PROPOSED REVISIONS to AAAHC STANDARDS
Effective 2005

The Standards and Survey Procedures Committee proposes the following revisions to the AAAHC accreditation standards to take effect with the publication of the 2005 Accreditation Handbook for Ambulatory Care:

(Additions are underlined, deletions in strikethrough. Numbering will be adjusted to reflect revisions.)

Chapter 2, Governance.

2-I-B. The governing body addresses and is fully 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...

[Revision would conform to Medicare Conditions of Coverage for ASCs and is recommended by CMS.]

2-I-C(3). Accredited organizations must notify AAAHC within 30 days of any significant organizational, operational, or financial changes including but not limited to mergers, change in majority interest, consolidation, name change, additional services or locations, death or incapacitation of physician or dentist in solo physician or dental organizations, changes in state license or federal certification or qualifying status, significant change in managed care enrollment, significant changes in a managed care delivery system or staff membership, bankruptcy, or other significant change in the financial viability of the organization.

[This paragraph is considered a condition of maintaining accreditation for organizations that have achieved accreditation rather than a true health care standard. Therefore, this requirement is removed from the standards, but is retained in AAAHC’s Policies and Procedures in the Handbook.]

2-II-B(4). Upon completion of the application, the credentials are verified according to procedures established in the bylaws, rules and regulations. The organization has established procedures to obtain information necessary for primary or secondary source verification of the application and is responsible for obtaining this information. An accreditable organization may use information provided by a CVO after proper assessment of the capability and quality of the CVO. Accreditation or certification of the CVO by AAAHC or another nationally recognized accreditation organization is one way of demonstrating capability and quality. Primary or acceptable secondary source verification is required for licensure, education, training and experience, unless a CVO, or an organization performing primary source verification that is accredited by a nationally recognized body is used. Where 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. Appendix J describes and contains examples of acceptable sources of secondary source verification.

[The first change addresses a common misconception that a CVO used to verify credentialing information must be accredited. Also, where a secondary source such as a CVO is used to verify credentialing, primary source verification is preferable, but secondary sources are acceptable whenever the circumstances appear to justify it. Organizations expect that CVOs they retain will perform primary source verification. However, the
Committee recognized that under exceptional circumstances, where primary sources do not exist or are impossible to verify, secondary source verification is acceptable.

2-II-B(5). Applicants shall apply for reappointment at least every three years, unless state law provides otherwise. On an application for reappointment, the organization verifies current licensure, information obtained from the National Practitioner Data Bank, DEA registration, if applicable, and reviews status of any board certifications and other pertinent information which includes, but is not limited to, items listed in Standard 2-II-B-3 (g) and peer review activities as described in Subchapter I of Chapter 5.

[Peer evaluation is mentioned in 2-II-B-3 (b) concerning initial appointment, but not in the standard relating to reappointment. The new language ties together peer review required in Chapter 5 with reappointment.]

2-II-B(8). In a solo physician practice, the physician’s credentials file shall be reviewed by a peer at least every three years, unless state law provides otherwise, to assure currency, accuracy and completeness... Applications are available for other physicians requesting credentialing and privileges to perform procedures in the solo physician’s organization, including any anesthesia providers...

[Credentialing is added for consistency with the rest of the standards in this section.]

2-II-D-C(4) Mechanisms are in place for the organization to notify licensing and/or disciplinary bodies or other appropriate authorities when a health care professional’s privileges are suspended or terminated, as required by state or federal law and regulations.

[This paragraph is made a full letter standard due to its importance and to facilitate accurate scoring.]

Chapter 3, Administration.

3-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:

... 6. 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
   ... 13. addressing the relationships with competing health care organizations so as to avoid antitrust and restraint of trade concerns
14. dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters, and the media
15. providing adequate orientation and training to familiarize all personnel with the organization's policies, procedures, and facilities.
Chapter 5, Quality Management and Improvement.

Subchapter I - Peer Review: An accreditable organization maintains an active, integrated, and organized process of peer review that is integrated into the as a part of its peer-based quality management and improvement program and is evidenced by the following characteristics:

A. The health care professionals and administrative staff understands, supports, and participates in a peer review program's of quality management and improvement, through organized mechanisms and are responsible to the governing body. The peer review program is evidenced in the quality improvement plan.

