facility, the organization ensures that:	☐	☐	☐	☐
1.	Health care professionals trained in the use of emergency equipment and basic life support (BLS) are present.	☐	☐	☐	☐
2.	At least one physician or dentist is present or immediately available by telephone.	☐	☐	☐	☐
L.	With the exception of those exempted in writing by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's clinical record.	☐	☐	☐	☐
M.	The findings and techniques of a procedure are accurately and completely documented immediately after the procedure by the health care professional who performed the procedure. This description is immediately available for patient care and becomes a part of the patient's clinical record.	☐	☐	☐	☐
N.	A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is ensured through the provision of adequate space, equipment, supplies, and personnel.	☐	☐	☐	☐
1.	Provisions have been made for the isolation or immediate transfer of a patient with a communicable disease.	☐	☐	☐	☐
2.	All persons entering operating or procedure rooms are properly attired as defined by the organization's written policy.	☐	☐	☐	☐
3.	Acceptable aseptic techniques are used by all persons in the surgical area.	☐	☐	☐	☐

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		SC	PC	NC	NA
4.	A written policy outlines the appropriate and timely surgical hand antisepsis (scrub) using either an antimicrobial soap or an alcohol-based handrub according to product manufacturer's recommended guidelines.	☐	☐	☐	☐
5.	Only authorized persons are allowed in the surgical or treatment areas, including laser rooms.	☐	☐	☐	☐
6.	Environmental controls are implemented to ensure a safe and sanitary environment.	☐	☐	☐	☐
7.	Suitable equipment is provided for the regular cleaning of all interior surfaces.	☐	☐	☐	☐
8.	Operating/procedure rooms are appropriately cleaned before each procedure.	☐	☐	☐	☐
9.	Freshly laundered attire is donned in an area inside of the organization prior to entry into areas designated as restricted.	☐	☐	☐	☐
10.	Attire used for personal protective equipment (PPE) or attire contaminated with blood or body fluid is laundered by a laundry that adheres to nationally recognized guidelines and is approved by the organization.	☐	☐	☐	☐
11.	As needed to minimize the potential contamination of the surgical environment and surgical staff, patient clothing is removed or covered prior to the patient's entry into a surgical area.	☐	☐	☐	☐
12.	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposure.	☐	☐	☐	☐
13.	Fire risks are identified and minimized, and staff members are prepared to address fire hazards, if necessary.	☐	☐	☐	☐
14.	Policies are in place for pre-procedure site antisepsis, as appropriate to service(s) provided and patient requirements and needs.	☐	☐	☐	☐
O.	Suitable equipment for immediate use and routine sterilization is available to ensure that operating room materials are sterile. The processes for cleaning and sterilization of supplies and equipment adhere to the manufacturer's instructions and recommendations.	☐	☐	☐	☐
P.	Sterilized materials are consistently packaged, labeled, and stored so as to identify sterility dates and maintain sterility. Internal and external indicators, including biological indicators, are used to demonstrate the safe processing of items undergoing sterilization.	☐	☐	☐	☐
Q.	High level disinfection processes adhere to equipment and chemical manufacturers' instructions.	☐	☐	☐	☐
R.	If procedures performed pose the risk that blood loss may require blood replacement, the organization must have written policies and procedures to address this situation.	☐	☐	☐	☐
S.	The organization must have alternate power available for OR and PACU areas.	☐	☐	☐	☐
T.	Periodic calibration and/or preventive maintenance of equipment is scheduled.	☐	☐	☐	☐

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		SC	PC	NC	NA
U.	The organization uses a written process to:	☐	☐	☐	☐
	1. Identify and/or designate the surgical procedure to be performed	☐	☐	☐	☐
	2. Ensure that the person performing the procedure marks the site.	☐	☐	☐	☐
	3. Involve the patient in the process for surgical site marking.	☐	☐	☐	☐
	4. Identify the operative tooth by marking a radiograph or dental diagram for dental procedures.	☐	☐	☐	☐
V.	Immediately prior to beginning a procedure, the provider performing the procedure assumes responsibility for the time out and engages the entire operating team.	☐	☐	☐	☐
W.	During the pre-procedure time out, the following items are verified:	☐	☐	☐	☐
	1. Patient identification.	☐	☐	☐	☐
	2. Intended procedure.	☐	☐	☐	☐
	3. Correct surgical site.	☐	☐	☐	☐
	4. All equipment necessary for performing the scheduled procedure is immediately available in the operating/procedure room.	☐	☐	☐	☐
	5. Any implantable devices intended to be used during the procedure are prepared before the procedure and available.	☐	☐	☐	☐
X.	A written process includes:	☐	☐	☐	☐
	1. Identification of the types of procedures requiring counts of sponges, sharps, and instruments.	☐	☐	☐	☐
	2. A count before the start of the procedure and before skin closure.	☐	☐	☐	☐
	3. Reporting the start and end count to the surgeon.	☐	☐	☐	☐
	4. Documentation of the counts in the patient's record.	☐	☐	☐	☐
Y.	The organization has written guidelines for internal transfer of care from one provider to another. These guidelines address:	☐	☐	☐	☐
	1. Information to be transferred about a patient's care, including treatment/services, current condition, and any recent or anticipated changes.	☐	☐	☐	☐
	2. How the information will be communicated among members of the health care team.	☐	☐	☐	☐
Z.	The organization follows established protocols for instructing patients in self-care after surgery and provides written instructions to patients.	☐	☐	☐	☐
AA.	Organizations that receive/store/issue blood and blood products for transfusion or human cells or tissues for transplantation must have written protocols for handling, maintenance, and storage, 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).	☐	☐	☐	☐

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	SC	PC	NC	NA
Standard BB will be applied to organizations that provide surgical, diagnostic, and/or therapeutic services to children.	☐	☐	☐	☐
BB. The organization defines pediatric patients, and has policies addressing the care provided and ensuring a safe environment through the provision of adequate space, equipment, supplies, medications, and personnel.	☐	☐	☐	☐
Subchapter II — Laser, Light-Based Technologies, and Other Energy-Emitting Equipment: This subchapter addresses surgery or procedures that involve laser, light-based technologies, or other energy-emitting equipment.	☐	☐	☐	☐
A. Policies and procedures should be established and implemented for these devices. Policies and procedures include, but are not limited to:	☐	☐	☐	☐
1. Safety programs.	☐	☐	☐	☐
2 Education and training of personnel, including a requirement for all personnel working with these devices to be adequately trained in the safety and use of each type of device utilized in patient care.	☐	☐	☐	☐
B. The organization ensures that its facility is a safe environment by:	☐	☐	☐	☐
1. Granting privileges for each specific device.	☐	☐	☐	☐
2. Ensuring that only authorized persons are allowed in treatment areas.	☐	☐	☐	☐
3. Using door and window coverings, where appropriate.	☐	☐	☐	☐
4. Prominently displaying warning signs at the entrance to treatment areas during procedures.	☐	☐	☐	☐
5. Requiring that personnel in treatment areas use protective eyewear as recommended by the device manufacturer.	☐	☐	☐	☐
6. When appropriate, using smoke evacuators and other devices to control tissue debris, and high filtration masks and/or wall suction with filters to minimize laser plume inhalation.	☐	☐	☐	☐
7. Appropriately disinfecting or sterilizing components that have direct patient contact.	☐	☐	☐	☐
8. Ensuring appropriate fire protection, including:	☐	☐	☐	☐
a. The immediate availability of electrical-rated fire extinguishers for equipment fires.	☐	☐	☐	☐
b. The maintenance of a wet environment around the operative field and the immediate availability of an open container of saline or water where ignition of flammable materials is possible.	☐	☐	☐	☐
c. The use of safe equipment and/or techniques, especially for procedures in and around the airway and when oxygen is in use.	☐	☐	☐	☐
d. The use of noncombustible materials, supplies, and solutions as appropriate.	☐	☐	☐	☐

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	SC	PC	NC	NA
e. Positioning drape material so that it is not in front of the laser beam; drapes should be checked prior to use of a laser to ensure that material has not shifted during the procedure.	☐	☐	☐	☐
9. Documenting that maintenance logs confirm the inspection and testing of these devices.	☐	☐	☐	☐
C. The organization ensures patient safety by:	☐	☐	☐	☐
1. Ensuring that procedures are done in accordance with device manufacturer's guidelines and are consistent with the current version of the ANSI Standard for Safe Use of Lasers in Health Care Facilities.	☐	☐	☐	☐
2. Protecting the patient's eyes, skin, hair, and other exposed areas.	☐	☐	☐	☐
3. Using non-reflective surgical instruments and supplies, when available.	☐	☐	☐	☐
4. Appropriately educating patients regarding procedure risks and potential complications.	☐	☐	☐	☐
Subchapter III — Renal Lithotripsy Services: Renal lithotripsy services made available by the organization meet the needs of the patients and are provided in accordance with ethical and professional practices as well as legal requirements.	☐	☐	☐	☐
A. Lithotripsy services provided by the organization are directed by an urologist who is qualified to assume clinical responsibility for the quality of services rendered.	☐	☐	☐	☐
B. The organization has written radiation safety and quality control policies and procedures regarding patient and staff exposure that are periodically reviewed by a qualified individual.	☐	☐	☐	☐
C. The organization establishes its own written policies and procedures to enable trained and experienced allied health care personnel to conduct duties necessary to assist in the provision of lithotripsy. These include, at a minimum:	☐	☐	☐	☐
1. Meeting state and federal licensure requirements for operation of radiation equipment.	☐	☐	☐	☐
2. Providing staff education, including orientation to equipment.	☐	☐	☐	☐
D. The organization must have equipment, adequate supplies, and written policies and procedures defining guidelines to provide appropriate treatment in accordance with manufacturer's guidelines. The organization's written guidelines include:	☐	☐	☐	☐
1. Indications.	☐	☐	☐	☐
2. Contraindications.	☐	☐	☐	☐
3. Maximum power setting.	☐	☐	☐	☐
4. Maximum number of shocks.	☐	☐	☐	☐
5. Position of patient.	☐	☐	☐	☐
6. Patient size and weight.	☐	☐	☐	☐
7. Utilization of equipment.	☐	☐	☐	☐

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		SC	PC	NC	NA
E.	The organization has written policies addressing:	☐	☐	☐	☐
1.	A recognized methodology for diagnosis and treatment, including pre-procedure evaluation (lab work, x-rays, etc.).	☐	☐	☐	☐
2.	The requirement that a provider shall perform the treatment and be present during treatment.	☐	☐	☐	☐
3.	Criteria for patient selection.	☐	☐	☐	☐
4.	The requirement that signed consent forms are obtained prior to treatment.	☐	☐	☐	☐
5.	Administration of anesthesia/medication. (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 he/she can safely undergo anesthesia/analgesia for lithotripsy.)	☐	☐	☐	☐
6.	Monitoring during treatment that uses American Society of Anesthesiologists (ASA) guidelines.	☐	☐	☐	☐
7.	Correction of medication-related and other medical conditions contributing to coagulopathy and the relationship to lithotripsy.	☐	☐	☐	☐
8.	Pre- and post-procedure teaching.	☐	☐	☐	☐
F.	The organization has written policies addressing the safety aspects of the treatment, including:	☐	☐	☐	☐
1.	Daily logging of lithotripter calibration/equipment checks on days when lithotripsy is provided.	☐	☐	☐	☐
2.	Preventive maintenance logs and maintenance records that include malfunctions with current documentation from the service contract provider that malfunctions have been corrected.	☐	☐	☐	☐
3.	Documentation from contracted vendors that perform calibration and preventive maintenance on equipment that work has been completed according to the contract.	☐	☐	☐	☐
G.	In addition to the clinical record requirements in Chapter 6, the following elements must be included when lithotripsy services are provided:	☐	☐	☐	☐
1.	History and physical indicate presence, location, and size of urinary stone, and document patient symptoms.	☐	☐	☐	☐
2.	Method of determining location and confirmation of presence of stone immediately prior to treatment.	☐	☐	☐	☐
3.	Operative treatment record.	☐	☐	☐	☐
a.	Selection of treatment modality.	☐	☐	☐	☐
b.	Number of shocks.	☐	☐	☐	☐
c.	Energy level.	☐	☐	☐	☐
d.	Radiation exposure.	☐	☐	☐	☐

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		SC	PC	NC	NA
H.	The organization confirms that outside providers of lithotripsy services ensure that their equipment and personnel are appropriate for the services provided. This includes:	☐	☐	☐	☐
1.	Equipment is properly maintained and maintenance records are available to the organization when the equipment is at the organization.	☐	☐	☐	☐
2.	The lithotripsy vendor provides the organization with documentation that the personnel provided are properly trained, licensed, and receive ongoing education and annual competency evaluation for the services they provide.	☐	☐	☐	☐

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11

Pharmaceutical Services

Pharmaceutical services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.

Note: This chapter applies to any organization that uses drugs or pharmaceutical medical supplies, regardless of the presence or absence of an on-site pharmacy.

Standard	Compliance			
	SC	PC	NC	NA
A. Pharmaceutical services are provided in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services in accordance with Standard 11.J.	☐	☐	☐	☐
B. Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws.	☐	☐	☐	☐
C. Staff demonstrates knowledge of applicable state and federal pharmaceutical laws.	☐	☐	☐	☐
D. Records and security are maintained to ensure the control and safe dispensing of drugs, including samples, in compliance with federal and state laws.	☐	☐	☐	☐
E. Staff informs patients concerning safe and effective use of medications consistent with legal requirements and patient needs.	☐	☐	☐	☐
F. Measures have been implemented to ensure that prescription pads are controlled and secured from unauthorized patient access, and pre-signed and/or postdated prescription pads are prohibited.	☐	☐	☐	☐
G. The organization has a policy, in accordance with state and federal requirements or guidelines, for disposal or return of expired medications.	☐	☐	☐	☐
1. All medications, including vaccines and samples, are monitored for expiration dates on a regular basis.	☐	☐	☐	☐
2. Expired items are disposed of in a safe manner that prevents unauthorized access.	☐	☐	☐	☐
H. All injectable medications drawn into syringes and oral medications removed from the packaging identified by the original manufacturer must be appropriately labeled if not administered immediately.	☐	☐	☐	☐
I. The organization must have policies in place for safe use of injectables and single-use syringes and needles that, at minimum, include CDC or comparable guidelines for safe injection practices.	☐	☐	☐	☐
J. Pharmaceutical services provided by the organization are directed by a licensed pharmacist or, when appropriate, by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.	☐	☐	☐	☐

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		SC	PC	NC	NA
K.	Providers or other health care professionals who prescribe, dispense, administer, and provide patient education on medications have easy access to current drug information and other decision support resources.	☐	☐	☐	☐
L.	If look-alike or sound-alike medications are present, the organization identifies and maintains a current list of these medications, and actions to prevent errors are evident.	☐	☐	☐	☐
M.	Procedures are established by the organization for maintenance, cleaning, distribution, and use of devices such as nebulizer units, intravenous infusion pumps, or any other mechanical device used in the medication delivery process.	☐	☐	☐	☐
N.	A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.	☐	☐	☐	☐
O.	Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.	☐	☐	☐	☐
P.	Patients are not required to use a pharmacy owned or operated by the organization.	☐	☐	☐	☐

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12

Pathology and Medical Laboratory Services

Pathology and medical laboratory services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
A. An accreditable organization:	☐	☐	☐	☐
1. Meets the requirements for waived tests or provider performed microscopy under CLIA (part 493 of Title 42 of the Code of Federal Regulations) and has obtained a Certificate of Waiver, and/or a Provider Performed Microscopy Certificate; and/or a CLIA Certificate as appropriate for the lab services provided.	☐	☐	☐	☐
2. Has procedures for obtaining routine and emergency laboratory services outside of its capabilities from a certified external laboratory to meet patient needs.	☐	☐	☐	☐
B. Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	☐	☐	☐	☐
1. Tests are performed in a timely manner.	☐	☐	☐	☐
2. Test results are distributed and copies of the results are maintained.	☐	☐	☐	☐
3. Appropriate quality control procedures are performed and documented including, but not limited to, calibrating equipment periodically and validating test results.	☐	☐	☐	☐
4. Staff with laboratory responsibilities have adequate training and demonstrated competence.	☐	☐	☐	☐
C. The organization has a policy to ensure that test results are reviewed and acknowledged in writing (manually or electronically) by the ordering physician or qualified designee.	☐	☐	☐	☐
D. Pathology and medical laboratory services provided by the organization are directed by a pathologist or another physician who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.	☐	☐	☐	☐
E. A sufficient number of adequately trained and experienced personnel are available to supervise and conduct the work of the laboratory.	☐	☐	☐	☐
F. Established procedures are followed in obtaining, identifying, storing, and transporting specimens.	☐	☐	☐	☐
G. Complete descriptions are available of each test procedure performed by the laboratory, including sources of reagents, standards, and calibration procedures, and information concerning the basis for the listed "normal" ranges.	☐	☐	☐	☐

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		SC	PC	NC	NA
H.	Sufficient space, equipment, and supplies are provided to perform the volume of work with optimal accuracy, precision, efficiency, and safety.	☐	☐	☐	☐
I.	If the lab is testing for Department of Transportation (DOT) regulated industries or federal agency employees, requirements of the Department of Health & Human Services (HHS) certification for medical review officer drug testing are met.	☐	☐	☐	☐

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13

Diagnostic and Other Imaging Services

Imaging services, including those used for diagnosing, monitoring, or assisting with procedures provided or made available by an accreditable organization, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
Standards A through F will be applied to organizations providing imaging services intraoperatively. Standards A through L will be applied to organizations that provide imaging services for diagnostic purposes.				
A. Imaging services provided by the organization are appropriate to the needs of the patient and support the organization's capabilities. Imaging services may include, but are not limited to: radiographic, fluoroscopic, ultrasonic, or other imaging services.	☐	☐	☐	☐
B Image interpretation is appropriately documented in a timely manner.	☐	☐	☐	☐
C. Records or reports of services provided are maintained.	☐	☐	☐	☐
D. Space, equipment, and supplies are sufficient to ensure the provision of quality services.	☐	☐	☐	☐
E. Health care professionals providing imaging services and/or interpreting results:	☐	☐	☐	☐
1. Have appropriate training and credentials.	☐	☐	☐	☐
2. Have been granted privileges to provide these services.	☐	☐	☐	☐
3. Have appropriate safety training and provide their services in a safe manner.	☐	☐	☐	☐
F. Policies and procedures that address the safety aspects of the imaging services include, but are not limited to:	☐	☐	☐	☐
1. Regulation of the use, removal, handling, and storage of potentially hazardous materials, if present.	☐	☐	☐	☐
2. Precautions against electrical, mechanical, magnetic, ultrasonic, radiation, and other potential hazards.	☐	☐	☐	☐
3. Proper shielding where radiation, magnetic field, and other potentially hazardous energy sources are used.	☐	☐	☐	☐
4. Acceptable monitoring devices or processes to ensure the safety of all personnel who might be exposed to radiation, magnetic fields, or otherwise harmful energy; if radiation exposure is not monitored, documentation exists within the organization to support this decision.	☐	☐	☐	☐

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		SC	PC	NC	NA
	5. Maintenance of appropriate exposure records.	☐	☐	☐	☐
	6. Instructions to personnel in safety precautions and in dealing with accidental hazardous energy field exposure.	☐	☐	☐	☐
	7. 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.	☐	☐	☐	☐
G.	Proper warning signs are in place, alerting the public and personnel to the presence of hazardous energy fields, emphasizing concern for particularly susceptible individuals, including:	☐	☐	☐	☐
	1. Pregnant females.	☐	☐	☐	☐
	2. In cases of magnetic resonance imaging:	☐	☐	☐	☐
	a. Patients with metal implantations.	☐	☐	☐	☐
	b. Patients or personnel with magnetically inscribed credit cards, where appropriate.	☐	☐	☐	☐
	c. Patients or personnel wearing metallic objects capable of potentially dangerous motion.	☐	☐	☐	☐
	d. Patients with pacemakers or internal defibrillators.	☐	☐	☐	☐
H.	The organization implements a process to identify the correct site and correct service that is to be performed and involves the patient in the process.	☐	☐	☐	☐
I.	A radiologist authenticates all examination reports, except reports of specific procedures that may be authenticated by specialist physicians or dentists who have been granted privileges by the governing body or its designee to authenticate such reports.	☐	☐	☐	☐
J.	Authenticated, dated reports of all examinations performed are made a part of the patient's clinical record.	☐	☐	☐	☐
K.	Diagnostic imaging services provided by the organization are directed by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of the services rendered.	☐	☐	☐	☐
L.	Diagnostic imaging tests are performed only upon the order of a health care professional. Such orders are accompanied by a concise statement of the reason for the examination.	☐	☐	☐	☐
M.	Diagnostic images are maintained in a readily accessible location for the time required by applicable laws and policies of the organization.	☐	☐	☐	☐
N.	The organization has a policy that addresses the storage and retention of diagnostic images.	☐	☐	☐	☐

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14

Dental Services

Dental services provided by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.