B. At least two (2) physicians (or dentists in dental practices) are involved in quality improvement activities in order to provide peer-based review. (In solo physician or dental organizations, such as office based surgical practices, independent practice associations, and dental practices, an outside physician or dentist is involved in quality assurance activities in order to provide peer-based review.)

[Language referring to quality improvement is deleted in order to avoid confusion and clarify that this provision covers peer review only. The requirements for a QI program are detailed in Subchapter II.]

1. At least two (2) health care professionals, who may include a physician or dentist, are involved to provide peer based review within their scope of practice for professionals such as nurse practitioners, certified registered nurse anesthetists, and physician assistants. Peer review as part of an employee’s performance evaluation is acceptable.

[This paragraph addresses peer review for allied health care professionals. It is envisioned that health care professionals provide peer review for like professionals. This type of peer review may be conducted through a performance evaluation of the organization’s employees.]

2. Peer review is consistent with the organization’s policies and procedures and evidenced in the quality improvement plan.

3. 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 by individual practitioners as well as practitioners in the aggregate is necessary for monitoring individual performance and establishing internal benchmarks.

[The individual practitioner’s data is analyzed to assess his/her performance (competency) and then the whole medical staff’s data is used to establish an internal norm for the organization, which individual practitioners are measured against. (internal benchmarking)]

C. Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.

D. Data related to established criteria are collected in an ongoing manner. Collected data are and periodically evaluated to identify acceptable or unacceptable or unexpected trends or occurrences that affect influence patient outcomes (results of care).
[Current Paragraphs E and F address the single topic of data collection and are therefore combined. The material in parentheses is stricken as “patient outcomes” is deemed as sufficiently descriptive.]

E. The results of data review, peer review, and internal benchmark comparisons are reported to the governing body.

[New standard clarifies that this information must be reported to the governing body]

F. The results of peer review are used as part of the process basis for granting continuation of clinical privileges, as described in Subchapter II of Chapter 2.

[New language refers to the credentialing and privileging process described in Chapter 2]

G. 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 provides for:

1. convenient access to reliable, up-to-date information library services that include materials pertinent to the clinical, educational, administrative, and research services provided offered by the organization

2. The organization encourages health care professionals to participate tion in seminars, workshops, and other 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 pertinent to its mission, goals, and objectives.

[This new standard combines the concepts of access to information and participation in educational programs, currently contained in Standards 7-A and C. Chapter 7 is being reassigned to other chapters.]

H. The organization provides a monitoring function to ensure the continued maintenance of licensure and/or certification of professional personnel who provide health care services at the organization.

[This requirement is currently found in Chapter 7, which is being reassigned to other chapters.]

Subchapter II-Quality Improvement Program: An accreditable organization maintains an active, integrated, organized, peer-based quality improvement (QI) program as evidenced by the following characteristics:

[This subchapter is significantly re-written to more accurately describe the attributes and components of a current quality improvement program.]

A. The organization develops and implements a quality improvement program that is broad in scope to addresses clinical, administrative, and cost-of-care performance issues, as well as actual patient outcomes, i.e. (results of care), including safety of patients. Exclusive concentration on administrative or cost-of-care issues does not fulfill this requirement. Characteristics of the program must include, but are not limited to:

1. a written description of the program that addresses the scope of the organization’s health care delivery services and how the quality improvement plan for these services are assessed

2. identification of the specific committee(s) or individuals responsible for the development, implementation and oversight of the program
3. participation in the program by clinical and administrative personnel, including physician involvement

4. quality improvement goals and objectives

5. development of processes to identify important problems or concerns that are appropriate for improving the quality of services provided by the organization

6. identification of quality improvement activities such as studies, including methods for benchmarking performance, to support the goals of the program

7. defined linkages between quality improvement activities, peer review and the risk management program

8. evaluation of the overall effectiveness of the program at least annually

9. identification of processes to report findings from the quality improvement activities to the organization’s governing body and throughout the organization as appropriate

B. Quality improvement activities, conducted by specific clinical disciplines within the organization (individual medical specialties, nursing, and so forth) are consistent with the characteristics of the organization’s overall quality improvement program.

C-B. The organization conducts specific Quality improvement activities that support the goals of the QI program. Quality improvement activities must include, but are not limited to, must either have the following characteristics (the five steps of “closing the QI loop”), or comply with 5 II D below:

1. the purpose of the study and the significance of the important problem(s) or concern(s) in the care of patients are identified. Sources of identifiable problems may include but are not limited to:
   a. unacceptable or unexpected outcomes results of ongoing monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, prescribing errors for medications, specific diagnoses, near misses, etc.
   b. the clinical performance and practice patterns of health care professionals
   c. variances from expected performance identified through clinical medical record review of the for quality of care, and completeness of entries and/or maintaining clinical record policies
   d. variances from expected results identified by quality controls processes, and use of diagnostic imaging, pathology, medical laboratory, and pharmaceutical services
   e. other professional, and technical and ancillary services provided
   f. assessment of and response to patient satisfaction surveys
   g. direct observation of process and/or practices
   h. staff concerns
   i. accessibility to care and/or timeliness of services
   j. medical/legal issues
k. wasteful practices

l. overutilization and underutilization of services

m. prevention, screening, evaluation, treatment or management of prevalent diseases, including chronic conditions, behavioral health, etc., provided by the organization

n. testing new or enhanced processes or methods of care

o. benchmarking against best practices, professional practice guidelines and performance measures, or established health care goals

p. short or long range planning goals

2. identification of performance measures, goals and objectives

2.3 identification of data related to established criteria to evaluate and analyze. The frequency, severity, and source of suspected problems or concerns are evaluated. Health care professionals participate in the evaluation of identified problems or concerns.

3. implementation of corrective actions such as interventions. Measures are implemented to resolve important problems or concerns that have been identified. Health care professionals as well as administrative staff participate in the resolution of the problems or concerns that are identified.

4. The problems or concerns are reevaluated, re-measurement of the problem to determine objectively whether the corrective measures have achieved and sustained demonstrable improvement. If the problem remains, alternative corrective measures are taken as needed to achieve and sustain improvement.

5. identification, analysis and implementation of additional corrective actions, if the problem remains, to achieve and sustain demonstrable improvement

5. Through the organization’s designated mechanisms, quality improvement activities are reported, as appropriate, to the proper personnel, the chief executive officer, and the governing body.

D. If an organization chooses not to follow the five steps of “closing the loop” outlined in 5 H C above, the organization must demonstrate that it has adopted alternative quality processes that are improving quality or addressing problems. While AAAHC does not specify a specific method of conducting quality improvement activities, exclusive concentration on ongoing monitor of care, without evidence of improving quality or addressing problems, does not fulfill this standard.

E. Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and are incorporated incorporation of such findings into the organization’s educational activities.

F. Appropriate records of quality improvement activities are maintained.

G. The organization’s quality improvement program will include participation in performance benchmarking activities that will allow for the have a process in place to review key indicators in comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals. This comparison could be a “report card” detailing performance or outcome measures appropriate to the organization. The organization will
utilize standardized minimum data sets to facilitate comparison of data and information within and among organizations.

1. The organization’s benchmarking system activities should may include, but are not limited to:
   a. the use of selected indicators performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served based on systematic, ongoing collection and analysis of reliable data
   b. systemically collecting and analyzing data related to the selected performance measures
   c. ensuring the reliability of data
   d. measurement measuring of changes in performance related to the performance measures/indicators
   e. use of collected data that reflects performance of health care professionals who serve the enrollees/patients and reflect the care requirements of the patient served
   f. the capacity to demonstrate demonstrating and sustaining significant performance improvement over time
   g. use using of benchmarks that are based on local, state, local or national standards, i.e. performance measures
   h. a reduction in gaps over time from benchmark norms.

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.

*This means that either the provisions of 5 II C or 5 II D, or a combination thereof, are means of demonstrating compliance with subchapter 5 II. For example, if an organization has adopted a quality improvement program (perhaps, for example, one based on a Continuous Quality Improvement model or a Total Quality Management model) that does not clearly meet the five elements in 5 II C, it still is in compliance with this subchapter if it complies with 5 II D.)