Standard	Compliance			
	SC	PC	NC	NA
Subchapter I — Dental Services: This chapter will be applied to organizations that provide primary dental care and general dentistry and/or oral maxillofacial services. For multi-specialty ASCs in which dentistry and oral maxillofacial surgery are among the specialties provided, this chapter will not be applicable. For those multi-specialty ASCs, Chapters 9 and 10 will be applied.	☐	☐	☐	☐
A. Dental services provided are appropriate to the needs of the patients and are consistent with the definition of dentistry according to state regulation.	☐	☐	☐	☐
B. Dental services performed in the facilities owned and operated by the organization are limited to those procedures that are approved by the governing body upon the recommendation of qualified dental personnel.	☐	☐	☐	☐
C. Dental procedures are performed only by dental health professionals who:	☐	☐	☐	☐
1. Are licensed to perform such procedures within the state or jurisdiction in which the organization is located.	☐	☐	☐	☐
2. Have been granted privileges to perform those procedures by the governing body of the organization, in accordance with Chapter 2.II.	☐	☐	☐	☐
D. Personnel assisting in the provision of dental services are appropriately qualified and available in sufficient numbers for the dental procedures provided.	☐	☐	☐	☐
E. An appropriate history and physical is conducted and periodically updated, which includes an assessment of the hard and soft tissues of the mouth.	☐	☐	☐	☐
F. The organization develops policies and procedures related to the identification, treatment, and management of pain.	☐	☐	☐	☐
G. The necessity or appropriateness of the proposed dental procedure(s), as well as alternative treatments and the order of care, have been discussed with the patient prior to delivery of services.	☐	☐	☐	☐
H. The informed consent of the patient is obtained and incorporated into the dental record prior to the procedure(s).	☐	☐	☐	☐
I. Clinical records are maintained according to the requirements found in Chapter 6.	☐	☐	☐	☐
J. The organization develops policies and procedures to evaluate dental laboratories to ensure that they meet the needs of the patient and adequately support the organization's clinical capabilities.	☐	☐	☐	☐
K. Anesthesia provided or made available meets the Standards contained in Chapter 9.	☐	☐	☐	☐

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		SC	PC	NC	NA
L.	Surgical and related services provided or made available meet the Standards contained in Chapter 10.	☐	☐	☐	☐
M.	Imaging services provided or made available meet the Standards contained in Chapter 13.	☐	☐	☐	☐
N.	The organization has guidelines to address the type, frequency, and indications for diagnostic radiographs.	☐	☐	☐	☐
O.	Health care professionals providing dental, surgical, or anesthesia services are prepared to evaluate, stabilize, and transfer medical emergencies that may occur or arise in conjunction with services provided by the organization.	☐	☐	☐	☐
P.	All clinical support staff with direct patient contact maintain, at a minimum, skills in basic life support (BLS).	☐	☐	☐	☐
Q.	The organization has a mechanism in place to evaluate and monitor dental products that the organization makes available for sale to patients to ensure that such practices are done in an ethical manner.	☐	☐	☐	☐

Subchapter II — Dental Home: The Dental Home subchapter will apply to organizations that choose this subchapter in the *Application for Survey*.

The services provided by an accreditable Dental Home are patient-centered, dentist-directed, comprehensive, accessible, continuous, and organized to meet the needs of the individual patient served. The foundation of a Dental Home is the relationship between the patient, his/her family (as appropriate), and the Dental Home. As used in these Standards, a Dental Home is the primary point of care for the patient.

The Dental Home will be assessed from the perspective of the patient on the following characteristics: ☐ ☐ ☐ ☐

A.	Relationship – communication, understanding, and collaboration. (In this context, "dentist" refers to the dentist or the physician- or dentist-directed health care team.)	☐	☐	☐	☐
1.	The patient can identify his/her dentist and patient care team members.	☐	☐	☐	☐
2.	The dentist explains information in a manner that is easy to understand (to include Standard 1.D).	☐	☐	☐	☐
3.	The dentist listens carefully to the patient and, when appropriate, the patient's personal caregiver(s). Caregivers may include a parent, legal guardian, or person with the patient's power of attorney.	☐	☐	☐	☐
4.	The dentist speaks to the patient about his/her health problems and concerns.	☐	☐	☐	☐
5.	The dentist provides easy-to-understand instructions about taking care of health concerns.	☐	☐	☐	☐
6.	The dentist knows important facts about the patient's health history.	☐	☐	☐	☐
7.	The dentist spends sufficient time with the patient.	☐	☐	☐	☐
8.	The dentist is as thorough as the patient feels is needed.	☐	☐	☐	☐
9.	The staff keeps the patient informed with regard to his/her appointment when delayed.	☐	☐	☐	☐

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		SC	PC	NC	NA
	10. The dentist addresses specific principles to prevent dental-related diseases.	☐	☐	☐	☐
	11. The dentist speaks with the patient about making lifestyle changes to help prevent dental-related disease.	☐	☐	☐	☐
	12. The dentist inquires as to the patient's concerns/worries/stressors regarding his/her dental health.	☐	☐	☐	☐
	13. The Dental Home provides services within a team framework, and that "team provider" concept has been conveyed to the patient.	☐	☐	☐	☐
	14. The family is included, as appropriate, in patient care decisions, treatment, and education.	☐	☐	☐	☐
	15. The Dental Home treats its patients with cultural sensitivity.	☐	☐	☐	☐
B.	Continuity of Care.	☐	☐	☐	☐
	1. A significant number (more than 50%) of the Dental Home visits of any patient are with the same dentist/dental care team.	☐	☐	☐	☐
	2. If a consultation is ordered for the patient, it is documented in the clinical record.	☐	☐	☐	☐
	3. Referrals for services (external to the Dental Home) are documented in the clinical record.	☐	☐	☐	☐
	4. Consultations (medical or dental opinions obtained from other health care professionals) are recorded in the clinical record.	☐	☐	☐	☐
	5. Referrals are disease- or procedure-specific.	☐	☐	☐	☐
	6. Patient referrals are recorded in the clinical record. Follow-up procedures exist and the results of the referral are appropriately reported to the Dental Home as they are made available.	☐	☐	☐	☐
	7. Follow-up appointments are documented in the clinical record.	☐	☐	☐	☐
	8. After-hour encounters are documented in the clinical record.	☐	☐	☐	☐
	9. Missed appointments are documented in the clinical record and managed appropriately depending on the patient's care need and diagnosis.	☐	☐	☐	☐
	10. Critical referrals, critical consultations, and critical diagnostic studies are tracked and appropriate follow-up is made when the results are not received within a timely manner.	☐	☐	☐	☐
	11. Transitions of care (e.g., pediatric to adult or adult to geriatric) is proactively planned, coordinated, and documented in the clinical record when indicated or when appropriate.	☐	☐	☐	☐

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		SC	PC	NC	NA
C.	Comprehensiveness of Care.	☐	☐	☐	☐
1.	If the Dental Home limits the population served, those limitations are disclosed to prospective patients.	☐	☐	☐	☐
2.	The Dental Home scope of service includes, but is not limited to:	☐	☐	☐	☐
a.	Preventive care (including surveillance and screening for special needs or assessment).	☐	☐	☐	☐
b.	Wellness care (healthy lifestyle issues—appropriate diet, tobacco cessation, home care, etc.).	☐	☐	☐	☐
c.	Acute pain and injury care.	☐	☐	☐	☐
d.	Chronic disease management.	☐	☐	☐	☐
e.	Advanced geriatric care	☐	☐	☐	☐
3.	Patient education and self-management resources are provided.	☐	☐	☐	☐
4.	The Dental Home knows of community resources to support the patient's (and family's, as appropriate) needs.	☐	☐	☐	☐
5.	The community's service limitations are known and alternate sources are coordinated by the Dental Home.	☐	☐	☐	☐
6.	Referrals are appropriate to the patient's needs. When referrals occur, the Dental Home collaborates with the specialist.	☐	☐	☐	☐
7.	The needs of the patient's personal caregiver (see definition in 14.II.A.3), when known, are assessed and addressed to the extent that they impact the care of the patient.	☐	☐	☐	☐
D.	Accessibility.	☐	☐	☐	☐
1.	The Dental Home establishes standards in writing to support patient access (e.g., provider availability, information, clinical record contents, advice, routine care, and urgent care). The Dental Home's data support that it meets those standards.	☐	☐	☐	☐
2.	Patients are routinely and continuously assessed for their perceptions about access to the Dental Home (e.g., provider availability, information, clinical record contents, advice, routine care, and urgent care).	☐	☐	☐	☐
3.	Patients are provided information about how to obtain dental care at any time (24/7/365).	☐	☐	☐	☐
4.	The Dental Home ensures on-call coverage (pre-arranged access to a clinician) when the Dental Home is not open.	☐	☐	☐	☐

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		SC	PC	NC	NA
E.	Quality.	☐	☐	☐	☐
1.	Patient care is dentist-directed.	☐	☐	☐	☐
2.	The Dental Home incorporates evidence-based guidelines and performance measures in delivering clinical services including:	☐	☐	☐	☐
a.	Preventive care (including surveillance and screening for special needs or assessment).	☐	☐	☐	☐
b.	Wellness care (healthy lifestyle issues—(appropriate diet, tobacco cessation, home care, etc.).	☐	☐	☐	☐
c.	Acute pain and injury care.	☐	☐	☐	☐
d.	Chronic disease management.	☐	☐	☐	☐
e.	Advanced geriatric care.	☐	☐	☐	☐
3.	The Dental Home periodically assesses its application of available evidence-based guidelines and/or performance measures to ensure that they are being used effectively and appropriately.	☐	☐	☐	☐
4.	Patient care is supervised by the Dental Home as evidenced by:	☐	☐	☐	☐
a.	Appropriate ordering of diagnostic radiographs (avoidance of redundancies and unnecessary exposure).	☐	☐	☐	☐
b.	Appropriate management of patient referrals (avoidance of unnecessary referrals).	☐	☐	☐	☐
5.	The Dental Home assesses and continuously improves the services it provides. Measurements, quality studies, data trending, and benchmarking are key tools used in the quality improvement/management program.	☐	☐	☐	☐
6.	In addition to the Standards presented in Chapter 5.I, the Dental Home's quality improvement program includes at least one study every three years on each of the following topics:	☐	☐	☐	☐
a.	Patient/dentist relationship.	☐	☐	☐	☐
b.	Continuity of care.	☐	☐	☐	☐
c.	Comprehensiveness of care.	☐	☐	☐	☐
d.	Accessibility to care.	☐	☐	☐	☐
e.	Clinical study.	☐	☐	☐	☐
F.	Electronic data management is continually assessed as a tool for facilitating the Standards above.	☐	☐	☐	☐

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Other Professional and Technical Services

Professional and technical services provided by an accreditable organization, even though they are not specifically mentioned in this handbook, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such services have the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
Subchapter I — General Services: This subchapter applies to organizations that provide other professional and technical services.	☐	☐	☐	☐
A. Such services may include, but are not limited to: various medical services, rehabilitation services (physical, occupational, vocational therapy), massage therapy, acupuncture, registered dieticians, aestheticians, audiologists, and other individuals who provide services to patients and may submit separate charges for their services.	☐	☐	☐	☐
B. Such services provided are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	☐	☐	☐	☐
C. Such services are provided by allied health professionals who have been credentialed/privileged in accordance with Standard 2.II.F or who have job descriptions outlined by the organization.	☐	☐	☐	☐
D. Such services are provided in accordance with ethical and professional practices and applicable federal and state laws and regulations.	☐	☐	☐	☐
E. Such services will be evaluated using applicable Standards from other chapters of this handbook.	☐	☐	☐	☐
Subchapter II — Travel Medicine: This subchapter applies only to organizations that provide travel medicine services.	☐	☐	☐	☐
A. Organizations providing travel medicine services will ensure that these services are appropriate to the needs of the patient and are adequately supported by the organization's clinical capabilities.	☐	☐	☐	☐
1. Travel medicine services are provided by personnel who have appropriate training, skills, and resource materials to provide quality services.	☐	☐	☐	☐
2. Travel medicine programs include:	☐	☐	☐	☐
a. Appropriate medical oversight.	☐	☐	☐	☐
b. Clearly defined standing orders and protocols, including management of adverse reactions to immunizations.	☐	☐	☐	☐

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	SC	PC	NC	NA
c. Access to current Centers for Disease Control (CDC) and U.S. Department of State travel recommendations.	☐	☐	☐	☐
d. Appropriate storage and management of vaccines.	☐	☐	☐	☐
3. Travel medicine services include:	☐	☐	☐	☐
a. Comprehensive travel destination-specific risk assessment.	☐	☐	☐	☐
b. Appropriate preventive medicine interventions.	☐	☐	☐	☐
c. Education in risk and risk reduction.	☐	☐	☐	☐
4. Entries in a patient's clinical record include:	☐	☐	☐	☐
a. Travel destination and current health status.	☐	☐	☐	☐
b. Immunization and vaccine name(s), dosage form, dosage administered, lot number, and quantity.	☐	☐	☐	☐
c. Prescription medications given, quantity and date, dosage, and directions for use.	☐	☐	☐	☐
d. Preventive health education.	☐	☐	☐	☐

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Health Education and Health Promotion

AAAHC encourages all health care organizations to provide or make available health education and health promotion services to meet the needs of the population served. These services should be provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
Standards A through G will be applied to all health education and health promotion services. Standards A through J will be applied to organizations providing comprehensive health education and disease prevention programs.				
A. Services provided by the organization are appropriate to the needs of the population served.	☐	☐	☐	☐
B. Health education and health promotion services are provided by personnel that:	☐	☐	☐	☐
1. Have necessary and appropriate training, education, credentials, and skills to carry out their responsibilities.	☐	☐	☐	☐
2. Have access to and use consultative services, as appropriate.	☐	☐	☐	☐
3. Have ready access to appropriate reference materials in health education and health promotion.	☐	☐	☐	☐
4. Participate in continuing professional education in health education and wellness.	☐	☐	☐	☐
C. Health education and health promotion programs should include, but may not be limited to:	☐	☐	☐	☐
1. Clearly defined educational goals and objectives.	☐	☐	☐	☐
2. Evaluation of whether the goals or objectives have been met.	☐	☐	☐	☐
D. The organization should have adequate resources for the health education and health promotion services available.	☐	☐	☐	☐
E. Marketing or advertising regarding the health education and health promotion activities accurately reflects the services provided by the organization.	☐	☐	☐	☐
F. Policies and procedures are established to assess satisfaction with the health education and health promotion services.	☐	☐	☐	☐
G. When appropriate, health education and health promotion services, whether they occur within the context of a clinical visit or not, should be referenced or documented in the patient's clinical record.	☐	☐	☐	☐

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		SC	PC	NC	NA
H.	Health education and disease prevention programs should be based on a complete needs assessment for the population served, which:	☐	☐	☐	☐
	1. Considers relevant health risks and health education needs.	☐	☐	☐	☐
	2. Uses a variety of data or data sources.	☐	☐	☐	☐
	3. Quantifies risk whenever possible.	☐	☐	☐	☐
	4. Uses data to direct programming.	☐	☐	☐	☐
I.	Health education and disease prevention programs should be comprehensive and consider the medical, psychological, social, and cultural needs of the population. Topics that should be considered include:	☐	☐	☐	☐
	1. Disease-specific screening and educational programs.	☐	☐	☐	☐
	2. Substance abuse prevention and education, including programs related to alcohol, tobacco, and other drugs.	☐	☐	☐	☐
	3. Promotion of healthy eating.	☐	☐	☐	☐
	4. Promotion of physical fitness.	☐	☐	☐	☐
	5. Sexuality education and skill building for healthy relationships.	☐	☐	☐	☐
	6. Sexual, physical, and emotional violence prevention.	☐	☐	☐	☐
	7. Promotion of and education about stress management and relaxation.	☐	☐	☐	☐
J.	Health education and disease prevention programs should be included in quality management and improvement activities.	☐	☐	☐	☐

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Behavioral Health Services

Behavioral health services are provided by an accreditable organization to meet the needs of its clients and the population served. Behavioral health services are provided in accordance with all ethical practices, professional practices, and legal requirements. Behavioral health services are designed to improve and enhance the emotional, mental, and behavioral health of the organization's targeted client population. Such an organization has the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
A. Behavioral health services are limited to those services that are approved by the governing body, consistent with the overall mission of the organization, and are responsive and specific to the diverse needs of the population being served. Behavioral health services may include, but are not limited to, the following:	☐	☐	☐	☐
1. Counseling or psychotherapy services.	☐	☐	☐	☐
2. Crisis intervention and emergency services.	☐	☐	☐	☐
3. Consultative and outreach services.	☐	☐	☐	☐
4. Referral services.	☐	☐	☐	☐
B. When behavioral health services are provided by an organization, those services are under the direction of a licensed professional who has been designated by the organization's governing body to provide such oversight.	☐	☐	☐	☐
C. Behavioral health services are provided only by health care professionals who are competent to perform such services. Such services are provided in accordance with AAAHC Standards and adhere to all applicable federal, state, and local requirements, and to appropriate standards of professional ethics.	☐	☐	☐	☐
D. Other personnel assisting in the provision or administration of behavioral health services are carefully selected and are subject to supervision by a licensed professional.	☐	☐	☐	☐
E. The organization has appropriate and adequate resources to provide quality behavioral health services. These resources include but are not limited to facilities, equipment, providers, and clinical and administrative support staff.	☐	☐	☐	☐
F. An initial behavioral health history and medical history of each client is present in the clinical record.	☐	☐	☐	☐
G. The clinical record is periodically updated, and may include assessment and management of:	☐	☐	☐	☐
1. Risk of harm to self or others.	☐	☐	☐	☐
2. Known or potential addictive behaviors and substance abuse.	☐	☐	☐	☐
3. Client self-understanding, motivation, and decision-making.	☐	☐	☐	☐

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		SC	PC	NC	NA
H.	The written and signed informed consent of the client is obtained and incorporated into the treatment plan, which may include but is not limited to procedures, therapies, medication management, and other modalities of care and treatment.	☐	☐	☐	☐
I.	The organization develops and adopts written policies and procedures regarding:	☐	☐	☐	☐
	1. Consistent client confidentiality and privacy assurances.	☐	☐	☐	☐
	2. Maintenance of client records according to AAAHC Standards.	☐	☐	☐	☐
	3. Client flow and case assignment.	☐	☐	☐	☐
	4. Situations arising from outreach programs (when provided) such as identification of individuals who need immediate services.	☐	☐	☐	☐
	5. Management of referrals and transfers to and from the facility.	☐	☐	☐	☐
	6. Cooperation with and coordination of medical care with behavioral health care.	☐	☐	☐	☐
	7. Safety and security of staff, clients, and the organization.	☐	☐	☐	☐

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Teaching and Publication Activities

If staff is involved in teaching or publishing, an accreditable organization has policies governing those activities that are consistent with its mission, goals, and objectives. Such an organization has the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
A. The organization has adopted written policies concerning teaching activities that address the formal relationship and responsibilities between the organization and the training institution and its trainees. Such written policies include, but are not limited to:	☐	☐	☐	☐
1. Time spent away from direct patient care and administrative activities.	☐	☐	☐	☐
2. Training and orientation of all students and postgraduate trainees, including the extent of their involvement in patient care activities.	☐	☐	☐	☐
3. The requirement or non-requirement for liability coverage.	☐	☐	☐	☐
4. Requirements for training and expectation of adherence by trainees to organizational policies, including state and federal guidelines such as HIPAA and OSHA.	☐	☐	☐	☐
B. The written policy concerning the provision of health care by personnel with student or postgraduate trainee status includes, but is not limited to:	☐	☐	☐	☐
1. A definition of “close and adequate supervision” of students and postgraduate trainees.	☐	☐	☐	☐
2. An established process for informing the patient of the student/trainee status and for obtaining patient consent for trainee participation in or observation of the patient’s care.	☐	☐	☐	☐
C. The organization adopts written policies regarding publishing activities that address:	☐	☐	☐	☐
1. The need for governing body approval for all publications that are either attributed to or result from care provided by the organization.	☐	☐	☐	☐

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Research Activities

If research is conducted, an accreditable organization establishes and implements policies governing research that are consistent with its mission, goals, and objectives, and with its clinical capabilities. Such an organization has the following characteristics:

Standard		Compliance			
		SC	PC	NC	NA
A.	Research activities including, but not limited to clinical trials of drugs and other biologicals, devices, implants, or instruments that are classified as investigational or experimental, and techniques that are new, experimental, innovative, or otherwise not yet accepted as standard medical or dental practice, are performed in accordance with ethical and professional practices and legal requirements. These activities are monitored at least annually.	☐	☐	☐	☐
B.	The written protocols for conducting research are approved by the governing body or its designee after medical (or dental) and legal review.	☐	☐	☐	☐
C.	Any research activities carried out within the organization are appropriate to the expertise of staff and the resources in the organization.	☐	☐	☐	☐
D.	Individuals engaged in research are provided with facilities.	☐	☐	☐	☐
E.	Provisions are made to ensure that the rights and welfare of all research subjects are protected and that informed consent of each subject is obtained in the language or manner primarily used by him or her.	☐	☐	☐	☐
F.	Professionals involved in research activities are informed of the organization's research policies.	☐	☐	☐	☐
G.	Information is available to patients and staff concerning a patient's right to refuse to participate in research.	☐	☐	☐	☐

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Overnight Care and Services

If an accreditable organization provides overnight care (i.e., has patients that are not discharged from the facility on the day they were admitted to the facility) and related services, such care and services meet the needs of the patients served and are provided in accordance with ethical and professional practices and legal requirements.

Note: This chapter applies to organizations, or sub-units thereof, that 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, receiving treatment for non-critical illnesses, or need only short-term or custodial care.

Standard	Compliance			
	SC	PC	NC	NA
A. The scope and limitations of overnight care and services are clearly specified. Such information is communicated to:	☐	☐	☐	☐
1. Physicians who refer and admit patients to the program.	☐	☐	☐	☐
2. Staff who provide the care and services.	☐	☐	☐	☐
3. Potential patients in advance of their referral to the program.	☐	☐	☐	☐
4. Other health care professionals and relevant community agencies.	☐	☐	☐	☐
B. A patient is admitted or discharged only upon the order of a physician who is responsible for the medical care of that patient.	☐	☐	☐	☐
C. Adequate supervision of overnight care and services is the responsibility of one or more qualified physicians who are approved by the governing body upon the recommendation of qualified medical staff.	☐	☐	☐	☐
D. At least one physician is present or immediately available by telephone whenever patients are present.	☐	☐	☐	☐
E. Providers may admit patients to this program if they:	☐	☐	☐	☐
1. Are licensed to treat patients or supervise care and services in this setting.	☐	☐	☐	☐
2. Have been granted such privileges by the governing body of the organization, in accordance with Chapter 2.II.	☐	☐	☐	☐
F. Policies and procedures clearly specify:	☐	☐	☐	☐
1. Clinical criteria for determining eligibility for admission.	☐	☐	☐	☐
2. Clinical responsibilities for each patient during his/her stay.	☐	☐	☐	☐
3. Arrangements for emergency services.	☐	☐	☐	☐
4. Arrangements for transfer to other health care services as needed.	☐	☐	☐	☐

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		SC	PC	NC	NA
G.	The organization has a written transfer agreement with a nearby hospital or grants admitting privileges only to physicians who have admitting privileges at a nearby hospital.	☐	☐	☐	☐
H.	The overnight care unit meets applicable local and state codes, including licensing requirements if the state licenses such units.	☐	☐	☐	☐
I.	Registered nurses and other health care professionals are appropriately trained and supervised, and are available in sufficient numbers to meet patient needs.	☐	☐	☐	☐
J.	At least one registered nurse is on duty at all times when patients are present.	☐	☐	☐	☐
K.	Treatment rooms are provided or made available to meet patient needs and physician requirements.	☐	☐	☐	☐
L.	Emergency power adequate for the size of the unit is available to protect the life and safety of patients.	☐	☐	☐	☐
M.	Appropriate isolation procedures are followed when any patient is admitted with a suspected or diagnosed communicable disease.	☐	☐	☐	☐
N.	Food service and refreshments are provided to meet the needs of patients.	☐	☐	☐	☐
	1. Evidence of compliance with local, state, and federal guidelines is present and adhered to regarding preparing, serving, disposal, and storing of food and drink for patient use.	☐	☐	☐	☐
	2. Special dietary requirements for patient care are met.	☐	☐	☐	☐
	3. Personnel providing food services meet local health department requirements.	☐	☐	☐	☐
O.	In addition to the applicable clinical records and health information requirements found in Chapter 6, the records for overnight care and services include:	☐	☐	☐	☐
	1. A current history and physical examination.	☐	☐	☐	☐
	2. Treatment orders.	☐	☐	☐	☐
	3. Nursing notes.	☐	☐	☐	☐
	4. Follow-up instructions to patients.	☐	☐	☐	☐
P.	If overnight care is the only service provided by the organization, that organization meets all other applicable Standards contained in this handbook.	☐	☐	☐	☐
Q.	If overnight care is only one of many services provided by the organization, these services shall be functionally integrated to ensure compliance with all other applicable Standards contained in this handbook.	☐	☐	☐	☐
R.	Overnight care and services are reviewed as part of the organization's quality improvement program.	☐	☐	☐	☐

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Occupational Health Services

Occupational medicine is a specialty devoted to the prevention and management of occupational and environmental injury, illness, and disability, and promotion of health and productivity of workers, their families, and communities. This chapter will apply if an organization provides extensive services, complex services, or markets itself as an occupational health center. If an organization provides basic employee health services to its own employees, Standards in Chapter 3 will be used to evaluate these services.

Standard	Compliance			
	SC	PC	NC	NA
A. Individuals who agree to laboratory testing or medical examinations at the request of their employer are afforded the patient rights noted in Chapter 1. In addition, they are informed of:	☐	☐	☐	☐
1. The purpose and scope of the evaluation and the role of the examiner.	☐	☐	☐	☐
2. Confidentiality protections and information that may be conveyed to the employer.	☐	☐	☐	☐
3. Whether medical follow-up is necessary.	☐	☐	☐	☐
B. Occupational health services are accurately portrayed to patients, employees, and purchasers of the services.	☐	☐	☐	☐
C. Occupational health services are provided by personnel who:	☐	☐	☐	☐
1. Have access to and use, as appropriate, consultative services associated with evaluating workplace hazards such as industrial hygiene, ergonomics, toxicology, occupational health nursing, epidemiology, and physicians with training in occupational medicine.	☐	☐	☐	☐
2. Have ready access to appropriate reference materials in occupational health and participate in occupational health continuing medical education.	☐	☐	☐	☐
D. The provision of high-quality occupational health services is demonstrated by the following, as appropriate:	☐	☐	☐	☐
1. An understanding of the specific workplace hazards for each employee/ patient served.	☐	☐	☐	☐
2. An understanding of the relationship of the condition or finding to workplace conditions and exposures.	☐	☐	☐	☐
3. A determination of whether the individual is able to perform essential functions of the job and whether accommodations are needed.	☐	☐	☐	☐
4. Preventive counsel concerning measures to reduce occupational exposures and hazards, including use of personal protective equipment.	☐	☐	☐	☐

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		SC	PC	NC	NA
	5. Compliance with occupational regulations such as the Occupational Safety and Health Act (OSHA), Americans with Disabilities Act (ADA), and state Workers' Compensation statutes concerning the organization's:	☐	☐	☐	☐
	a. Training and credentials of personnel.	☐	☐	☐	☐
	b. Policies, procedures, and forms.	☐	☐	☐	☐
	c. Equipment, including calibration and maintenance.	☐	☐	☐	☐
	d. Clinical records and record management.	☐	☐	☐	☐
E.	Entries in a patient's clinical record for each visit include, as appropriate:	☐	☐	☐	☐
	1. An occupational and exposure history, including essential job functions, conditions of work, and hazards of the job.	☐	☐	☐	☐
	2. The individual's current functional abilities.	☐	☐	☐	☐
	3. Whether the individual is able to perform essential job functions and suggestions for accommodations or restrictions.	☐	☐	☐	☐
	4. The relationship of medical conditions or abnormal findings to workplace conditions and exposures.	☐	☐	☐	☐
	5. Preventive counsel concerning reduction of workplace exposures and use of personal protective equipment.	☐	☐	☐	☐
	6. Relevant communications concerning the patient, work activities, or exposures, including communications with employers, insurance carriers, union representatives, and attorneys.	☐	☐	☐	☐
F.	Medical management of injury or illness minimizes disability and promotes functional recovery, directing special attention to cases in which:	☐	☐	☐	☐
	1. Recovery has been delayed.	☐	☐	☐	☐
	2. Functional abilities have decreased during treatment.	☐	☐	☐	☐
	3. Injury or illness is recurrent.	☐	☐	☐	☐
	4. There is permanent impairment, disability, or restriction.	☐	☐	☐	☐
G.	Work placement evaluations such as preplacement, transfer, or fitness for duty examinations assess current health and ability to perform the job as well as the extent and duration of recent health changes affecting job performance.	☐	☐	☐	☐
H.	Organizations providing medical surveillance evaluations of employees to identify adverse effects from exposure to workplace hazards ensure that:	☐	☐	☐	☐
	1. The health professionals performing or interpreting these evaluations have specific knowledge about the hazardous agent, including its effects, permissible and actual exposure levels, biologic monitoring, and regulatory requirements.	☐	☐	☐	☐
	2. Whenever possible, surveillance data is statistically analyzed for health trends and effects of exposure.	☐	☐	☐	☐
	3. Workplace data for similar workers with similar exposures are considered in the evaluation of the employee.	☐	☐	☐	☐

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		SC	PC	NC	NA
I.	Organizations providing certification examinations mandated under state or federal statutes ensure that:	☐	☐	☐	☐
1.	The health care professional performing the evaluation has access to the statute and related materials.	☐	☐	☐	☐
2.	The health care professional understands the statute as it relates to the exam.	☐	☐	☐	☐
J.	Organizations providing occupational health testing and ancillary service programs such as urine collection for drugs of abuse, breath alcohol content testing, blood lead determinations, audiograms, or chest x-rays, ensure that these programs are administered under appropriate written protocols, which are:	☐	☐	☐	☐
1.	Specific to the service provided, addressing all relevant topics such as specimen collection, handling, transportation, receipt and report of results, record management, equipment, equipment calibration, and maintenance.	☐	☐	☐	☐
2.	Under the supervision of a licensed physician or, if allowed, another health care professional.	☐	☐	☐	☐
3.	Reviewed and updated periodically.	☐	☐	☐	☐
K.	Organizations providing consulting services ensure that the role and responsibilities of the consultant are clearly defined.	☐	☐	☐	☐
L.	Organizations providing training and educational programs ensure that each program:	☐	☐	☐	☐
1.	Has written objectives.	☐	☐	☐	☐
2.	Is tailored to the specific worker population and work conditions.	☐	☐	☐	☐
3.	Includes an evaluation process and uses the results to improve program quality.	☐	☐	☐	☐
M.	If the organization is responsible for emergency and/or community preparedness planning, it ensures that:	☐	☐	☐	☐
1.	The disaster plan:	☐	☐	☐	☐
a.	Includes likely worksite scenarios for disasters, estimating potential morbidity and mortality.	☐	☐	☐	☐
b.	Includes appropriate plans for medical segregation, decontamination, evacuation, and transportation in collaboration with local emergency planning committees.	☐	☐	☐	☐
2.	The toxicologic exposure plan:	☐	☐	☐	☐
a.	Provides counsel on the identification, decontamination, and evacuation of potentially exposed individuals or communities.	☐	☐	☐	☐
b.	Ensures appropriate emergency treatment protocols for potentially acute exposures to toxic agents handled by employees.	☐	☐	☐	☐
c.	Provides appropriate medical expertise for the case management of individual acute toxic exposures.	☐	☐	☐	☐
d.	Provides sufficient training and exercises to ensure that the plan will be effective.	☐	☐	☐	☐

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Immediate/Urgent Care Services

If an accreditable organization implies by its activities, advertising, or practices that its **primary** mission is to provide medical care of an urgent or immediate nature on a non-appointment basis, such care meets the needs of the patients it intends to serve. Such immediate care and urgent care is provided in accordance with ethical and professional practices and adheres to applicable local, state, and federal requirements. Such an organization has the following characteristics:

Standard		Compliance			
		SC	PC	NC	NA
A.	The range of services offered by the organization and its hours of operation are clearly defined and communicated to the public and relevant organizations.	☐	☐	☐	☐
B.	Such organizations, unless they also provide emergency services, do not solicit patients with life-threatening conditions.	☐	☐	☐	☐
C.	Patients seeking immediate/urgent care services are seen without prior appointments.	☐	☐	☐	☐
D.	Immediate/urgent care services are performed only by health care professionals who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical staff and after medical review of the health care professional's documented education, training, experience, and current competence.	☐	☐	☐	☐
E.	During hours of operation, at least one qualified physician is present.	☐	☐	☐	☐
F.	The organization is prepared in terms of personnel, equipment, and procedures to evaluate, stabilize, and transfer medical emergencies that may present themselves or arise in conjunction with services provided by the organization.	☐	☐	☐	☐
G.	Equipment, drugs, and other agents necessary to provide immediate/urgent care services are available.	☐	☐	☐	☐
H.	Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, poison control centers, and hospitals as needed to ensure high-quality patient care.	☐	☐	☐	☐
I.	Laboratory and imaging services described in Chapters 12 and 13 are available to meet the needs of patients receiving immediate/urgent care.	☐	☐	☐	☐
J.	Arrangements have been made to ensure that adequate specialty consultation services are available.	☐	☐	☐	☐
K.	All clinical support staff with direct patient contact maintain, at a minimum, skills in basic life support (BLS).	☐	☐	☐	☐

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		SC	PC	NC	NA
L.	Health care professionals who are currently trained in ACLS or ATLS are present to provide advanced resuscitative techniques when patients are present. When pediatric patients are served, medical personnel who are currently trained in pediatric advanced life support (PALS) and age- and size-appropriate resuscitative equipment must be available at all times. 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.	☐	☐	☐	☐

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Emergency Services

If an accreditable organization implies by its activities, advertising, or practice that it provides emergency services on a regular basis to meet life-, limb-, or function-threatening conditions, such services meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Standard		Compliance			
		SC	PC	NC	NA
A.	Emergency services are provided 24 hours per day, every day of the year.	☐	☐	☐	☐
B.	Emergency services are performed only by health care professionals who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical staff and after medical review of the health care professional's documented education, training, experience, and current competence.	☐	☐	☐	☐
C.	At least one qualified physician is present at all times.	☐	☐	☐	☐
D.	Health care professionals assisting in the provision of emergency services are appropriately qualified, trained, and supervised and are available in sufficient numbers for the emergency services provided.	☐	☐	☐	☐
E.	Unless otherwise provided for by the governing body, equipment, drugs, and other agents recommended by the Emergency Care Guidelines of the American College of Emergency Physicians are available.	☐	☐	☐	☐
F.	Laboratory and imaging services described in Chapters 12 and 13 are immediately available.	☐	☐	☐	☐
G.	Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, poison control centers, and hospitals as needed to ensure high-quality patient care.	☐	☐	☐	☐
H.	Adequate specialty consultation services are immediately available.	☐	☐	☐	☐
I.	All clinical support staff with direct patient contact maintain, at a minimum, skills in basic life support (BLS).	☐	☐	☐	☐
J.	Health care professionals, with documentation of current training in ACLS or ATLS to provide advanced resuscitative techniques, are present when patients are present. When pediatric patients are served, health care professionals with documentation of current training in pediatric advanced life support (PALS) and age- and size-appropriate resuscitative equipment must be available at all times. 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.	☐	☐	☐	☐

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Radiation Oncology Treatment Services

Radiation oncology treatment services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
A. Radiation oncology treatment services provided by the organization are appropriate to the needs of the patient and are adequately supported by the organization's capabilities.	☐	☐	☐	☐
B. Radiation oncology services appropriate to the organization's function include, but are not limited to:	☐	☐	☐	☐
1. Consultation services.	☐	☐	☐	☐
2. Simulation of treatment.	☐	☐	☐	☐
3. Treatment planning.	☐	☐	☐	☐
4. Clinical treatment management including but not limited to the use of teletherapy and brachytherapy.	☐	☐	☐	☐
5. Maintaining reports of services and radiographic images appropriate to the therapy, as required by applicable laws and policy of the organization.	☐	☐	☐	☐
6. Appropriate follow-up care of all patients.	☐	☐	☐	☐
C. Radiation oncology services provided by the organization are directed by a physician who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.	☐	☐	☐	☐
D. The radiation oncology service has written safety and quality control policies and procedures, including policies and procedures for teletherapy and brachytherapy, that must be reviewed at least annually by a qualified medical physicist. The policies and procedures include, but are not limited to:	☐	☐	☐	☐
1. The designation of a radiation safety officer and committee that meets on a periodic basis.	☐	☐	☐	☐
2. A program to maintain personnel exposure records.	☐	☐	☐	☐
3. Annual calibration of teletherapy units.	☐	☐	☐	☐
4. Annual review of the radiation safety program by a qualified medical physicist.	☐	☐	☐	☐
5. A program to inspect interlock systems of all treatment units.	☐	☐	☐	☐
6. Maintaining records of machine performance, maintenance, and malfunctions.	☐	☐	☐	☐
7. Periodic testing of all sealed sources, satisfying all relevant radiation regulations.	☐	☐	☐	☐

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		SC	PC	NC	NA
	8. A program for maintenance and repair of equipment.	☐	☐	☐	☐
	9. Quality control procedures for all therapeutic equipment.	☐	☐	☐	☐
	10. Regulation of the acquisition, use, removal, handling, and storage of potentially hazardous materials.	☐	☐	☐	☐
E.	The radiation oncology treatment service employs a sufficient number of adequately trained and qualified health care professionals who are available and able to supervise and conduct work of the service, including the following:	☐	☐	☐	☐
	1. A radiation technologist certified by the American Registry of Radiologic Technologists (ARRT), or state-licensed technologist.	☐	☐	☐	☐
	2. A dosimetrist.	☐	☐	☐	☐
	3. A qualified radiation physicist.	☐	☐	☐	☐
	4. Such 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.	☐	☐	☐	☐
F.	The radiation oncology service should have adequate facilities and equipment to provide appropriate treatments and related treatments, which include:	☐	☐	☐	☐
	1. Supervoltage 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, GammaKnife, TomoTherapy, and cobalt-60 machines).	☐	☐	☐	☐
	2. A kilovoltage x-ray source or electron-beam for skin lesions.	☐	☐	☐	☐
	3. Access to computerized dosimetry.	☐	☐	☐	☐
	4. Access to simulation and/or CT imaging equipment.	☐	☐	☐	☐
	5. Access to patient transport.	☐	☐	☐	☐
	6. Personal immobilization devices with procedures to ensure proper identification to match each device to the proper patient.	☐	☐	☐	☐
	7. Technologies for shaping dose distributions, including but not limited to multi-leaf collimators, metal alloy, or sheet lead; procedures for proper identifying and linking each device (or electronic file) to the patient and radiation field; and established procedures for identification, handling, storage, and removal of devices made of metal alloys.	☐	☐	☐	☐
	8. 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, appropriate storage containers are used and equipment is available and used to test the procedure room and storage containers in order to ensure that no potentially harmful residual radiation is present on site.	☐	☐	☐	☐

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		SC	PC	NC	NA
G.	The radiation oncology service has policies addressing the quality of care, including but not limited to policies for:	☐	☐	☐	☐
1.	A recognized methodology for diagnosis and treatment including, but not limited to, the use of teletherapy and brachytherapy.	☐	☐	☐	☐
2.	Performing therapeutic services on the written order of a radiation oncologist.	☐	☐	☐	☐
3.	Requiring that a physician be present or immediately available during treatment. In situations in which the physician is not present but is immediately available, qualified support personnel are present.	☐	☐	☐	☐
4.	Reviewing chart and port film weekly for on-going therapies.	☐	☐	☐	☐
5.	Periodic new patient review.	☐	☐	☐	☐
6.	Obtaining signed informed consent prior to treatment.	☐	☐	☐	☐
7.	Documenting treatment setups with photographs.	☐	☐	☐	☐
8.	Accessing emergency treatment.	☐	☐	☐	☐
H.	The facility has access to appropriate supporting facilities, including diagnostic laboratories and imaging facilities.	☐	☐	☐	☐
I.	In addition to the applicable clinical records and health information requirements found in Chapter 6, the following are documented:	☐	☐	☐	☐
1.	Confirmation of the presence of malignancy by histopathology or a statement of benign condition.	☐	☐	☐	☐
2.	Definition of tumor location, extent, and stage.	☐	☐	☐	☐
3.	Definition of treatment volume.	☐	☐	☐	☐
4.	Selection of dose.	☐	☐	☐	☐
5.	Selection of treatment modality.	☐	☐	☐	☐
6.	Selection of treatment technique.	☐	☐	☐	☐
7.	Dosimetry calculations.	☐	☐	☐	☐
8.	Supervision of treatment and record of patient progress and tolerance.	☐	☐	☐	☐
9.	Summary of completion with statement of follow-up plan.	☐	☐	☐	☐

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Medical Home

The services provided by an accreditable Medical Home are patient-centered, physician-, nurse practitioner or physician assistant-directed,* 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, his/her 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 chapter will apply to organizations that choose the chapter in the *Application for Survey*. The Medical Home will be assessed from the perspective of the patient on the following characteristics.