1Benchmarking: A systematic comparison of products, services or work processes of similar organizations to identify best practices known to date for the purpose of continuous quality improvement.

2 Performance Measure: A clearly defined statement or question describing information to be collected for purposes of improving processes and outcomes of care.

Subchapter III - 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 an organization’s patients and employees. Such an organization has the following characteristics:

A. The governing body of the organization is responsible for overseeing the program of risk management that includes the elements listed in Standard 5-III-C, and as appropriate to the organization, requirements described in Chapters 2 and 3.
B. There is a person or committee responsible for the risk management program.

C. Elements of a risk management program address safety of patients and other important issues, which may include the following:

1. consistent application of the risk management program throughout the organization, including all departments and all service locations
2. methods by which a patient may be dismissed from care or refused care
3. methods of collection of unpaid accounts should be reviewed before referral to a collection agency with consideration of such factors as outcome
   [Requirement moved to Administration chapter as new Standard 3-A-6 (d)]
4. reporting, reviewing and appropriate analysis of all adverse incidents, as defined in Standard 2-I-B-22, reported by employees, patients, health care professionals and others
5. periodic review of all litigation involving the organization and its staff and health care professionals
6. review of all deaths, trauma, or other adverse incidents as defined in Standard 2-I-B-22, including reactions to drugs and materials
7. review of patient complaints
8. communications with the professional liability insurance carrier
9. methods of dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters, and the media
10. methods for addressing the relationships with competing health care organizations so as to avoid antitrust and restraint of trade concerns
11. providing for managing a situation in which a health care professional physician becomes incapacitated during a medical or surgical procedure
12. impaired health care professionals
13. methods for complying with all applicable government regulations
14. methods for complying with contractual agreements
15. establishment and documentation of coverage after normal working hours
16. methods for prevention of unauthorized prescribing
17. processes to identify and/or designate the surgical site and involve the patient in those processes.

[The elements retained in Standard 5-III-C would be evaluated as full standards and scored as SC, PC, NC or N/A, as with any other standard. Previous paragraphs (9) and (10) and (13) are moved to 3-A-14 and 3-A-13 respectively. Paragraphs (13) and (14) are covered in Standards 2-I-B-18 and 2-I-B-11 respectively]

D. The risk management program conducts a periodic review of clinical records and clinical record policies.

E. Education in risk management activities is provided to all staff and affiliated persons working within the organization, as appropriate.

Chapter 6, Clinical Records and Health Information.

6-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. Any abbreviations and dose designations must be standardized according to a list approved by the organization.

[Recommended by work group appointed by Standards Committee to review the applicability of certain safe practices for patient safety. This item was included in a recent report of the National Quality Forum.]

6-J. The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and uniform location in all patient charts at each patient encounter on a current basis.

Chapter 7, Professional Improvement. [The standards found in Chapter 7 are reassigned to Chapters 3 and 5, where they fit more logically, as follows:

Former 7-A, access to information: new 5-I-G-1.
Former 7-C, 7-D, participation in internal or external educational activities: new 5-I-G-2.
Former 7-E, monitoring maintenance of licensure and/or certification of professional personnel: new 5-I-H.]

Chapter 8, Facilities and Environment.

8-B-2(c). ... At a minimum, the organization provides a comprehensive emergency plan to address internal and external emergencies, including .... a requirement for at least four drills a year of the internal emergency plan**

** Appropriate to facilities’ activities and environment. Examples include building fires, surgical fires, tornados, hurricanes, earthquakes, bomb threats, violence, and chemical, biological or nuclear threats.

[Examples provided to clarify that drills may address risks other than fire.]

8-Q. Alternate power, adequate for the protection of the life and safety of patients and staff, is available for the following: Special attention is given to

1. any areas where procedures are provided
2. operative and recovery areas for surgical services
3. treatment areas where emergency services are provided.

[These revisions are designed to improve scoring and applicability]

Chapter 9, Anesthesia Services.

9-H. Medical records include entries related to anesthesia administration.

[New standard would conform to Medicare Conditions of Coverage for ASCs and is recommended by CMS.]