Standard	Compliance			
	SC	PC	NC	NA
A. Relationship – communication, understanding, and collaboration (in this context, "provider" refers to the physician or the physician-, nurse practitioner-, physician assistant, or behavioral health professional-directed health care team).	☐	☐	☐	☐
1. The patient can identify his/her provider and patient care team members.	☐	☐	☐	☐
2. Patients are fully empowered to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.	☐	☐	☐	☐
3. Patients are provided with information and explanation regarding the Medical Home approach to care.	☐	☐	☐	☐
4. The provider explains information in a way that is easy to understand.	☐	☐	☐	☐
5. The provider listens carefully to the patient and, when appropriate, the patient's personal caregiver(s). Caregivers may include a parent, legal guardian, or person with the patient's power of attorney.	☐	☐	☐	☐
6. The provider speaks to the patient about his/her health problems and concerns.	☐	☐	☐	☐
7. The provider provides easy-to-understand instructions about taking care of health concerns.	☐	☐	☐	☐
8. The provider knows important facts about the patient's health history.	☐	☐	☐	☐
9. The provider spends sufficient time with the patient.	☐	☐	☐	☐
10. The provider is as thorough as the patient feels is needed.	☐	☐	☐	☐
11. The staff keeps the patient informed regarding his/her appointment when it is delayed.	☐	☐	☐	☐
12. The provider addresses specific principles to prevent illness.	☐	☐	☐	☐
13. The provider speaks with the patient about making lifestyle changes to help prevent illness.	☐	☐	☐	☐
14. The provider inquires as to the patient's concerns, worries, and stressors.	☐	☐	☐	☐

**As permitted by state law/regulation.*

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		SC	PC	NC	NA
	15. The provider inquires as to the patient's mental health status (e.g., sad, empty, or depressed).	☐	☐	☐	☐
	16. The Medical Home provides services within a team framework, and that "team" provider concept has been conveyed to the patient.	☐	☐	☐	☐
	17. The family is included, as appropriate, in patient care decisions, treatment, and education.	☐	☐	☐	☐
	18. The Medical Home treats its patients with cultural sensitivity.	☐	☐	☐	☐
B.	Accessibility.	☐	☐	☐	☐
	1. The Medical Home establishes standards in writing to support patient access, such as provider availability, treatment plan information, clinical record contents, advice, routine care, and urgent care; the Medical Home's data indicates that it meets those standards.	☐	☐	☐	☐
	2. Patients are routinely and continuously assessed for their perceptions about access to the Medical Home (provider availability, treatment plan information, clinical record contents, advice, routine care, and urgent care).	☐	☐	☐	☐
	3. Patients are provided information about how to obtain medical care at any time, 24 hours per day, every day of the year.	☐	☐	☐	☐
	4. The Medical Home ensures on-call coverage (pre-arranged access to a clinician) when the Medical Home is not open.	☐	☐	☐	☐
C.	Comprehensiveness of care.	☐	☐	☐	☐
	1. If the Medical Home limits the population served, those limitations are disclosed to prospective patients.	☐	☐	☐	☐
	2. The Medical Home scope of service includes, but is not limited to:	☐	☐	☐	☐
	a. Preventive care including surveillance, anticipatory medical and oral health care guidance, and age-appropriate screening including well baby care.	☐	☐	☐	☐
	b. Wellness care including healthy lifestyle issues such as appropriate sleep, stress relief, weight management, healthy diet, oral care, and others, as appropriate.	☐	☐	☐	☐
	c. Health risk appraisal and health risk assessment and discussions with the patient.	☐	☐	☐	☐
	d. Acute illness and injury care.	☐	☐	☐	☐
	e. Chronic illness management.	☐	☐	☐	☐
	f. Documented discussions regarding end-of-life or palliative care, as appropriate.	☐	☐	☐	☐
	3. Patient education and self-management resources are provided.	☐	☐	☐	☐
	4. The Medical Home has knowledge of community resources that support the patient's (and as appropriate, the family's) needs.	☐	☐	☐	☐
	5. The community's service limitations are known and alternate sources are coordinated by the Medical Home.	☐	☐	☐	☐

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		SC	PC	NC	NA
	6. Referrals are appropriate to the patient's needs. When referrals occur, the Medical Home collaborates with the specialist.	☐	☐	☐	☐
	7. The needs of the patient's personal caregiver (see definition in Standard 25.A.5), when known, are assessed and addressed to the extent that they impact the care of the patient.	☐	☐	☐	☐
D.	Continuity of care.	☐	☐	☐	☐
	1. A significant number (more than 50%) of the Medical Home visits of any patient are with the same physician/physician team.	☐	☐	☐	☐
	2. If a consultation is ordered for the patient, it is documented in the clinical record.	☐	☐	☐	☐
	3. Referrals for services (external to the Medical Home) are documented in the clinical record.	☐	☐	☐	☐
	4. Consultations (medical opinions obtained from other health care professionals) are recorded in the clinical record.	☐	☐	☐	☐
	5. Referrals are disease- or procedure-specific.	☐	☐	☐	☐
	6. Patient referrals are recorded in the clinical record. Follow-up procedures exist, and the results of the referral are appropriately reported to the Medical Home as they are made available.	☐	☐	☐	☐
	7. Follow-up appointments are documented in the clinical record.	☐	☐	☐	☐
	8. After-hour encounters are documented in the clinical record.	☐	☐	☐	☐
	9. Missed appointments are documented in the clinical record and managed appropriately depending on the patient's care needs and diagnosis.	☐	☐	☐	☐
	10. Critical referrals, critical consultations, and critical diagnostic studies are tracked, and appropriate follow-up is made when the results are not received in a timely manner.	☐	☐	☐	☐
	11. Transitions of care (e.g., pediatric to adult or adult to geriatric) are proactively planned, coordinated, and documented in the clinical record when indicated or when appropriate.	☐	☐	☐	☐
E.	Quality.	☐	☐	☐	☐
	1. Patient care is directed by a physician, nurse practitioner, or physician assistant.	☐	☐	☐	☐
	2. The Medical Home incorporates evidence-based guidelines and performance measures in delivering clinical services.	☐	☐	☐	☐
	3. The Medical Home periodically assesses its use of evidence-based guidelines and performance measures to ensure that they are current and being used effectively and appropriately.	☐	☐	☐	☐
	4. The Medical Home provides high-quality supervision of patient care, as evidenced by:	☐	☐	☐	☐
	a. Appropriate and timely diagnosis based on findings of the current history and physical examination.	☐	☐	☐	☐

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		SC	PC	NC	NA
	b. Medication review and update including prescription, over-the-counter, and diet supplements, and if indicated, use of recreational drugs and substances.	☐	☐	☐	☐
	c. Appropriate ordering of diagnostic tests.	☐	☐	☐	☐
	d. Absence of clinically unnecessary diagnostic or therapeutic procedures.	☐	☐	☐	☐
	e. Appropriate management of patient referrals (avoidance of unnecessary referrals).	☐	☐	☐	☐
5.	The Medical Home assesses and continuously improves the services it provides; measurements, quality studies, data trending, and benchmarking are key tools in the quality improvement/management program.	☐	☐	☐	☐
6.	In addition to the Standards presented in Chapter 5.I, the Medical Home's quality improvement program includes at least one study every three years on each of the following topics:	☐	☐	☐	☐
	a. Patient/primary care provider relationship.	☐	☐	☐	☐
	b. Accessibility to care.	☐	☐	☐	☐
	c. Comprehensiveness of care.	☐	☐	☐	☐
	d. Continuity of care.	☐	☐	☐	☐
	e. Clinical study.	☐	☐	☐	☐
	Note: A single quality improvement study may include more than one of the five topic areas listed above.				
F.	Electronic data management is continually assessed as a tool for facilitating the Standards above.	☐	☐	☐	☐

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Summary Table

Indicate your organization's compliance level for the chapters and use this information to identify and prioritize areas for attention.

	SC	PC	NC	N/A
1. Patient Rights and Responsibilities				
2. Governance				
I. General Requirements				
II. Credentialing and Privileging				
III. Peer Review				
3. Administration				
4. Quality of Care Provided				
5. Quality Management and Improvement				
I. Quality Improvement Program				
II. Risk Management				
6. Clinical Records and Health Information				
7. Infection Prevention and Control and Safety				
I. Infection Prevention and Control				
II. Safety				
8. Facilities and Environment				
9. Anesthesia Care Services				
10. Surgical and Related Services				
I. General Requirements				
II. Laser, Light-Based Technologies, and Other Energy-Emitting Equipment				
III. Renal Lithotripsy Services				
11. Pharmaceutical Services				
12. Pathology and Medical Laboratory Services				
13. Diagnostic and Other Imaging Services				
14. Dental Services				
I. Dental Services				
II. Dental Home				
15. Other Professional and Technical Services				
I. General Services				
II. 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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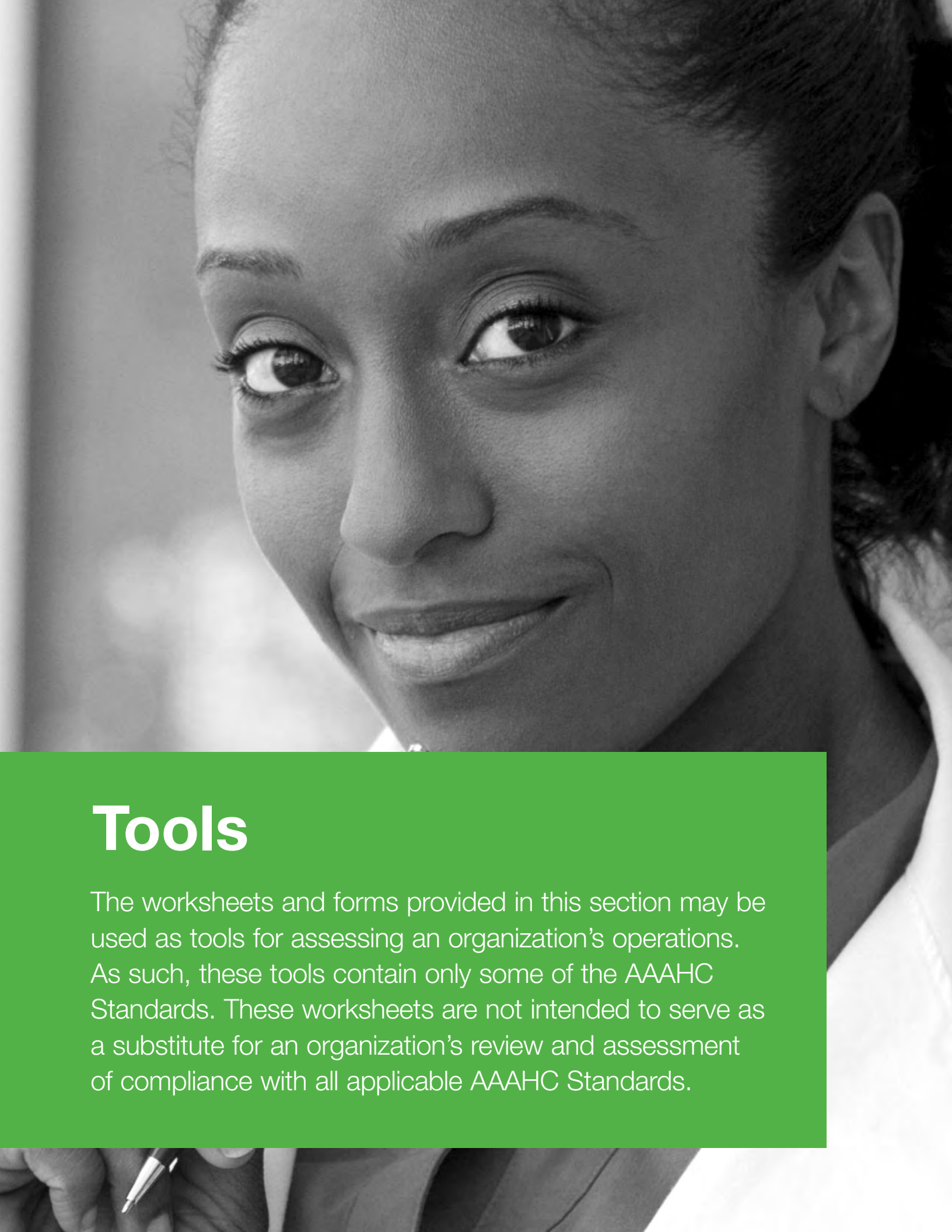

Tools

The worksheets and forms provided in this section may be used as tools for assessing an organization's operations. As such, these tools contain only some of the AAAHC Standards. These worksheets are not intended to serve as a substitute for an organization's review and assessment of compliance with all applicable AAAHC Standards.

Developing Meaningful Quality Improvement Studies

An accreditable organization maintains an active, integrated, organized, ongoing, data-driven program of quality management and improvement. The chart below assumes that you have an existing, written program (Std. 5.I.A) and is intended to help you use existing monitoring activities (Std. 5.I.B) to generate QI studies that will result in meaningful organizational improvement.

PART I: COLLECT DATA

Are you collecting data? — **HINT** → Refer to your QI program, risk assessment, actual problems, other programs requiring surveillance, state requirements for mandatory reporting, physician scorecards/dashboards, and required quality metrics for ideas.

Y

Is your data quantitative? — **HINT** → Use numeric values such as "10%," "20 out of 50," "within 1 degree." Avoid vague terminology.

Y

Based on the data collected, can you identify your current performance level? — **HINT** → Check frequency and consistency of collection. Identify specific intervals at which you will analyze the results and determine your performance.

Y

Don't stop here. Put your data to work for you; go to Part II.

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PART II: COMPARE PERFORMANCE

Have you identified a performance goal? — HINT → Setting a goal helps determine if current performance is acceptable.

Y

Did you use a benchmark to determine your goal? — HINT → Benchmarking compares your current performance measure to a specific metric. **External benchmarks** can come from nationally-recognized guidelines, federal quality measurements, a professional association for your medical specialty, the AAAHC Institute, a literature review, or other sources. **Internal benchmarks** compare current performance to an internal metric, e.g. the same measure from last month or year, the result from another department or physician. Most goals can be benchmarked.

Y

Is your goal SMART?

- **S**pecific to what you want to achieve?
- **M**easurable?
- **A**chievable?
- **R**elevant to improvement?
- **T**ime-bound?

HINT →

Specific means it can be translated into action.

Measurable means quantitative; it has a numeric value.

Achievable means realistic. Benchmarking may help establish a realistic goal.

Relevant means the goal is related to your organization and matters.

Time-bound means you've established a date for completion.

Y

Don't stop here. Put your data to work for you; go to Part III.

PART III: SOLVE THE QUALITY EQUATION

QA

Current Performance **>/=** Performance Goal

THEN → Continue monitoring; it's a **QUALITY ACTIVITY**

QI

Current Performance **<** Performance Goal

→ Consider developing a **QUALITY IMPROVEMENT Study** using the 10 elements.

Did you meet your goal? — N →

Your monitoring activity indicates potential for improvement. Corrective action and re-measurement are the next steps. **Continue to Part IV.**

Y

Congratulations! Your monitoring is a quality activity and can remain part of your quality improvement program. IT IS NOT ELIGIBLE TO BE USED AS A QI STUDY BECAUSE THERE IS NO GAP REQUIRING IMPROVEMENT TO MEET YOUR GOAL. Report your findings to the governing body and others. Celebrate your success!

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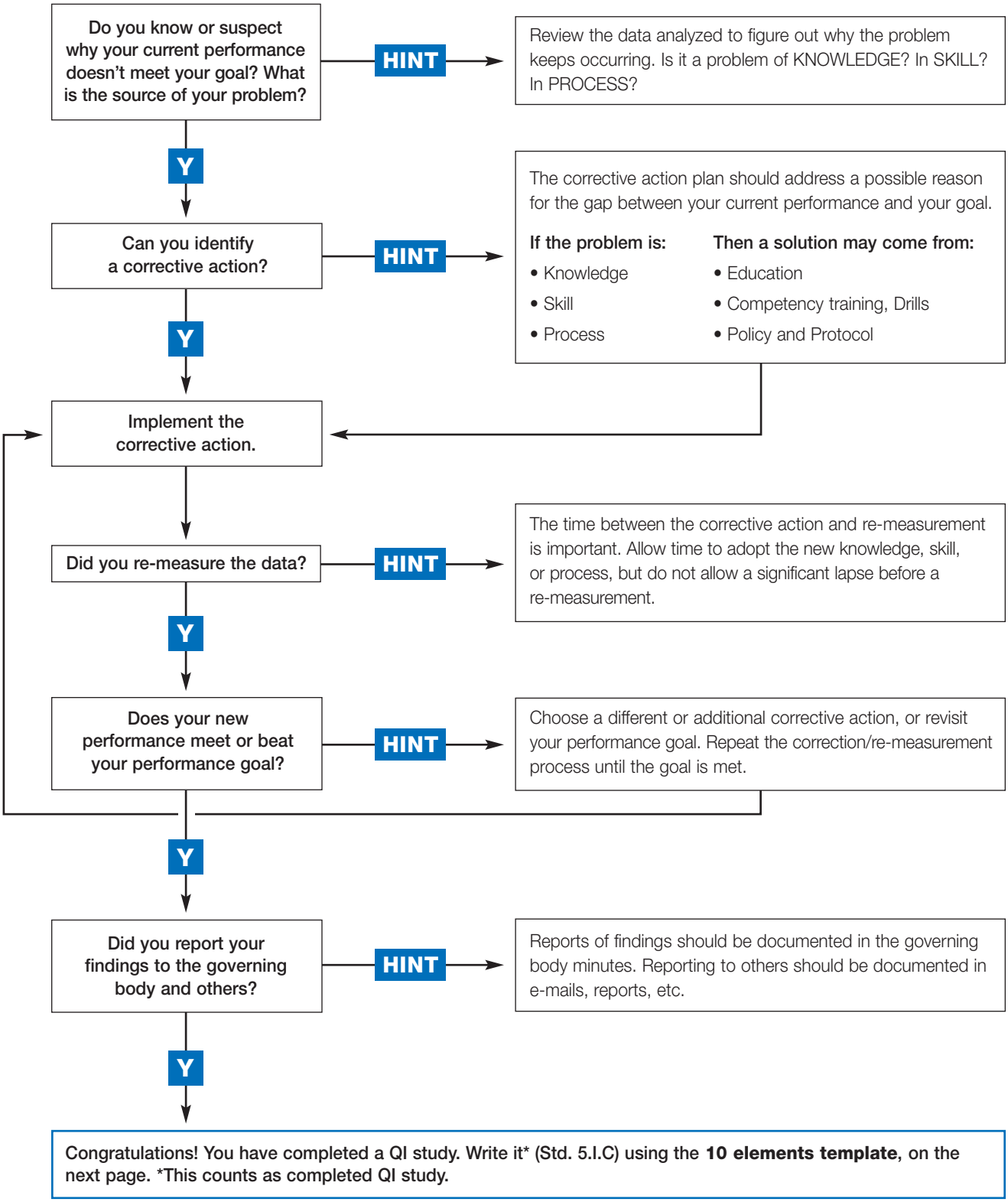
PART IV: BUILDING A QI STUDY



The following template is designed to help you through the process of documenting a QI study in your organization. Feel free to photocopy these pages for use with multiple studies.

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.1	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization	1. Briefly state your known or suspected problem. 2. Describe why it is important for your organization to address this problem.

Use the space below to state the purpose of the QI study you are conducting, and to describe why it is important for your organization to address this problem:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.2	Identification of the *performance goal* against which the organization will compare its *current performance* in the area of study	Determine and describe the level of performance your organization wants to achieve in the area of study. For example, if you are studying medication error rates, your goal might be to have zero medication errors. If you are studying rates of compliance with a particular policy, your goal might be 100% compliance. Before setting your goal, it is often useful to determine if there are internal or external benchmarks available to help you decide on a goal that is both realistic and constructive. Zero occurrences or 100% compliance may not be realistic for every issue you study.

Use the space below to identify the performance goal for the QI study you are conducting:

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AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.3	Description of the data that will be collected in order to determine the organization's current performance in the area of study	Determine the following: 1. What data is needed in order to verify: • Whether the problem actually exists (if this is uncertain) • The frequency and severity of the problem expressed as a number or percentage • The source(s) of the problem 2. How will the data be collected? For example, if you are studying medication error rates, what information do you need in order to determine your current error rate? How will you collect that information?

Use the space below to describe the data you will collect for the QI study you are conducting, and how you will collect it:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.4	Evidence of data collection	Describe the data you actually collected. For example, did you review X number of charts for patient visits that occurred from Month A to Month F? What did you look at in those charts? What information did you extract from them? How did you record the data that you collected? At this point you are not trying to describe your conclusions about the data — just the data itself.

AFTER YOU HAVE COLLECTED THE DATA FOR THE QI STUDY, use the space below to briefly describe the data collected.

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AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.5	Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).	1. Carefully analyze the data you have collected. (The complexity of the analysis you need to do will depend on various factors, such as the amount and type of data you have collected.) 2. Determine what the data tells you about whether the suspected problem actually exists. Describe how the data was analyzed and your findings (conclusions) regarding whether or not the problem exists. 3. If the problem DOES exist, determine what the data tells you about the frequency, severity, and source(s) of the problem(s), and proceed to 5.I.C.6. 4. If the problem DOES NOT exist, proceed as described in 5.I.C.10, then choose another known or suspected problem and begin again at 5.I.C.1. Refer to Chapter 5.I.C, elements 1-10 and the associated footnote, page 45.

Use the space below to briefly record your findings for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.6	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	Compare the results of your data analysis to the performance goal you identified in Standard 5.I.C.2. For example, if the data indicates that you currently have 65% compliance and the goal is 90% compliance, a simple statement to that effect is sufficient.

Use the space below to briefly state your comparison of current performance vs. goal for the QI study you are conducting:

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AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.7	Implementation of corrective action(s) to resolve identified problem(s)	1. Based on what you have learned about the frequency, severity, and source(s) of the problem(s), determine what corrective action(s) you will take to improve your performance in the area of study. 2. Implement the selected corrective action(s) and determine the appropriate length of time until re-measurement is to occur.

Use the space below to describe what corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.8	Re-measurement (a second round of data collection and analysis as described in 5.I.C.4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement	1. At the designated re-measurement time, repeat the steps shown for Standards 5.I.C.4 and 5.I.C.5. 2. Compare the results of your second round of data collection and analysis to the performance goal you identified in Standard 5.I.C.2, and determine whether the corrective actions have achieved the desired performance goal.

Use the space below to describe the second round of data collected and how you collected it. Also state your comparison of the new current performance vs. goal for the QI study you are conducting:

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AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.9	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved	1. Determine whether this step is applicable to the study you are conducting. If you have met and are sustaining your performance goal, this step does not apply. 2. If this step does apply, repeat the steps shown for Standards 5.I.C.7 to 5.I.C.8 until your performance goal has been achieved in a sustainable manner.

Use the space below to indicate whether this step applies to the QI study you are conducting. If it applies, describe what additional corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented. Also describe the additional round of data collected and how you collected it, and state your comparison of the new current performance vs. goal for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.I.C.10	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop")	1. Report your QI study and its results to your governing body. ***Ensure that the governing body's review of the report is appropriately documented.*** 2. Determine who else in the organization needs to know about the results of the study. Communicate the findings to those people, ***and document that this has occurred.*** 3. Determine whether other educational activities of the organization should reflect the findings of the study. If so, take appropriate steps to have this occur.

Use the space below to describe how the results of the study will be reviewed by the governing body, and how this review will be documented. Also describe other groups that will be notified of the study's results, and how this notification will take place, and educational activities that will take place as a result of this study.

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Organizations are expected to develop an application document appropriate to the operations and services provided. This is a sample document for reference only and is not available in template format.

Sample Application for Privileges

(Organization Name)

(Street Address)

(City, State and ZIP Code)

Instructions:

1. **Information must be typed or printed.**
2. **All questions must be answered and forms must be signed where indicated. Please initial the bottom of each page of this application.**
3. **If more space is needed, please attach additional sheets and reference the questions being answered.**
4. **If there is a break in the continuity of your medical education, internship, residency, hospital affiliations, medical practice, etc., please explain.**
5. **Please return the following with your application:**
   a. Curriculum vitae
   b. Copy of your current state license
   c. Current IRS W-9s, if applicable
   d. Copy of narcotic registration (federal/state) (DEA and CDS)
   e. Request for Privileges (completed and signed)
   f. Copy of declarations page of professional liability insurance policy including applicant's name, effective date, expiration date, and policy limits
   g. Copy of Board Certification (if applicable)
   h. Copy of professional school/diploma, residency certificates, and Fellowship certificates
   i. Copy of hepatitis-B vaccination or waiver
   j. Copy of most recent tuberculosis PPD test, if applicable

Identifying Information

Last Name (Jr., Sr., etc.) First Name Middle S. S. #

List other names by which you have been known: Last Name First Name Middle

Primary Professional Group Name and Address Years Associated (YYYY-YYYY)

City State ZIP

Telephone Number Fax Number E-mail

Home Address Home Telephone Number

City State ZIP

Alternate Telephone Number

Date of Birth Place of Birth Citizenship

Physician Providing Coverage Telephone Number Fax Number E-mail Cell Phone

Medicare Unique Provider ID Number NPI Number Medicaid Number

Medical Licensure/Certification

State License Number Original Date of Issue (mm/dd/yyyy) Expires (mm/dd/yyyy)

Controlled Substances Registration Certification Number (Your State Name) Expires (mm/dd/yyyy)

DEA Registration Number Expires (mm/dd/yyyy)

Applicant Initials _____ Date _____

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(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Other State Medical Licenses — Past and Present:

State License Number | Original Date of issue (mm/dd/yyyy) | State License Number | Original Date of Issue (mm/dd/yyyy)

Do you currently practice in this state? Yes No | Explain:

Pre-Medical Education

College/University | Degrees/Honors

Address | Date of Graduation (mm/dd/yyyy)

City | State | ZIP

Medical Education

Medical/Professional School | Degree/Honors

Address | Date of Graduation (mm/dd/yyyy)

City | State | ZIP

Other Professional Education

Name of Institution | Degree/Honors

Address | Date of Graduation (mm/dd/yyyy)

City | State | ZIP

Internship

Name of Institution | Dates Attended (mm/dd/yyyy-mm/dd/yyyy)

Address | Full Name of Program Director or Department Chair

Type | Kind (Medical, Surgical, etc.)

Program successfully completed? If no, attach an explanation. . . . . ☐ Yes ☐ No

☐ Rotating ☐ Straight If straight, list specialty: _____

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. . . . . ☐ Yes ☐ No

☐ If more than one internship, check here and attach additional information including responses to the above items specific to the additional internships.

Applicant Initials _____ Date _____

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(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Residency Programs

Name of Institution | Dates Attended (mm/dd/yyyy-mm/dd/yyyy)

Address

City | State | ZIP

Type of Residency | Full Name of Program Director or Department Chair

Program successfully completed? If no, attach an explanation. . . . . . ☐ Yes ☐ No

Name of Institution | Dates Attended (mm/dd/yyyy-mm/dd/yyyy)

City | State | ZIP

Type of Residency | Full Name of Program Director or Department Chair

Program successfully completed? If no, attach an explanation. . . . . . ☐ Yes ☐ No

Training, Fellowships, Preceptorships, Postgraduate Education

List in chronological order. Give complete school or hospital name and address, including ZIP code, beginning and ending dates, and name of your immediate superior.

Name of Institution | Address | City | State | ZIP

Dates Attended (mm/dd/yyyy-mm/dd/yyyy) | Name of Immediate Superior | Type of Fellowship

Did you successfully complete this program? If no, please attach an explanation.. . . . . . ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. . . . . . ☐ Yes ☐ No

Name of Institution | Address | City | State | ZIP

Dates Attended (mm/dd/yyyy-mm/dd/yyyy) | Name of Immediate Superior | Type of Fellowship

Did you successfully complete this program? If no, please attach an explanation.. . . . . . ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. . . . . . ☐ Yes ☐ No

Name of Institution | Address | City | State | ZIP

Dates Attended (mm/dd/yyyy-mm/dd/yyyy) | Name of Immediate Superior | Type of Fellowship

Did you successfully complete this program? If no, please attach an explanation.. . . . . . ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. . . . . . ☐ Yes ☐ No

Applicant Initials ___________ Date ___________

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(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Hospital and University Affiliations

List all present and past affiliations in chronological order. Indicate "Membership Status" as: Active/Courtesy, etc., or Academic Title. Use an additional sheet if necessary.

Name of Institution (1) Address City State ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Name of Institution (2) Address City State ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Name of Institution (3) Address City State ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Name of Institution (4) Address City State ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Applicant Initials _____ Date _____

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(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Previous Group/Medical Practice

Type of Organization	Name of Organization	Address	
City	State	ZIP	Dates Practicing (mm/dd/yyyy-mm/dd/yyyy)
Type of Organization	Name of Organization	Address	
City	State	ZIP	Dates Practicing (mm/dd/yyyy-mm/dd/yyyy)
Type of Organization	Name of Organization	Address	
City	State	ZIP	Dates Practicing (mm/dd/yyyy-mm/dd/yyyy)

Certification

Certified by American Board of (Specialty)	Certification #	Dates (Certification/Recertification/Expiration) (mm/dd/yyyy)
Subspecialty Board Status (Name of Board)	Certification #	Dates (Certification/Recertification/Expiration) (mm/dd/yyyy)
If Not Certified, Give Present Status	Date	Date of Exam

Professional Societies, Awarded Fellowships (ACS, ACP, etc.)

List all memberships past, present, or pending in professional societies. Please include dates of membership. Please give complete names and addresses, including ZIP codes in all instances. Attach an additional sheet if necessary.

Applicant Initials _____ Date _____

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(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Professional Peer References

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference must be from the Chief of the department or service where the applicant last furnished professional services.

Last Name (1)	First	Middle	Degree	Title	Professional Relationship	Specialty	Years Known
Address				City		State	ZIP
Phone		Fax			E-mail		

Last Name (2)	First	Middle	Degree	Title	Professional Relationship	Specialty	Years Known
Address				City		State	ZIP
Phone		Fax			E-mail		

Last Name (3)	First	Middle	Degree	Title	Professional Relationship	Specialty	Years Known
Address				City		State	ZIP
Phone		Fax			E-mail		

Professional Liability

Insurance Carrier	Address	City	State	ZIP
Policy limits	Per Occurrence ($)	Aggregate ($)		
Policy #	Agent	Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	

Type of coverage: ☐ Claims made ☐ Occurrence

Have any professional liability lawsuits been filed against you during the past ten years (including those closed)? ☐ Yes ☐ No

Are there any now still pending? ☐ Yes ☐ No

Has any judgment, payment of claim, or settlement ever been made against you in any professional liability cases? ☐ Yes ☐ No

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? ☐ Yes ☐ No

Have you ever been denied professional insurance, or has your policy ever been cancelled? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

Applicant Initials _____ Date _____

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_____
(Organization Name)

_____
(Street Address)

_____
(City, State, and ZIP Code)

Professional Sanctions

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled, and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint, and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil, or disciplinary action by any state or federal agency that licenses providers? ☐ Yes ☐ No
3. Have you lost any board certification(s), and/or failed to rectify? ☐ Yes ☐ No
4. Have you been examined by a Capital Certifying Board but failed to pass? ☐ Yes ☐ No
5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) or any other practitioner data bank? ☐ Yes ☐ No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended, or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ Yes ☐ No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or memberships been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation, or non-renewed? ☐ Yes ☐ No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ Yes ☐ No
10. Have you ever been reprimanded, censured, excluded, suspended, and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS, and/or any other governmental health-related programs? ☐ Yes ☐ No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities, and/or any other third-party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ Yes ☐ No
12. Have you been denied membership and/or been subject to probation, reprimand, sanction, or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? ☐ Yes ☐ No
13. Have you withdrawn an application or any portion or an application for appointment or reappointment for clinical privileges or staff appointment or for license or membership in an IPA, PHO, professional group or society, health care entity, or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No
14. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☐ No
15. Have you been the subject of a civil or criminal or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

Health Status

1. Do you have a medical condition, physical defect, or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
2. Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

Applicant Initials _____ Date _____

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(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Chemical Substances or Alcohol Abuse

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☐ No
2. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

By *applying* for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application, and I authorize the "Organization," its medical staff, and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the "Organization," its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the "Organization" and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the "Organization" or to members of its medical staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any questions the "Organization" may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability and hold harmless the "Organization" and any other third party for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By *accepting* appointment and/or reappointment to the medical staff at (insert organization name), I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules, and regulations of the "Organization", as well as the principles, standards, and ethics of the national, state, and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards." I further agree to abide by such further Governing Standards as may be enacted from time to time.

In addition, I agree to notify the "Organization" of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations, and releases to this application to serve as the original.

Signature of Applicant Date

Print Name

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Sample Application for Privileges

_____
(Organization Name)

_____
(Street Address)

_____
(City, State, and ZIP Code)

RE: _____
(Applicant Name, Title)

Temporary Privileges

☐ Appointment recommended to the category of _____ staff with the following clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____
Executive Director

_____
Date

_____
Medical Director

Medical Executive Committee

☐ Appointment recommended to the category of _____ staff with the following clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____
Date

_____
Medical Executive Committee Member

Board of Directors

☐ Appointment recommended to the category of _____ staff with the following clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____
Date

_____
Board of Directors Member

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(Organization Name)

(Street Address)

(City, State, and ZIP Code)

RE: (Applicant Name, Title)

Dear Sir or Madam:

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of (Organization Name). The applicant has given your name as a reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for clinical staff privileges. Your response will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

	Reliable	Usually Reliable	Problems
Clinical knowledge	☐	☐	☐
Clinical judgment	☐	☐	☐
Technical proficiency	☐	☐	☐
Professional relations with patients	☐	☐	☐
Ethical conduct	☐	☐	☐
Record keeping	☐	☐	☐
Ability to understand and speak English	☐	☐	☐
Participation in medical staff affairs	☐	☐	☐

What is your opinion regarding the applicant's competency in performing the privileges shown on the attachment?

Additional comments:

Recommendation:

Signature Title Date

Name (Please print)

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_____
(Organization Name)

_____
(Street Address)

_____
(City, State, and ZIP Code)

Medical Staff Office

Regarding the appointment of: _____
(Applicant Name, Title)

Dear Sir or Madam:

The applicant named above is seeking medical staff privileges at our organization. We would appreciate answers to the questions found below.

This physician's current staff status: _____

QUESTIONS	Yes	No	Do Not Know
Have this practitioner's privileges been restricted, suspended, revoked, or surrendered?	☐	☐	☐
Has this practitioner's professional performance been within or above the acceptable standard of care within the last two years?	☐	☐	☐
Has the practitioner's morbidity rate, mortality rate, infection rate, or complication rate exceeded your organization's criteria for the standards of practice?	☐	☐	☐
Has the practitioner been suspended for clinical records violations within the last two years? If yes, how many times? _____	☐	☐	☐
Has this practitioner's behavior been disruptive to patient care?	☐	☐	☐
Have there been written complaints about this practitioner by patients, hospital staff, or members of the medical staff?	☐	☐	☐
Has the practitioner been subjected to any disciplinary action by this hospital or licensing body during the past two years?	☐	☐	☐
To the best of your knowledge, has this individual been involved in a malpractice claim or action during the past two years? If yes, please provide us with the information regarding the malpractice claim or action during the past two years.	☐	☐	☐
At the appropriate time, will you likely re-appoint this individual to your medical staff?	☐	☐	☐

Thank you for your effort and assistance with this request.

Signature Title Date

Name (Please print)

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Credentialing Records Worksheet

Instructions, unless Y/N is indicated:

Adequate = **A**
Inadequate = **I**
Not Applicable = **NA**

Related 2015 Standards		Credential Record Identifier									
	*Indicate most recent credentialing cycle: **IA** = initial application cycle; **RA** = reappointment cycle. Information recorded below is related to most recent cycle unless otherwise noted.* >										
	Indicate professional license type for each individual (e.g., MD, DDS, APRN, PT, etc.) >										
2.II.F	Is this provider an allied health professional (AHP)? **Y/N**										
	Does the organization have an appointment/reappointment process for AHPs? **Y/N**										
	If yes, review organization process and determine the following:										
	Is organization process consistent with state law, and based on education, training, experience, and current competence? **Y/N**										
	Identify and evaluate applicable AAAHC Standards shown below that are required by organization process for AHP credentialing and privileging.										
(IA) 2.II.B.3.h (RA) 2.II.B.5.a	Complete and signed formal application for privileges, including liability release was received. **Y/N**										
2.II.B.3.a; 4	Education was verified (at least at initial appointment).										
	Training and/or other relevant experience was verified (at least at initial appointment or when additional privileges are requested).										
(IA) 2.II.B.3.b (RA) 2.II.B.5.b	Peer evaluation(s) were obtained at initial appointment. If reappointment, there is evidence of that peer review results/activities were incorporated into reappointment determination.										
(IA) 2.II.B.3.c (RA) 2.II.B.5.b	Current state licensure was verified and documented at time of appointment or reappointment. **Y/N**										
	If required by the organization, Board certification was verified. **Y/N**										
(IA) 2.II.B.3.d (RA) 2.II.B.5.b	DEA registration was verified; if applicable.										
(IA) 2.II.B.3.e (RA) 2.II.B.5.b	Current medical liability coverage, meeting governing body requirements, was verified.										
(IA) 2.II.B.3.f (RA) 2.II.B.5.b	Evidence of current query of the NPDB.										
(IA) 2.II.B.3.g (RA) 2.II.B.5.a.ii	There is evidence that the credentialing process requires written applicant attestation of other pertinent information. **Y/N**										
At a minimum, the following attestations are present:											
2.II.B.3.g.i	Professional liability claims history.										
2.II.B.3.g.ii	Information on licensure revocation, supervision, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations.										
2.II.B.3.g.iii	Complaints or adverse action reports filed against the applicant with a local, state or national professional society or licensure board.										
2.II.B.3.g.iv	Refusal or cancellation of professional liability coverage.										
2.II.B.3.g.v	Denial, suspension, limitation, termination or non-renewal of professional privileges at any hospital, health plan, medical group, or other health care entity.										

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Credentialing Records Worksheet

Related 2015 Standard(s)		Credential Record Identifier									
	*Indicate most recent credentialing cycle: **IA** = initial application cycle; **RA** = reappointment cycle. Information recorded below is related to most recent cycle unless otherwise noted.* >										
	Indicate professional license type for each individual (e.g., MD, DDS, APRN, PT, etc.) >										
2.II.B.3.g.vi	DEA and state license actions.										
2.II.B.3.g.vii	Disclosure of any Medicare/Medicaid sanctions.										
2.II.B.3.g.viii	Conviction of a criminal offense other than minor traffic violations.										
2.II.B.3.g.ix	Current physical, mental health, or chemical dependency problems that would interfere with an applicant's ability to provide high quality patient care and professional service.										
2.II.A; 2.II.B.4	Credentialing process followed the organization's policies and procedures, medical staff bylaws, etc.										
2.II.B.2	Credentialing process was accomplished in a timely manner; and, if being reappointed, created no lapse in being credentialed and privileged.										
2.II.B.5	Length of appointment follows state law and organization policy. Reappointment occurs at least once every three years or more frequently if required by state law or organization policy.										
2.II.D	Privileges were granted or denied based on an applicant's written request and are for a specified period of time that follows state law, organization policy, or occurs at least once every three years.										
2.I.C.17	If the governing body or state has determined a requirement for provider continuing education, there is evidence of current compliance.										
2.II.D	Privileges granted are consistent with provider's license, experience, and scope of services provided by organization.										
2.II.B.7	If a solo medical or dental practice, the provider's credentialing file is reviewed for currency, accuracy, and completeness by an outside physician (for a medical practice) or by an outside dentist (for a dental practice). Documentation of outsider's review is present or available.										

Record additional comments below.