9-K-1. A physician or dentist is present or immediately available until the medical discharge of the patient. Medical discharge refers to discharging a patient following clinical recovery from surgery and anesthesia.
9-L. Personnel qualified to provide anesthesia and personnel qualified in advanced resuscitative techniques (ACLS or and when pediatric patients are served, PALS) are present or immediately available until the patient has been physically medically discharged. The individual is considered “immediately available” if he or she can be present to initiate the application of resuscitative techniques in a timely manner.

[In 2004, the standards were revised to no longer require a physician or dentist to be present or immediately available until physical discharge of a patient. The conforming changes in 9-K-1 and 9-L clarify the expectations that a physician or dentist must be present, not merely immediately available, until a patient’s medical discharge, and that personnel qualified in advanced resuscitative techniques must be present and not merely immediately available until physical discharge.]

9-U. 1. In addition to the items noted in the previous anesthesia standard, section H, administration of general anesthesia requires end-tidal CO2 monitoring. Such monitoring is recommended for administration of deep sedation.

2. A means of measuring body temperature must be readily available for administration of general anesthesia.

[Revision clarifies the fact that end-tidal CO2 monitoring requirement is not required for deep sedation procedures, although it is recommended for those procedures.]

Chapter 10. Surgical Services.

10-I. Personnel qualified in advanced resuscitative techniques (ACLS or and when pediatric patients are served, PALS) are present or immediately available until all patients operated on that day have been physically discharged. The individual is considered “immediately available” if he or she can be present to ensure the application of resuscitative techniques in a timely manner. At least one physician or dentist is present or immediately available by telephone any time patients are present.

[In 2004, the standards were revised to no longer require a physician or dentist to be present or immediately available until physical discharge of a patient. The conforming change in 10-I clarifies the expectation that personnel qualified in advanced resuscitative techniques must be present and not merely immediately available until physical discharge.]

10-L-4. Only authorized persons are allowed in the surgical or treatment area, including laser rooms, and must decontaminate hands with either a hygienic hand rub or by washing with a disinfectant soap prior to and after direct contact with each patient.

[Recommended by work group appointed by Standards Committee to review the applicability of certain safe practices for patient safety. This item was included in a recent report of the National Quality Forum.]

10-R. The organization utilizes a process to identify and/or designate the surgical site and involves the patient in that process. The person performing the procedure marks the site.

[Consistent with the American Academy of Orthopedic Surgeons’ guidelines, the surgeon performing the procedure should mark the site, as he or she is ultimately responsible for knowing the site of surgery.]

10-S. Immediately prior to beginning a procedure, the operating team verifies the patient’s identification, intended procedure, correct surgical site and that all equipment routinely necessary for performing
the scheduled procedure, along with any implantable devices to be used, are immediately available in the operating room. The operating surgeon is personally responsible for ensuring that all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure.

[New standard is recommended by work group appointed by Standards Committee to review the applicability of certain safe practices for patient safety. This item was addressed in a recent report of the National Quality Forum.]

10-S. A procedure has been established for the observation and care of the patient during the preoperative preparation and postoperative recovery periods. Upon completion of a patient's procedure and until medical discharge, the staff performs repeated, frequent assessments of the patient's blood pressure or hemodynamic status, oxygen saturation, level of consciousness, pain relief and condition of the procedure site as appropriate.

[The new sentence provides more specific guidance relating to recovery care monitoring.]

10-W-9. The organization ensures that its facility provides a safe environment for utilizing laser technology, including … documenting that maintaining laser maintenance logs are current and visually inspecting and testing the laser before each use.

[Where the laser equipment is leased from an independent contractor, the responsibility for maintaining the log may be the contractor’s, but the organization being surveyed is still responsible for checking and documenting the log.]

Chapter 16, Pathology and Medical Laboratory Services.

Subchapter I - CLIA-Waived Tests: This subchapter applies only to health care organizations providing services that meet the Clinical Laboratory Improvement Amendments of 1988 (CLIA) requirements for waived tests.