Credential Record Identifier	Comments

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Clinical Records Worksheet

Instructions:

Mark each box as:

Adequate – **A**
Inadequate – **I**
Not Applicable – **N/A**

Related 2015 Standard(s)		File Identifier									
4.E.3	The diagnosis is appropriate for the findings in the current history and physical examination.										
4.E.4	Medication reconciliation is performed.										
4.E.5	Treatment is consistent with clinical impression or working diagnosis.										
4.E.6, 8	The record documents appropriate and timely consultation and follow-up of referrals, tests, and findings.										
6.C	The record includes appropriate patient identifiers including, at least: name, identification number (if appropriate), date of birth, gender, and responsible party (if applicable).										
6.D	Clinical record entries are legible and easily accessible within the record by the organization's personnel.										
6.E	For records with three or more visits/admissions OR complex and lengthy records, summaries of past and current diagnoses or problems, including past procedures, are documented.										
6.F	The presence or absence of allergies and untoward reactions to drugs or materials is recorded in a prominent and consistently defined location, verified at each patient encounter, and updated when new allergies or sensitivities are identified.										
6.G	Content and format of the record are uniform and consistent with the organization's clinical records policies.										
6.H	Evidence of documentation regarding missed and canceled appointments. Documentation may be within the patient clinical record, in a separately-maintained log, or elsewhere as determined by the organization.										
6.I	**Entries for patient visits include the following, as applicable:**										
6.I.1	Date (and department, if departmentalized).										
6.I.2	Chief complaint or purpose of visit.										
6.I.3	Clinical findings.										
6.I.4	Studies ordered (e.g., laboratory or x-ray studies).										
6.I.5	Care rendered and therapies administered.										
6.I.6	Changes in prescription and non-prescription medication(s) with name and dosage, when available.										
6.I.7	Discharge diagnosis or impression.										
6.I.8	Disposition, recommendations, and instructions given to the patient.										
6.I.9	Verification of contents by health care professionals.										
6.I.10	Signature of, or authentication by, health care professional on the clinical record entries.										

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Related 2015 Standard(s)		File Identifier									
6.J; 6.K	Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) were reviewed and incorporated into the record as required by the organization's policies. The date, with or without time of entry, is documented in the patient's record.										
6.L	Significant patient advice given by text, email, or by telephone, including medical advice provided after-hours, is permanently entered in the clinical record and appropriately signed or initialed.										
6.M	Any notation in the 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.										
6.N; 10.I.H	If applicable, the record reflects discussions with the patient concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedure, as well as discussions of treatment alternatives and advance directives as applicable.										
6.O	If applicable, summaries or pertinent records of patients treated elsewhere or transferred to another health care provider are present.										
Review records for the following Standards if the adjunct chapters are applicable to the organization:											
9.F, 10.I.H	Properly executed informed consent(s) was (were) obtained prior to anesthesia administration and pre-operatively. One consent form may be used to satisfy the requirements of these two Standards.										
9.J	If local or topical anesthesia or minimal sedation is administered, clinical records include entries that, at minimum, address patient evaluation and the administration plan.										
9.K.1-3	If moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia is administered, clinical records include entries that, at minimum, address pre-anesthesia evaluation; intra-anesthesia administration, monitoring, and evaluation; and post-anesthesia recovery evaluation.										
10.I.D	An appropriate and current health history with a list of current medications and dosages (when available), physical examination, and pertinent diagnostic studies are present in the record within 30 days or according to local, state, or federal requirements prior to the scheduled surgery/procedure.										
10.I.L	With the exception of those exempted in writing by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's clinical record.										
10.I.M	The findings and techniques of a procedure were accurately and completely documented immediately after the procedure by the health care professional who performed the procedure; this description was immediately available for patient care and became a part of the patient's record.										
14.I.E	For dental services, the clinical record includes an appropriate history and physical that is periodically updated and includes an assessment of the hard and soft tissues of the mouth.										

Record file identifier and comments on next page.

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File Identifier	Comments

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Personnel Records Worksheet

Instructions:

Mark each box as:

Adequate – **A**

Inadequate – **I**

Not Applicable – **N/A**

Related 2015 Standard(s)	*When licensed, indicate the license type (e.g., MD, RN, RT) as part of the record identifier. >*	Record Identifier									
2.I.C.14; 3.A.3, 10	Evidence of HIPAA training and compliance.										
2.II.B; 3.B	File contains employment-related items as required by the organization's personnel policies (job application, resume, job description, verification of references, results of background check, employee benefit forms).										
2.II.B.4; 2.II.B.6	Verification of professional license/certification (if applicable) and evidence of ongoing monitoring of date-sensitive information.										
2.II.D; 3.B.2	Evidence that the person holds qualifications commensurate with job responsibilities and authority including, if applicable, appropriate licensure or certification.										
3.B.4	Documentation of initial orientation within 30 days of hire, and annual/ ongoing training.										
3.B.5	Evidence of periodic performance appraisals including current competence.										
3.B.7	Evidence that personnel policies were made known to the employee at the time of employment.										
3.B.8	Evidence of verification of employment eligibility, such as I-9 (Immigration and Naturalization Form) and visa if applicable. (**Note:** Organization may choose to keep I-9 forms separate from personnel files.)										
3.C.3	Evidence of participation in initial exposure control training, and retraining within one year of last training.										
3.C.4.a	Evidence of signed hepatitis-B immunization acceptance/declination (when applicable).										
3.C.5	Evidence of immunization(s) program and employee acceptance/ declination, based on state and/or organization policy (when applicable).										
3.C.6	Evidence of tuberculosis detection plan, when appropriate.										
3.F	Evidence of documentation of significant workplace exposure and injuries is maintained consistent with applicable reporting requirements.										
4.A; 7.II.F; 9.I; 9.Q; 10.I.K	Evidence of current BLS, ACLS, PALS, ATLS training (if required); PEARS training is not accepted in lieu of PALS training.										
5.II.E; 7.I.R; 7.II.S	Evidence of education in risk management, infection control and safety policies/processes within first 30 days of employment, annually thereafter, and when there is an identified need.										
7.I.G.1	Evidence of education in sharps injury prevention, provided within first 30 days of employment, annually thereafter, and when there is an identified need.										

Use the Record identifier and insert comments on the next page.

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File Identifier	Comments

Satellite Facility Worksheet

Instructions:

Mark each box as:

Adequate – **A**
Inadequate – **I**
Not Applicable – **N/A**

Related 2015 Standard(s)		Site Name/Location									
	The *Notice of Accreditation Survey* is posted in accordance with AAAHC policies.										
	If currently accredited, is the AAAHC certificate posted and does it reflect the organization's legal name? (Yes or No)										
Chapter 1	Does this location maintain the same patient rights and responsibilities policies and procedures as the main site? (Reflect your findings in Chapter 1.)										
1.F.1-2	Information about patient rights and responsibilities is available to patients.										
1.F.10	Patients are informed about providing feedback (suggestions, complaints, grievances) and contact information is posted for other applicable regulatory authorities such as state and federal agencies.										
Chapter 4	Does the site have the necessary mechanisms to provide quality care, such as trained staff?										
Chapter 4	Is there a process for patient medical emergencies and other emergencies?										
Chapter 4	Is there a provision for continuity of care across all settings accredited with the main site?										
Chapter 4	Are there policies for adherence to the same standard of care as the main site?										
5.I.A	Site participates in quality improvement activities.										
5.I.C	Site conducts QI studies specific to this location.										
5.II.A.2, 3	Staff knows the policies regarding managing situations in which a health care professional is impaired or becomes incapacitated during a medical or surgical procedure.										
5.II.A.4	Organization has established and documented its provision for after-hours coverage for this site.										
Chapter 6	Are there clinical records at this site? **If so, complete a Clinical Records Worksheet for each surveyed site. (Reflect your findings in Chapter 6.)**										
Chapter 6	Does this site adhere to the organization's clinical record policy?										
7.I.E	Staff and providers at this site adhere to the organization's infection control program, policies and procedures. (Reflect your findings in Chapter 7.I.)										
7.I.B.6	Site has implemented a plan of action to prevent, identify, minimize, and manage infections and communicable diseases.										
7.I.F.1-3	Site adheres to processes for the cleaning, disinfection, and sterilization of instruments, equipment, supplies, and implants.										
7.I.G.1-5	The site adheres to the organization's written sharps injury prevention program including items in Stds. 7.I.G.1-5.										
7.I.H	Adequate safeguards to protect the patient from cross-infection and provide a safe environment, are ensured through the provision of adequate space, equipment, supplies, and personnel.										

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Related 2015 Standard(s)		Site Name/Location									
7.I.O.1-4	Staff at this site adhere to the organization's written policies addressing cleaning of patient treatment and care areas.										
7.II.C	Staff and providers at this site receive safety program training and adhere to the safety program.										
7.II.E	Site has a written emergency and disaster preparedness plan that includes a provision for safe evacuation, especially of individuals who are at greater risk.										
7.II.F	Personnel currently trained in basic life support (BLS) and the uses of cardiac and all other emergency equipment and supplies are present in this location to provide patient care when patients are present.										
7.II.J	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposure.										
7.II.K	Evidence of compliance with local, state, and federal guidelines regarding preparing, serving, disposal, and storing of patient food and drink if provided.										
7.II.Q	Products, including medications, reagents, solutions, and supplies that have a manufacturer's printed expiration date are monitored. The site follows the local, state, federal, and organization's policies for disposal or return of expired medications and supplies.										
8.A.1-3	Site complies with all applicable local, state, and federal codes and regulations governing physical plant and fire safety regulations.										
8.A.4	Site has periodic inspection by the local or state fire control agency, if this service is available in the community.										
8.B.1	Site contains fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire.										
8.B.2	Site has prominently displayed illuminated signs with emergency power at all exits, including exits from each floor or hall.										
8.B.3	Site has emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of patients and staff, in case of emergency.										
8.B.4	Site has stairwells protected by fire doors, when applicable.										
8.B.5	Site provides reception areas, toilets, and telephones in accordance with patient and visitor volume.										
8.B.6	Site provides examination rooms, dressing rooms, and reception areas that are constructed and maintained in a manner that ensures patient privacy during interviews, examinations, treatment, and consultation.										
8.B.7	The site is operated in a safe and secure manner and has written policies addressing safety and security practices.										
8.C	Site has the necessary personnel, equipment, and procedures to deliver safe care, and to handle medical and other emergencies that may arise.										
8.D	The facility provides documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment.										
8.E.1-4	Site conducts scenario-based drills of the internal emergency and disaster preparedness plan. At least one drill is conducted each calendar quarter. One drill is a CPR technique drill. There is a written evaluation of each drill including any corrections or modifications to the plan which are promptly implemented.										
8.F	Smoking is prohibited within the site.										

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Related 2015 Standard(s)		Site Name/Location									
8.G	Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are identified and addressed.										
8.H	Provisions are made to reasonably accommodate disabled individuals.										
8.I	Adequate lighting and ventilation are provided in all areas.										
8.J	Site is clean and properly maintained.										
8.K	A system exists for the proper identification, management, handling, transport, treatment, and disposal of hazardous materials and wastes whether solid, liquid, or gas.										
8.L	Space allocated for a particular function or service is adequate for the activities performed therein.										
8.M	Appropriate emergency equipment and supplies are maintained and readily accessible to all patient care areas.										
8.N	Policies and procedures regarding medical equipment include its standardized use, and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer specifications.										
8.O	Testing of the fire alarm and inspection of fire suppression systems, including verification of signal transmission are performed and documented.										
8.Q	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. Recommended temperature ranges are readily available to staff performing the monitoring function.										
Chapter 9	Are anesthesia services provided at this site? **If yes, use the comments section to describe the anesthesia services provided. If this is a survey of an anesthesia group providing care at different facilities, please assess Chapter 9 compliance at each facility.**										
Chapter 9	Does this site adhere to the organization's policies and procedures with regard to the delivery of anesthesia services?										
Chapter 10	Are surgical services provided at this site? **If yes, use the comments section to describe the surgical services provided.**										
10.I.S	Alternate power, adequate for the protection of the type of surgery performed, is available in operative and recovery areas.										
Chapter 11	Does the site provide any pharmaceutical services or is there a pharmacy maintained onsite? **If yes, use the comments section to describe the pharmaceutical services provided.**										
Chapter 11	Records and security are maintained to ensure control and safe dispensing, including samples, in compliance with federal and state law.										
11.F	Prescription pads are controlled and secured from unauthorized access.										
11.G	There is a policy for safe disposal/return of expired medications. All meds, including vaccines and samples, are monitored for expiration on a regular basis.										
Chapter 12	Does the site have a CLIA waiver, a CLIA Provider Performed Microscopy Certificate, or a CLIA Certificate for this location?										
Chapter 13	Are diagnostic and/or other imaging services provided? **If yes, use the comments section to describe imaging services.**										
Chapter 13	Does this site adhere to the organization's policies and procedures with regard to the delivery of diagnostic and/or imaging services?										

Date

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Please reference the site and Standard identifier related to each comment.

Standard Identifier	Location	Comments

If more space is needed, photocopy this page.

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Resources

Resources for Credentials Verification

Primary Source Verification

Primary Source Verification is documented verification by an entity that issued a credential, such as a medical school or residency program, indicating that an individual's statement of possession of a credential is true. Verification can be done by mail, fax, telephone, or electronically, provided the means by which it was accomplished is documented and measures are taken to demonstrate there was no interference in the communication by an outside party.

The following sites maintain lists of schools and certifying boards that may be helpful in obtaining primary source verification.

For verification from	Resource Organization	Web address
Chiropractic schools	Association of Chiropractic Colleges	www.chirocolleges.org/members.html
Dental schools	American Dental Association	www.ada.org/coda/find-a-program/search-dental-programs
Medical schools	Association of American Medical Colleges	www.aamc.org/medicalschools
	Liaison Committee on Medical Education	www.lcme.org/directory.htm
Nursing schools	American Association of Colleges of Nursing	www.aacn.nche.edu/membership/nursing-program-search
Physician Assistant schools	American Academy of Physician Assistants	http://directory.paeaonline.org
Podiatric schools	American Assn of Colleges of Podiatric medicine	http://www.aacpm.org/html/collegelinks/cl_schools.asp
Residency and Fellowship programs	Accreditation Council on Graduate Medical Education	http://www.acgme.org/ads/public
State licensing agencies	Federation of State Medical Boards	www.fsmb.org/pdc
	American Association of Dental Boards	www.dentalboards.org/states

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Secondary Source Verification

Secondary source verification is documentation of a credential obtained through a verification report from an entity (such as those listed below) that has, itself, performed the primary source verification. Information received from any of these sources must meet the same transmission and documentation requirements as outlined above for primary sources.

Also valid for compliance with AAAHC Standards is primary or acceptable secondary source verification from another organization such as a hospital or medical group *provided it supplies directly, without transmission or involvement by the applicant or other third party, original documents or photocopies of the verification reports it has relied upon. A statement that it has performed verification is not sufficient.*

Documents, diplomas, certificates or transcripts provided directly by the applicant rather than by the primary or secondary source are not acceptable.

The following are a few internet resources for verification of credentials:

Resource Organization	Web address
American Medical Association Physician Masterfile	www.ama-assn.org/Masterfile
Federation of Chiropractic Licensing Boards	www.fclb.org
American Association of Dental Boards	www.aadexam.org
Federation of State Medical Boards	www.fsmb.org/directory_smb.html
American Association of Nurse Anesthetists	www.aana.com
American Board of Medical Specialties	www.abms.org/Products_and_Publications/Certification_Verification/default.aspx
American Osteopathic Information Association	www.doprofiles.org
American Nurses Credentialing Center	www.nursecredentialing.org/Certification/VerifyCertification.aspx
Educational Commission for Foreign Medical Graduates	www.ecfmg.org/cvs/index.html
National Commission on Certification of Physician Assistants	www.nccpa.net

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Malignant Hyperthermia Guidelines

To assist organizations, the following official statement was obtained from the Malignant Hypothermia Association of the United States. “All facilities where MH triggering anesthetics (i.e., chloroform (trichloromethane, methyl trichloride), halothane, enflurane, isoflurane, desflurane, sevoflurane, methoxyflurane, trichloroethylene, xenon and succinylcholine) are administered (including ambulatory surgery centers and offices) should stock a minimum of 36 vials of dantrolene sodium for injection. If potent volatile agents are not used, and succinylcholine is available for resuscitation, a minimum of 36 vials of dantrolene should be available. If none of these are used or available, then dantrolene need not be present.”

For resources, listings of safe and unsafe anesthetic agents, and further general information regarding malignant hyperthermia, contact: Malignant Hyperthermia Association of the United States (MHAUS), 1 North Main Street, PO Box 1069, Sherburne, NY 13460-1069, non-emergency information 800.986.4287. The malignant hyperthermia emergency treatment protocol in poster format and many educational resources for medical professionals and the general public are available at www.mhaus.org.

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Internet Resources

The following are Internet resources that may provide helpful information for ambulatory health organizations. Organizations are also encouraged to seek any available resources from national professional associations, such as the American College Health Association (http://www.acha.org) or the American Congress of Obstetricians & Gynecologists (http://www.acog.org). Use of these resources does not imply compliance with AAAHC accreditation Standards.

Chapter 1

- Advance Directives (www.nlm.nih.gov/medlineplus/advancedirectives.html)
- American Academy of Family Physicians (http://www.aafp.org)
- Americans with Disabilities Act (www.ada.gov)
- Federation of State Medical Boards (http://www.fsmb.org/directory_smb.html)
- U.S. Office of Civil Rights (http://www.hhs.gov/ocr/civilrights/index.html)

Chapter 2

- Accreditation Council for Graduate Medical Education (www.acgme.org)
- American Academy of Pediatrics (http://www.aap.org)
- American Academy of Physician Assistants (http://www.aapa.org)
- American Association of Colleges of Nursing (http://www.aacn.nche.edu/CCNE/reports/accprog.asp)
- American Association of Colleges of Podiatric Medicine (http://www.aacpm.org/html/collegelinks/cl_schools.asp)
- American Association of Dental Boards (http://www.dentalboards.org)
- American Association of Nurse Anesthetists (http://www.aana.com/Pages/default.aspx)
- American Board of Medical Specialties (http://www.abms.org)
- American Board of Podiatric Surgery (https://www.abfas.org)
- American Dental Association (Specialty Boards Recognized by ADA) (http://www.ada.org/494.aspx)
- American Medical Association Physician Master Profile (http://www.ama-assn.org/amaprofiles)
- American Midwifery Certification Board (http://www.amcbmidwife.org)
- American Nurses Credentialing Center (http://www.nursecredentialing.org/Certification/VerifyCertification.aspx)
- American Osteopathic Association (http://www.osteopathic.org/index.cfm?pageid=ado_license)
- American Podiatric Medical Association (Specialty Boards Recognized by the APMA) (http://www.apma.org)
- Americans with Disabilities Act (http://www.ada.gov)
- Association of American Medical Colleges (http://www.aamc.org)
- Centers for Medicare and Medicaid Services (http://www.cms.gov)
- Centers for Medicare and Medicaid Services, Medicare Fraud & Abuse (https://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf)
- Commission on Dietetic Registration (CDR) (http://www.cdrnet.org)
- Drug Enforcement Agency (http://deanumber.com)
- Educational Commission for Foreign Medical Graduates (http://www.ecfmg.org/cvs/index.html)
- Federation of Chiropractic Licensing Boards (http://www.fclb.org)
- Federation of State Medical Boards (http://www.fsmb.org/directory_smb.html)
- National Commission on Certification of Physician Assistants (https://www.nccpa.net)
- National Council of State Boards of Nursing Nursys® (https://www.nursys.com)
- National Practitioner Data Bank (http://www.npdb-hipdb.hrsa.gov)
- NPDB Proactive Disclosure Service (http://www.npdb-hipdb.hrsa.gov/pds.html)
- National Student Clearinghouse (http://www.studentclearinghouse.org)
- Occupational Safety and Health Administration, Bloodborne Pathogens and Needlestick Prevention (http://osha.gov/SLTC/bloodbornepathogens/index.html)
- U.S. Office of Civil Rights (http://www.hhs.gov/ocr/privacy/index.html)

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Chapter 3

- Ambulatory Surgery Center Association (http://ascassociation.org)
- Centers for Disease Control and Prevention (http://www.cdc.gov)
- Immunization Action Coalition (http://www.immunize.org)
- The Journal of Ambulatory Care Management (http://www.ambulatorycaremanagement.com)
- Medical Group Management Association (http://www.mgma.com)
- National Institute for Occupational Safety and Health (NIOSH) (http://www.cdc.gov/niosh)
- U.S. Citizenship and Immigration Services (http://www.uscis.gov)

Chapter 4

- Centers for Disease Control, National Notifiable Diseases Surveillance System (http://www.cdc.gov/osels/ph_surveillance/nndss/nndsshis.htm)
- U.S. Office of Civil Rights, Limited English Proficiency (LEP) (http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep)

Chapter 5

- AAAHC Institute for Quality Improvement (http://www.aaahc.org/institute)
- Ambulatory Surgery Center Association, Benchmarking (http://www.ascassociation.org/resourcecenter/benchmarking)
- Surgical Outcomes Information Exchange (http://www.soix.com)

Chapter 6

- The American Health Information Management Association (AHIMA) (http://www.ahima.org)
- U.S. National Library of Medicine National Institutes of Health (http://www.nlm.nih.gov/services/medical_records.html)

Chapter 7

- Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse (http://www.guideline.gov)
- Agency for Healthcare Research and Quality, Patient Safety Tools: Improving Safety at the Point of Care, Toolkit and Resource Descriptions (http://archive.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/pips/index.html)
- American College of Gastroenterology (http://www.gi.org)
- American Gastroenterological Association (http://www.gastro.org)
- American Society for Gastrointestinal Endoscopy (http://www.asge.org)
- Association for the Advancement of Medical Instrumentation (http://www.aami.org)
- Association for Professionals in Infection Control and Epidemiology, Inc. (www.apic.org)
- Centers for Disease Control – Main site (http://www.cdc.gov)
  - CDC Outpatient Guide with Checklist (http://www.cdc.gov/HAI/settings/outpatient/Outpatient-Care-Guidelines.html)
  - CDC Hand Hygiene (http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf)
  - CDC Multidose Vials (http://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html)
  - CDC Disinfection and Sterilization (http://www.cdc.gov/hicpac/pdf/guidelines/disinfection_nov_2008.pdf)
  - CDC Environmental Cleaning (http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf)
- Infection Control Today (http://www.infectioncontroltoday.com)
- Multi-society Guideline for Reprocessing Flexible Gastrointestinal Endoscopes (http://www.shea-online.org/Assets/files/position_papers/SHEA_endoscopes.pdf)
- Occupational Safety and Health Administration, Safety and Health Topics, Healthcare Facilities (http://www.osha.gov/SLTC/healthcarefacilities)
  - OSHA Bloodborne Pathogens (https//www.osha.gov/SLTC/bloodbornepathogens/standards.html)
  - OSHA Personal Protective Equipment (https://www.osha.gov/Publications/osha3151.html)
- One and Only Campaign/Safe Injection Practices (http://oneandonlycampaign.org)
- Society of Gastroenterology Nurses and Associates, Inc. (http://www.sgna.org)
  - SGNA High Level Disinfection Guideline (http://www.sgna.org/Portals/0/Education/Practice%20Guidelines/SGNA_HLDGuideline13.pdf)
- Society for Healthcare Epidemiology of America (http://www.shea-online.org)
- U.S. Environmental Protection Agency (http://www.epa.gov)
- U.S. Food and Drug Administration Services, MedWatch: The FDA Safety Information and Adverse Event Reporting Program (http://www.fda.gov/Safety/MedWatch/default.htm)
- World Health Organization (http://www.who.int/en)

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Chapter 8

- Federal Emergency Management Agency, Multi-Hazard Mitigation Planning (http://www.fema.gov/hazard-mitigation-planning)
- National Fire Protection Association (http://www.nfpa.org/index.asp)
- World Health Organization (http://www.who.int)

Chapter 9

- American Heart Association (http://www.heart.org/HEARTORG/)
- American Society of Anesthesiologists (ASA) (http://www.asahq.org)
- Association of periOperative Registered Nurses (http://www.aorn.org)
- Malignant Hyperthermia Association of the United States (http://www.mhaus.org)
- Sedation Facts (http://www.sgna.org/issues/sedationfactsorg/sedationadministration.aspx)
- Society for Ambulatory Anesthesia (SAMBA) (http://www.sambahq.org)
- Society for Pediatric Anesthesia (http://www.pedsanesthesia.org)

Chapter 10

- American Academy of Cosmetic Surgery (http://www.cosmeticsurgery.org)
- American Academy of Dermatology (http://www.aad.org)
- American Academy of Facial Plastic and Reconstructive Surgery (http://www.aafprs.org)
- American Association of Oral and Maxillofacial Surgeons (http://myoms.org)
- American College of Mohs Surgery (http://www.mohscollege.org)
- American College of Surgeons (http://www.facs.org)
- American National Standards Institute, Standard for Safe Use of Lasers in Health Care Facilities (http://webstore.ansi.org/RecordDetail.aspx?sku=ANSI+Z136.1+and+Z136.3+Combination+Set)
- American Society of Anesthesiologists (http://www.asahq.org)
- American Society for Dermatologic Surgery (http://www.asds.net)
- Association of Surgical Technologists (AST) Recommended Standards of Practice for Laundering of Scrub Attire (http://www.ast.org/uploadedFiles/Main_Site/Content/About_Us/Standard%20Laundering%20Scrub%20Attire.pdf)
- U.S. Food and Drug Administration, 510(k) Clearances (http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/510kClearances/default.htm)
- World Health Organization, WHO Surgical Safety Checklist and Implementation Manual (http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html)

Chapter 11

- Institute for Safe Medication Practices (http://www.ismp.org)
- U.S. Department of Justice Drug Enforcement Administration, Office of Diversion Control (http://www.deadiversion.usdoj.gov/index.html)
- U.S. Food and Drug Administration, MedWatch Safety Alerts for Human Medical Products (http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/default.htm)
- U.S. Food and Drug Administration, Recalls, Market Withdrawals and Safety Alerts (http://www.fda.gov/safety/recalls/default.htm)
- USP 797.org (http://usp797.org)

Chapter 12

- Centers for Disease Control and Prevention, Clinical Laboratory Improvement Amendments (CLIA) (http://wwwn.cdc.gov/clia/default.aspx)
- Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) (http://www.cms.hhs.gov/clia)
- Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA), How to Obtain a CLIA Certificate of Waiver (http://www.cms.hhs.gov/CLIA/downloads/HowObtainCertificateofWaiver.pdf)
- U.S. Department of Transportation, Federal Highway Administration (http://www.fhwa.dot.gov)

Chapter 13

- Medline Plus, Diagnostic Imaging (http://www.nlm.nih.gov/medlineplus/diagnosticimaging.html)

Chapter 14

- American Academy of Dental Group Practice (http://www.aadgp.org)
- American Dental Association (http://www.ada.org)

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Chapter 15

- Centers for Disease Control and Prevention, Travelers' Health (http://wwwnc.cdc.gov/travel)

Chapter 16

- American Association for Health Education (http://www.cnheo.org/aahe.htm)
- National Commission for Health Education Credentialing, Inc. (http://www.nchec.org)

Chapter 17

- National Institute of Mental Health (http://www.nimh.nih.gov)
- National Alliance on Mental Illness, Mental Health Professionals: Who They Are and How to Find One (http://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Finding-a-Mental-Health-Professional.)

Chapter 18

- Accreditation Council for Graduate Medical Education (www.acgme.org)
- Alliance for Clinical Education (www.allianceforclinicaleducation.org/about/about.htm)

Chapter 19

- U.S. Food and Drug Administration, Information Sheet Guidance for Institutional Review Boards (IRBs), Clinical Investigators, and Sponsors (http://www.fda.gov/ScienceResearch/SpecialTopics/RunningClinicalTrials/GuidancesInformationSheetsandNotices/ucm113709.htm)

Chapter 20

- Ambulatory Surgery Centers Association (www.ascassociation.org)

Chapter 21

- Department of Transportation, Federal Highway Administration (http://www.fhwa.dot.gov)
- Federal Aviation Administration (http://www.faa.gov)
- United States Nuclear Regulatory Commission (http://www.nrc.gov)

Chapter 22

- National Association for Ambulatory Care, National Urgent Care Practice Standards Certification (http://www.urgentcare.org)

Chapter 23

- American College of Emergency Physicians (www.acep.org)

Chapter 24

- American Registry of Radiologic Technologists (https://www.arrt.org)

Chapter 25

- American Academy of Family Physicians (www.aafp.org)
- American Academy of Pediatrics, National Center for Medical Home Implementation (http://www.medicalhomeinfo.org)
- American College of Physicians, Patient-Centered Medical Home: ACP Delivers Expanded PCMH Resources Online (http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/resources_tools)

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Glossary and Useful Terms

Terms are defined for the purpose of facilitating interpretation of AAAHC Standards.

Note: Asterisks indicate glossary items that have associated web addresses. These can be found in the **Internet Resources** section of the *Handbook*, immediately following the Resources tab.

ADA*	Americans with Disabilities Act
Administrative controls	The use of administrative measures (i.e., policies, procedures, training, warning labels, and enforcement measures) to reduce risk.
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.
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 professionals	Includes, but is not limited to, advance practice registered nurses and physician assistants. Accredited 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.
Antimicrobial soap	A soap (i.e., detergent) containing an antiseptic agent.
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.
APRN (also APN)	Advanced practice registered nurse; 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).

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ASA*	American Society of Anesthesiologists. This professional organization has well-recognized anesthesia, analgesia, and sedation-related standards and guidelines.
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 (clinical, financial, personnel, etc.) 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. Refer to the Resources section of this *Handbook* for other suggested sources.
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 the similar process.
Benchmarking, internal	The comparison of performance within an organization, such as by physician or department, or over time.
Bioburden	The degree of microbial contamination. The microbiological load (i.e., number of viable organisms in or on the object or surface) or organic material on a surface or object prior to decontamination or sterilization. Also known as "bioload" or "microbial load."
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 pathogens	Disease-producing microorganisms spread by contact with blood, or other body fluids contaminated with blood.
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.
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.

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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.
CLIA*	Clinical Laboratory Improvement Amendments (CLIA) — All laboratories must possess a CLIA waiver, or a CLIA Certificate to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
Clinical support staff	Clinical support staff works under the direct supervision or order of a licensed health care professional. Clinical support staff provides 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.
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.
Credentialing	A process through which an organization reviews and validates the professional qualifications of applicants (i.e., physicians, allied health professionals) requesting clinical privileges.
Credentials	Evidence of qualifications (e.g., licenses, certifications, education, and experience).
Credentials Verification Organization (CVO)	A service company providing primary source verification of practitioners' credentials on behalf of an accredited organization.
CRNA	Certified registered nurse anesthetist
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].
Discharge, medical	Medical discharge may occur 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.

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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.*
Engineering controls	Controls (e.g., sharps disposal containers, self-sheathing needles, and medical devices such as sharps with engineered injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.
Exposure time	A period of time during a sterilization or disinfection process in which items are exposed to the sterilant or disinfectant at the parameters specified by the manufacturer (e.g., time, concentration, temperature, pressure). Always follow manufacturer's instructions and recommendations.
Food and Drug Administration (FDA)	An agency within the U.S. Department of Health and Human Services that 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-acquired infection (HAI)	Any infection associated with a medical or surgical intervention. The term "health care-acquired" replaces the outdated term "nosocomial."
Health care professional	An individual who provides health services to a patient.
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.

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Hospital grade disinfectant	A germicide that is registered by EPA for use on inanimate objects in hospitals, clinics, dental offices, or any other medical-related facility. Efficacy is demonstrated against Salmonella choleraesuis, Staphylococcus aureus, and Pseudomonas aeruginosa.
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.
Injection safety	A set of measures taken to perform injections in an optimally safe manner for patients, health care personnel, and others.
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.
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.
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. Refer to Resources, page 141.
Mechanical indicator	A device (e.g., gauge, meter, display, printout) that displays an element of the sterilization process (e.g., time, temperature, pressure).
Medical staff	Includes all credentialed and privileged health care professionals.
NIOSH*	The National Institute for Occupational Safety and Health is 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.
Occupational 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.

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OPIM	Other Potentially Infectious Materials. 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 licensed individuals	Those licensed practitioners who are authorized in accordance with their state scope of practice laws or regulations, such as advanced practice registered nurses, registered nurses, physical therapists, and social workers.
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.
Peer review vs. performance review	Members of the medical staff participate in establishing peer review criteria and undergo peer review as described in Standards 2.II and 2.III, and in accordance with the organization's peer review policies and procedures. In addition to other organizationally-defined allied healthcare professionals, advance practice registered nurses, physician assistants, and anesthesiologist assistants undergo peer review. Other allied healthcare professionals undergo performance review according to the organization's policy and at least annually.
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.

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Personal protective equipment (PPE)	Personal protective equipment is specialized clothing or equipment (e.g., 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 physician assistant is a licensed health professional who practices medicine as a member of a team with his/her supervising physician.
Plain or non-antimicrobial soap	Soaps or detergents that do not contain antimicrobial agents or contain very low concentrations of such agents; these agents are effective solely as product preservative.
Post-exposure evaluation	The evaluation and appropriate treatment of a health care worker following an occupational exposure to suspected or confirmed bloodborne pathogens.
Primary source verification	The process of obtaining an applicant's credentials (the document itself or verification of the document) directly from the original or primary source. Verification can be done by mail, fax, telephone, or electronically, provided that the means by which it is obtained are 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. An organization's formal privileging process uses appropriate criteria. Approval, modification, or denial of an applicant using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non-arbitrary manner. See pages 38-39.
Procedure/treatment room	A room, as designated by the organization, in which various treatments or procedures are performed.
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. This term is older and not as likely to be used today within health care, because of its focus on minimum standards of quality. 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. The AAAHC Standards require an accredited organization to have a written QI program approved by its governing body.

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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 in order 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 (i.e., physicians, allied health 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.
Regulated waste	Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and micro-biological wastes containing blood or other potentially infectious materials. Hazardous waste and pharmaceutical waste is not considered regulated waste.
Secondary source verification	Acceptable secondary source verification is documented verification of a credential by (1) obtaining a verification report from an acceptable entity that has already performed primary source verification, or (2) by viewing the credential or a notarized copy of the credential.
Spaulding classification	This classification system divides medical devices into categories based on the risk of infection involved with their use. It is widely accepted and used by the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), epidemiologists, microbiologists, and professional medical organizations to help determine the degree of disinfection or sterilization required for various medical equipment and patient care items.
Surgical Site Infection (SSI)	An infection that occurs after surgery in the part of the body where the surgery took place.
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.

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Surfactant	A compound that lowers the surface tension (or interfacial tension) between two liquids or between a liquid and a solid. Surfectants may act as detergents, wetting agents, emulsifiers, foaming agents, and dispersants.
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.
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.
Universal precautions	An approach to infection control that treats human blood and certain human body fluids as if they were known to be infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and other blood-borne pathogens.
Vaccine	A product that improves immunity to a specific disease.
Work practice controls	Practices incorporated into the everyday work routine that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles using a two-handed technique).
Workers' 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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Appendices

Appendix A

Standards Revisions for 2016

The table below identifies the changes to the AAAHC Standards for 2016. For reader convenience, the updates are listed by Chapter based on their location in the 2015 edition of the *Accreditation Handbook for Ambulatory Health Care*.

Most of the changes for 2016 are intended to reduce redundancy among Standards and improve clarity in interpretation. Additional changes have been made to Standards for which assessment of compliance was based on multiple factors. In most of these instances, individual decision points have been separated into discrete elements or sub-elements to facilitate consistency in evaluation.

The general nature of each change is briefly noted under "type of change." Specific edits appear under "additional notes." Minor edits or other additions to the content of a Standard appear *in italics*; deletions appear ~~as strikethroughs~~; more extensive edits and new Standards appear in blue.

2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 1: Patient Rights and Responsibilities			
1.F.7	19.G	Moved to improve applicability	
1.F.8-12	1.F.7-11	Renumbered to reflect relocation of 1.F.7	
Chapter 2: Governance, Subchapter II: Credentialing and Privileging			
2.II.B.5.b		Edited for clarity	Upon receipt of the completed reappointment application, the organization will *conduct primary or secondary source* ~~verify~~ *verification…*
2.II.F	2.II.F.1-2	Separated decision points	The governing body provides a process for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for allied health care professionals. 1. The process is consistent with state law. 2. The process includes verification of education, training, experience, and current competence, and primary or secondary source verification of licensure or certification, as applicable.

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 5: Quality Management and Improvement			
5.II.A	5.II.E	Renumbered and focused	Documented education regarding the risk management *program, policies, and* activities *including adverse incident reporting,* is provided…
	7.II.S	Relocated to improve contextual relevance and focus	Documented education regarding the safety program, policies, and activities is provided to all staff within 30 days of beginning employment, annually thereafter, and when there is an identified need.
5.II.B	7.I.R	Relocated to improve contextual relevance	
5.II.G	5.II.B	Relocated and expanded for clarity	The governing body designates a person or committee to be responsible for implementation, ongoing management, *and consistent application* of the risk management program *and/or policies throughout the organization, including all departments and service locations.*
5.II.C	5.II.B	Deleted with intent absorbed in new Standard	
5.II.D	5.II.C	Edited for clarity	The risk management *program and/or policies include ongoing* processes that address patient safety and…
5.II.E	5.II.D	Renumbered and edited for clarity	The organization's risk management program *and/or policies* include...
5.II.F.1-6	5.II.A.1-7	Relocated with elements separated for distinct decision points	*The organization's governing body approves a written risk management program and/or policies that address:*

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 7: Infection Prevention and Control and Safety			
7.I.A		Edited for clarity	…and reporting the results *to the governing body* and other…
	7.I.B.4	New sub-element to separate decision points	The written infection prevention and control program is: 4. The result of a formal, documented infection prevention risk assessment to ensure that the program is relevant to the organization. 5. In compliance with all applicable state and federal requirements.
7.I.B.5-6	7.I.B.6-7	Renumbered	~~6~~ 7. ~~Clear to include~~ *Focused on* direct intervention…
7.I.F	7.I.F.1-3	Separated decision points	Processes for the cleaning, disinfection and… adhere to: *1. Nationally recognized guidelines* *2. Manufacturer's instructions for use* *3.* State and federal guidelines.
7.I.H		Reduced redundancy	The organization provides ~~a safe and sanitary environment for treating patients. This includes~~ safeguards to protect the patient...
7.I.O	7.I.O.4	New sub-element of 7.I.O	4. Requirements that cleaning products are used according to the manufacturer's instructions for use.
7.I.P		Edited for clarity	Medical devices for use with multiple patients are ~~cleaned and disinfected~~ *processed* between patients *according to the manufacturer's instructions…*
7.I.Q		Edited for clarity	A written policy outlines appropriate hand hygiene using products according to the product manufacturer's *instructions for use.*

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 7, Infection Prevention and Control and Safety, Subchapter II: Safety			
7.II.A.2		Deleted to reduce redundancy with 2016 5.II.C.4	
7.II.K		Edited for clarity	*Food and drink for patient use is stored, prepared, served, and disposed of in compliance with local, state, and federal guidelines.*
7.II.L	7.II.L.1-2	Edited for clarity and separation of decision points	~~Patients are educated about prescribed medical devices and associated protocols and guidelines. Patient competence with each device is verified before independent use.~~ *When a medical device is provided to a patient:* *1. The patient is educated about the use of the device.* *2. Patient understanding of how to use the device is verified before independent use.*
7.II.N		Edited for clarity	Reprocessing of *manufacturer-labeled* single-use devices must comply with FDA regulation *and is limited to devices approved for reprocessing in accordance with* FDA 510(k) clearance.
7.II.P	7.II.Q	Standard divided to separate decision points and order reversed	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 manufacturer's guidelines.
	7.II.P		The organization has a policy for disposal or return of expired medications and supplies that complies with local, state, and federal guidelines.
7.II.Q & R	7.II.R.1-2	Renumbered to combine related Standards while separating decision points	Prior to use, appropriate education is provided to intended operators of newly-acquired devices or products to be used in the care of patients. 1. A designated person is responsible for ensuring that clinical education occurs prior to the use of the devices or products. 2. Vendor representatives are not used as the sole source for clinical education.

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 8: Facilities and Environment			
8.B.5		Edited for current relevance	Provide reception areas *and* toilets ~~and telephones~~ appropriate for patient and visitor volume.
8.Q		Edited for clarity	~~Ongoing~~ 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. Recommended* temperature ranges are readily available to staff performing the monitoring function.
Chapter 9: Anesthesia Care Services			
9.A	9.A	Edited for separation of decision points	Anesthesia services provided by the organization are limited to those techniques that are approved by the governing body upon recommendation of qualified professional personnel.
	9.B		Anesthesia is only administered by anesthesiologists, other qualified physicians, dentists, certified registered nurse anesthetists, or other qualified[1] health care professionals approved by the governing body pursuant to with Chapter 2.II.
9.B	9.C.1-2	Rewritten for clarity and separation of decision points	~~Adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians or dentists who are approved and have privileges for supervision granted by the governing body.~~ *The organization ensures the appropriate supervision of anesthesia services.* *1. The governing body has approved one or more qualified physicians or dentists as responsible for the supervision of anesthesia services, and has granted privileges for supervision to those responsible for it.* *2. Other qualified health care professionals[1] must be directly supervised by a physician or dentist who has been granted privileges for supervision.*

[1]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 Chapter 2.II.