A. An accreditable organization requiring laboratory services
   1. meets the requirements for waived tests under the Clinical Laboratory Improvement Act (CLIA) (part 493 of Title 42 of the code of federal regulations) if it performs its own laboratory services, performs only waived tests, and has obtained a certificate of waiver; and/or
   2. has procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with CLIA if it does not perform its own laboratory services.

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.

C. Pathology and medical laboratory services include, but are not limited to,
   1. conducting laboratory procedures that are appropriate to the needs of the patients
   2. performing tests in a timely manner
   3. distributing test results within 24 hours after completion of a test and maintaining a copy of the results in the laboratory
4. performing and documenting appropriate quality control assurance procedures, including, but not limited to, calibrating equipment periodically and validating test results through use of standardized control specimens or laboratories.

5. Staff performing tests have adequate training and competence to perform the tests.

D. Dated reports of all examinations performed, including those performed in outside laboratories, are made a part of the patient's medical record, with documentation that the tests have been reviewed.

E. Established procedures are followed in obtaining, identifying, storing, and transporting specimens.

Subchapter II – CLIA Laboratories: This subchapter applies to health care organizations providing laboratory services that require certification under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

A. An accreditable organization providing laboratory services meets the requirements of the Clinical Laboratory Improvement Act (CLIA) (part 493 of Title 42 of the code of federal regulations) and has obtained a CLIA certificate 2 if it provides its own laboratory services.

2. has procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with CLIA if it does not provide its own laboratory services.

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.

C. Pathology and medical laboratory services include, but are not limited to,

1. conducting laboratory procedures that are appropriate to the needs of the patients
2. performing tests in a timely manner
3. distributing test results within 24 hours after completion of a test and maintaining a copy of the results in the laboratory
4. performing and documenting appropriate quality assurance procedures, including, but not limited to, calibrating equipment periodically and validating test results through use of standardized control specimens or laboratories.

D. Dated reports of all examinations performed are made a part of the patient's medical record, with documentation that the tests have been reviewed.

E. 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.

F. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the laboratory.

G. Established procedures are followed in obtaining, identifying, storing, and transporting specimens.
H. 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 is also available.

I. Sufficient space, equipment, and supplies are provided to perform the volume of work with optimal accuracy, precision, efficiency, and safety.

J. Meets requirement of the Department of Health & Human Services (HHS) certification for medical review officer drug testing if the lab is testing for Department of Transportation (DOT) regulated industries or federal agency employees.

1 According to the U.S. Dept. of Health and Human Services, certain tests on human specimens for the diagnosis, prevention, or treatment of disease, or for the assessment of health, deemed to employ simple methodologies and pose no risk of harm to patients if performed incorrectly, are waived from CLIA certification requirements. For a current list of waived tests, see, www.cms.hhs.gov/clia/waivetbl.pdf.


[Chapter 16 is revised pursuant to recommendations submitted by a work group that reviewed the chapter for relevancy and consistency. Subchapter I applies to organizations that perform CLIA-waived lab tests, while Subchapter II addresses requirements for full service labs certifiable under CLIA. Only one of the two subchapters is applicable to any one organization being surveyed.]

Chapter 19, Employee and Occupational Health Services.

19-II-N. Organizations providing travel medicine services will assure that these services are appropriate to the needs of the employees and 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
   c. access to current CDC and State Department 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. immunizations (s) given and dosage
   c. medication (s) given, quantity, and date
   d. preventive health education.
[New travel medicine standards will enable AAAHC to improve its surveys of occupational health organizations offering travel medicine, and potentially accredit the growing number of freestanding and government agency travel medicine programs.]

Chapter 23, Managed Care Organizations.

23-N. The managed care organization works to improve the health status of its members with chronic conditions.

23-O. The managed care organization is responsible for confirming that provider organizations that it contracts with, such as surgery centers, hospitals, home health agencies, nursing homes, behavioral health providers, pathology and medical laboratories (those services listed in the Adjunct Chapters), have been reviewed and approved by a recognized accrediting body. The managed care organization must develop and implement standards of participation, if a recognized accrediting body has not approved the provider organization.

[The Committee agreed with the recommendations made by the Managed Care Advisory Committee to add these two standards to respond to regulatory demands for a more defined process and focused standards in this area.]