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 9: Anesthesia Care Services *(continued)*			
9.C	9.D	Renumbered	*Written* policies and procedures…
9.D	9.E.1-2	Rewritten for clarity and separation of decision points	*Patients are examined immediately prior to the administration of an anesthetic to evaluate the risks of anesthesia relative to the procedure to be performed.* *1. The examination is conducted by a health care professional privileged to administer anesthesia in accordance with Standard 9.B.* *2. Based on the results of the examination, the health care professional develops and documents a plan of anesthesia.*
9.E	9.F	Renumbered	
9.F	9.B	Renumbered	Anesthesia is *only* administered by…
9.U.1		Edited for clarity	Organizations…must: 1. Adopt *current* nationally-recognized…
9.Y & Z	9.Y.1-2	Combined like topics as elements of one Standard	~~Organizations that provide sedative, hypnotic, or analgesic drugs that do not have an antagonist medication (for example, propofol) will identify who in the organization, as noted in Standard 9.F, is privileged to administer these drugs.~~ *In settings where anesthesia may be provided by other than an anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an anesthesiologist assistant within his/her scope of practice:* *1. Such personnel must be privileged by the governing body to administer sedative, hypnotic, or analgesic drugs that do not have an antagonist medication (for example, propofol) if these drugs are used.* *2. A written protocol defines how the organization will respond in the event that a deeper-than-intended level of sedation occurs.*
9.AA-BB	9.Z-AA	Renumbered	

2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 10: Surgical and Related Services, Subchapter I: General Requirements			
10.I.H & I	**10.I.H.1-2**	Combined and clarified Standards covering one process	The patient provides informed consent for the proposed procedure to be performed. 1. There is documentation that the necessity or appropriateness of the proposed procedure or surgery, as well as alternative treatment techniques, have been discussed with the patient. 2. The organization obtains written informed consent from the patient or the patient's representative before the procedure or surgery is performed.
10.I.J	**10.I.I**	Renumbered	
10.I.K & L	**10.I.J.1-2**	Combined and renumbered	Each operating room is designed, *constructed,* and equipped *to support* the types of surgery conducted. *1. The design and equipment facilitate the physical safety of all persons in the area.* *2. The design, construction, and equipment comply with applicable state and local codes.*
10.I.M	**10.I.K.1-2**	Separated decision points	*Whenever patients are present in the facility, the organization ensures that:* *1. Health care professionals trained in the use of emergency equipment and basic life support (BLS) are present.* *2. At least one physician or dentist is present or immediately available by telephone.*
10.I.N	**10.I.L**	Edited for clarity	With the exception of those ~~tissues~~ exempted *in writing*…tissues removed during surgery…
10.I.O-S	**10.I.M-Q**	Renumbered	
10.I.Q.1		Removed as redundant with 7.II.M	
10.I.T	**10.I.R**	Edited for clarity	~~Organizations that perform~~ If procedures performed pose the risk that blood loss may require blood replacement, the organization must have *written* policies and procedures to address this situation.

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 10: Surgical and Related Services, Subchapter I: General Requirements *(continued)*			
10.I.U	**10.I.S**	Edited for clarity	The organization must have alternate power ~~adequate for the type of surgery performed is available in operative and recovery areas~~ for OR and PACU areas.
10.I.V	**10.I.T**	Renumbered	
10.I.W	**10.I.U.1-4**	Separated decision points	The organization uses a *written* process to: 1. *Identify and/or designate the surgical procedure to be performed* 2. *Ensure that the person performing the procedure marks the site.* 3. *Involve the patient in the process for surgical site marking.* 4. *Identify the operative tooth by marking a radiograph or dental diagram for dental procedures.*
10.I.X	**10.I.V**	Renumbered and divided Standard to separate decision points	Immediately prior to beginning a procedure, the *provider performing the procedure assumes responsibility for the time out and engages the entire operating team.*
	10.I.W		*During the pre-procedure time out, the following items are verified:* 1. *Patient identification.* 2. *Intended procedure.* 3. *Correct surgical site.* 4. *All equipment necessary for performing the scheduled procedure are immediately available in the operating/procedure room.* 5. *Any implantable devices intended to be used during the procedure are prepared before the procedure and available.*

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 10: Surgical and Related Services, Subchapter I: General Requirements *(continued)*			
10.I.Y	10.I.X.1-4	Renumbered and expanded Standard for clarity and to separate decision points	*The organization has a written process that requires:* *1. Identification of the types of procedures requiring counts of sponges, sharps, and instruments.* *2. A count before the start of the procedure and before skin closure.* *3. Reporting the start and end count to the surgeon.* *4. Documentation of the counts in the patient's record.*
10.I.Z	10.I.Y	Renumbered and separated decision points	The organization has written guidelines for internal transfer of care from one provider to another. These guidelines address: 1. Information to be transferred about a patient's care, including treatment/services, current condition, and any recent or anticipated changes. 2. How the information will be communicated among members of the health care team.
10.I.AA	10.I.Z	Renumbered and edited for clarity	The organization follows established protocols for instructing patients in self-care after surgery and provides written instructions to patients ~~who receive moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia.~~
10.I.BB-CC	10.I.AA-BB	Renumbered	
Chapter 10: Surgical and Related Services, Subchapter III: Renal Lithotripsy Services			
10.III.B		Edited for clarity	*The organization has written* radiation safety and quality control policies and procedures regarding patient and staff exposure that are periodically reviewed by a qualified individual.

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 12: Pathology and Medical Laboratory Services In the 2016 edition of the Standards, the separation of Chapter 12 into subchapters has been eliminated.			
12.A		Edited for clarity	An accreditable organization: 1. Meets the requirements for waived tests or provider-performed microscopy under CLIA (part 493 of Title 42 of the Code of Federal Regulations) ~~if it performs its own laboratory services, performs only waived tests and/or provider-performed microscopy tests,~~ and has obtained a Certificate of Waiver and/or a Provider Performed Microscopy Certificate, and/or *a CLIA Certificate, as appropriate for the lab services provided.* 2. Has procedures for obtaining routine and emergency laboratory services *outside of its capabilities* from a certified *external* laboratory to meet patient needs.
12.B-C.1-5	12.B.1-4	Combined to reduce redundancy; renumbered	Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities. ~~1. Conducting laboratory procedures that are appropriate to the needs of the patients.~~ *1. Tests are performed in a timely manner.* *2. Test results are distributed and copies of the results are maintained.* *3. Appropriate quality control procedures are performed and documented including, but not limited to, calibrating equipment periodically and validating test results.* *4. Staff with laboratory responsibilities have adequate training and demonstrated competence.*
12.D	12.C	Renumbered and edited for clarity	The organization has a policy to ensure that test results are reviewed *and acknowledged in writing (manually or electronically) by* the ordering physician *or qualified designee.*

2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 12: Pathology and Medical Laboratory Services *(continued)* In the 2016 edition of the Standards, the separation of Chapter 12 into subchapters has been eliminated.			
12.II.E-I	12.D-H	Renumbered	
12.II.J	12.I	Edited for highlight applicability	*If the lab is testing for Department of Transportation (DOT) regulated industries or federal agency employees,* the requirements of the…
Chapter 13: Diagnostic and other Imaging Services			
13.A-B.1	13.A	Combined related elements	
13.B.2	13.B	Renumbered and moved from element to full Standard	~~Interpreting images and ensuring~~ *Image interpretation* is appropriately documented in a timely manner.
13.B.3	13.C	Renumbered and moved from element to full Standard	~~Maintaining appropriate~~ Records or reports of services provided *are maintained*.
13.B.4	13.D	Renumbered and moved from element to full Standard	~~Providing adequate~~ Space, equipment, and supplies *are sufficient* to ensure the provision of quality services.
13.C	13.E	Renumbered	
13.D.1-4	13.F.1-4	Renumbered and edited for clarity	Policies *and procedures* that address… 1. Regulation of the use, removal, handling, and storage of potentially hazardous materials, *if present.*
13.E-L	13.G-N	Renumbered	
Chapter 14: Dental Services			
14.II.B.12, C.8, D.5, E.7	14.F	Combined in new Standard to reduce redundancy	Electronic data management is continually assessed as a tool for facilitating the Standards above.

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2015 Standard identifier	2016 Standard identifier (if changed)	Type of change	Additional notes
Chapter 18: Teaching and Publication Activities			
18.A.1-5	18.A.1-4	Element removed, others renumbered	~~1. The terms and conditions of reimbursement or other compensation.~~
18.C.1-2	18.C.1	Element removed, edited for clarity	*The organization adopts* written policies regarding publishing activities that address: 1. The need for governing body approval of all publications that are *either* attributed to or result from care *provided by* the organization. ~~2. Governing body approval of the terms and conditions of compensation from publication and the cost of publication.~~
Chapter 25: Medical Home			
25.A		Edited for clarity	Relationship – communication, understanding, and collaboration (in this context, ~~"physician"~~ *"provider"* refers to the physician-, nurse practitioner-, physician assistant-, *or behavioral health professional*-directed health care team). 1-14, ~~physician~~ *provider*
25.B.5, C.8, D.12, E.7	25.F	Combined in new Standard to reduce redundancy	Electronic data management is continually assessed as a tool for facilitating the Standards above.
25.C.2.f		Edited for clarity	Comprehensiveness of care 2. The Medical Home scope of services includes, but is not limited to: f. *Documented discussion regarding* end-of-life *or palliative care, as appropriate.*

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Appendix B

Interim, Random, and Discretionary Surveys

INTERIM SURVEY

This survey is conducted for organizations that are currently AAAHC-accredited and for which oversight is required to assess ongoing compliance with the accreditation Standards. Following the Interim 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. Organizations are not eligible for a new accreditation term as a result of an Interim Survey. A survey fee is assessed for an Interim Survey. Following an Interim Survey, the organization will receive an accreditation decision letter and survey report.

RANDOM SURVEY

To support ongoing quality improvement initiatives, an accredited organization may be selected by AAAHC for a Random Survey from 9 to 30 months after an accreditation survey. Random Surveys are unannounced. Organizations are selected on a proportionate basis across practice settings, geographic areas, and accreditation decision categories. These unannounced surveys, which are conducted by one surveyor and may last one full day, are a means by which AAAHC can evaluate the consistency and quality of its program, while also demonstrating to the public and regulators that accredited organizations remain committed to AAAHC Standards throughout the accreditation cycle. Random Surveys also provide AAAHC and its surveyors with opportunities to further consult with accredited organizations in the interval between regular surveys. No fee shall be charged to the organization when a Random Survey is conducted.

If, as a result of a Random Survey, AAAHC determines that the organization is not in substantial compliance with the Standards, the organization's accreditation term may be reduced, revoked, or it may be determined that an Interim Survey is necessary. Organizations are not eligible for a new accreditation term as a result of a Random Survey. (**Refer to Denial or Revocation of Accreditation**, page 15.) Following a Random Survey, the organization will receive an accreditation decision letter and a survey report.

DISCRETIONARY SURVEY

A discretionary Survey is conducted "for cause," when concerns have been raised about 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. A fee may be charged to the organization when a Discretionary Survey is conducted.

If, as a result of a Discretionary Survey, AAAHC determines that the organization is not in substantial compliance with the Standards, the organization's accreditation term may be reduced, revoked, or it may be determined that an Interim Survey is necessary. Organizations are not eligible for a new accreditation term as a result of a Discretionary Survey. (Refer to **Denial or Revocation of Accreditation**, page 15.) Following a Discretionary Survey, the organization will receive an accreditation decision letter and a survey report.

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Appendix C

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

Initial Decision and Opportunity to Submit Additional Material

A proposed recommendation with respect to accreditation by AAAHC is reported to the chief medical executive and the administrative head of the organization. If the proposed recommendation is to deny accreditation or revoke accreditation, 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 the AAAHC office 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 substantially compliant. The information that is provided will be considered by AAAHC in rendering the final 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 Executive Director 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 ten calendar days of the date of the notification, along with a one-time nonrefundable payment of $3500.00 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 $3500.00 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 $3500.00. 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 on-site 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.

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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 AAAHC Survey Eligibility Criteria.

(2) The organization fails to notify AAAHC of a significant change (for a complete list of what constitutes significant changes, see **Continuation of Accreditation Following a Significant Change** on page 16).

(3) 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 organizations, 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 re-accreditation is denied, 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** on page 16.

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

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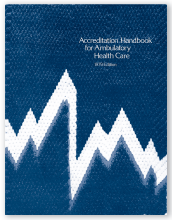
Appendix D

AAAHC Timeline

1979

1979

AAAHC is founded to offer an accreditation program for primary and surgical care organizations.



Charter Board of Directors members: American College Health Association (ACHA), American Group Practice Association (now AMGA), Federated Ambulatory Surgery Association (now ASCA), Group Health Association of America (now AAHP), the Medical Group Management Association (MGMA), National Association of Community Health Centers (NACHC)

1983

AAAHC adds an accreditation program for managed care organizations.

American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) joins the Board as a member organization.

1987

American Academy of Dental Group Practice (AADGP) joins the AAAHC Board.

1989

American Association of Oral and Maxillofacial Surgeons (AAOMS) and American Academy of Cosmetic Surgery (AACS) join the Board.

1996

Centers for Medicare & Medicaid Services (CMS) grant "deemed status" to AAAHC for Medicare certification of ambulatory surgery centers. This status has been continuously renewed with the current term running to 2018.

1998

The Mackool Eye Institute (Astoria, NY) becomes the 1000th organization accredited by AAAHC.

1999

American College of Obstetricians and Gynecologists (ACOG), American Society of Anesthesiologists (ASA), Society for Ambulatory Anesthesia (SAMBA) and the American Academy of Dermatology (AAD) join AAAHC.

Institute for Quality Improvement

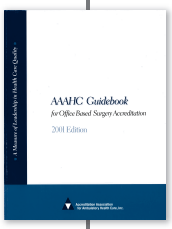
AAAHC Institute for Quality Improvement is established to help health care organizations identify, measure, and achieve QI goals.

HEALTHCARE CONSULTANTS INTERNATIONAL, INC.

Healthcare Consultants International is established as a for-profit consulting group to aid organizations in preparing for accreditation.

2001

Office-based surgery accreditation program established.



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2004

American Gastroenterological Association (AGA) joins the AAAHC Board.

2005

American College of Gastroenterology (ACG), American Society for Gastrointestinal Endoscopy (ASGE) join the AAAHC Board.

2007

CMS grants deemed status for health maintenance and preferred provider organizations participating in Medicare Advantage.

2009

AAAHC launches first-in-nation Medical Home accreditation based on point-of-care review.

Bureau of Primary Health Care (BPHC) awards a contract for AAAHC accreditation of federally supported health centers.

2010

AAAHC International is founded and expands AAAHC accreditation to Central and South America.

AAAHC INTERNATIONAL

2011

Rochester Surgery Center (MI) becomes the 5,000th organization accredited by AAAHC.

Association of periOperative Registered Nurses (AORN) joins the AAAHC Board.

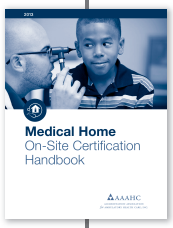
2012

ACCREDITATION ASSOCIATION FOR HOSPITALS / HEALTH SYSTEMS

Accreditation Association for Hospitals/Health Systems (AAHHS) established to bring accreditation resources to smaller, rural hospitals.

American Dental Association (ADA) joins the AAAHC Board.

AAAHC expands its Medical Home program to include a second form of recognition: On-Site Certification.



2013

AAAHC Health Plan accreditation is accepted by CMS for plans participating in State and Federal Exchanges under the Patient Protection and Affordable Care Act (PPACA).

2014

AAAHC is 35 Years Strong, celebrating a continuing history of improving quality and patient in ambulatory health care.

AAAHC 35 YEARS STRONG

AAAHC International is re-named Acreditas Global.

ACREDITAS *Global*

2015

2015

The Accreditation Association (parent of AAAHC) acquires the Health Facilities Accreditation Program (HFAP) from the American Osteopathic Association (AOA) and places it under the direction of AAHHS.

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Appendix E

Members and Leadership

AAAHC Member Organizations:

Alphabetical by organization

ASCA Foundation
American Academy of Cosmetic Surgery (AACS)
American Academy of Dental Group Practice (AADGP)
American Academy of Dermatology (AAD)
American Academy of Facial Plastic & Reconstructive Surgery (AAFPRS)
American Association of Oral & Maxillofacial Surgeons (AAOMS)
American College of Gastroenterology (ACG)
American College Health Association (ACHA)
American College of Mohs Surgery (ACMS)
American Congress of Obstetricians & Gynecologists (ACOG)
American Dental Association (ADA)
American Gastroenterological Association (AGA)
American Society of Anesthesiologists (ASA)
American Society for Dermatologic Surgery Association (ASDSA)
American Society for Gastrointestinal Endoscopy (ASGE)
Association of periOperative Registered Nurses (AORN)
Society for Ambulatory Anesthesia (SAMBA)

Current Officers (2015-2016)

Frank Chapman, MBA; Board Chair
Meena Desai, MD; Vice Chair
Kenneth Sadler, DDS, MPA, FACD, FICD; Treasurer
Arnaldo Valedon, MD; Secretary

Medical Director

Jack Egnatinsky, MD

The Accreditation Association President and CEO

Stephen A. Martin, Jr., PhD, MPH, 2015-

Current AAAHC Board of Directors

In alphabetical order

Edward S. Bentley, MD, 2006-
Frank J. Chapman, MBA, 2005-
Ira Cheifetz, DMD, 2013-
W. Patrick Davey, MD, MBA, 2003-
Jan Davidson, MSN, RN, CPHRM, 2011-
Mark S. DeFrancesco, MD, MBA, 2000-
Meena Desai, MD, 2009-
Robin Elwood, MD, 2015-
Ann Geier, RN, MS, CNOR, CASC, 2014-
Richard D. Gentile, MD, 2006-
David Hamel, DDS, 2015-
Joy Himmel, PsyD, PMHCNS-BC, LPC, 2015-
George Hruza, MD, 2015-
Sandra Jones, LHRM, CHCQM, MBA, MSM, 2012-
John P. Keats, MD, CPE, 2014-
Lawrence S. Kim, MD, 2004-
Ross Levy, MD, 2012-
W. Elwyn Lyles, MD, FACG, 2011-
S. Teri McGillis, MD, 2006-
Mark Mandell-Brown, MD, 2013-
Beverly K. Philip, MD, 2000-
Kenneth M. Sadler, DDS, MPA, FACD, 2005-
David M. Shapiro, MD, 2013-
James Schall, DDS, 2011-
Edwin W. Slade, DMD, JD, 2004-
Scott Tenner, MD, FACG, MPH, 2007-
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Mary Ann Vann, MD, 2008-
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Timothy Peterson, MD
Dennis Schultz, MD

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Mark S. DeFrancesco, MD, MBA, 2009-2010
Bruce N. Rogers, DDS, MBA, 2008-2009
Raymond E. Grundman, 2007-2008
Roy C. Grekin, MD, 2006-2007
Francis P. DiPlacido, DMD, 2005-2006
Gerald G. Edds, MD, 2003-2005
C. William Hanke, MD, 2001-2003
William H. Beeson, MD, 1999-2001
Margaret W. Bridwell, MD, 1997-1999
Bernard A. Kershner, 1995-1997
Sam J.W. Romeo, MD, MBA, 1993-1995
Frank J. Newman, MD, 1991-1993
Carl J. Battaglia, MD, 1989-1991
Nicholas D. Wing, MD, 1987-1989
David J. McIntyre, MD, 1985-1987
John R. Johnson, 1983-1985
Wallace A. Reed, MD, 1981-1983
John F. Rose, Jr., MD, 1979-1981

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Frank Chapman, MBA, 2014-2015
W. Patrick Davey, MD, MBA, FACP, 2013-2014
Margaret E. Spear, MD, 2012-2013
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Jack Egnatinsky, MD, 2010-2011
Marshall M. Baker, MS, FACMPE, 2009-2010
Mark S. DeFrancesco, MD, MBA, 2008-2009
Bruce N. Rogers, DDS, MBA, 2007-2008
Raymond E. Grundman, 2006-2007
Roy C. Grekin, MD, 2005-2006
Francis P. DiPlacido, DMD, 2003-2005
Gerald G. Edds, MD, 2001-2003
C. William Hanke, MD, 1999-2001
William H. Beeson, MD, 1997-1999
Margaret W. Bridwell, MD, 1995-1997
Bernard A. Kershner, 1993-1995
Sam J.W. Romeo, MD, MBA, 1991-1993
Frank J. Newman, MD, 1989-1991
Carl J. Battaglia, MD, 1988-1989
Joseph C. Belshe, MD, 1987-1988
Nicholas D. Wing, MD, 1985-1987
David J. McIntyre, MD, 1983-1985
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Beverly K. Philip, MD, 2006-2009
Raymond E. Grundman, 2005-2006
Benjamin S. Snyder, 1989-2005
Stanley E. Salzman, 1986-1989
Bernard A. Kershner, 1985-1986
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John R. Johnson, 1981-1983
William E. Costello, 1979-1981

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Timothy Peterson, MD, 2012-2013
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Karen M. McKellar, 2009-2010
Marshall M. Baker, MS, FACMPE, 2008-2009
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Ronald S. Moen, Sr., 1979-1990

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