Proposed Changes to AASM Standards for Accreditation

Overview

The American Academy of Sleep Medicine (AASM) recently released proposed changes to the *AASM Standards for Accreditation* that include both substantial revisions to current standards and the addition of new draft standards. If implemented, the proposed changes will impact currently accredited entities and future applicants.

The AASM previously released the Proposed AASM Standards for Accreditation draft, including a brief summary of the proposed changes. Because the proposed standards make significant changes to the current accreditation standards, the AASM has created this overview to provide additional clarification regarding the major aspects of accreditation that will be affected should these proposed standards be adopted and implemented. The following is not an exhaustive list of every revision found in the proposed standards draft; however, this overview provides a fuller explanation of the major changes to the standards.

AASM members, accredited facilities and other stakeholders are encouraged to review the proposed standards carefully and provide feedback to accreditation@aasmnet.org **by Dec. 15, 2015**.

STANDARDS SECTION B: PERSONNEL

The Medical Director must be board certified in sleep medicine. In 2013, the Board of Directors announced that effective January 1, 2016, the medical director of every accredited facility must be boarded in sleep medicine. Although this is mentioned in the current standards, this has been fully integrated into proposed Standard B-3-FH.

The Board Certified Sleep Specialist position has been eliminated. Current accreditation standards B-7-F, B-8-F, and B-9-F have been eliminated as the position of Board Certified Sleep Specialist has been removed from the standards. As the medical director must now be board certified, the responsibilities previously overseen by the Board Certified Sleep Specialist, outlined in current standard B-8-F, now fall to the medical director as outlined in proposed standard B-4-FH. This does not affect the ability of those individuals to interpret sleep studies but does shift those specific responsibilities to the medical director.

Interpreting clinicians may be licensed physicians board certified in sleep medicine or licensed, ABSM-certified psychologists for both facility and HSAT accreditations. Interpreting clinician standards (proposed standards B-7-FH, B-8-FH, B-9-FH) have been outlined to apply to both facility and HSAT interpreting clinicians. ABSM-certified psychologists may now interpret HSAT.

A criminal background check is required prior to employing new staff. Currently, background checks are recommended by the AASM but are not required. Proposed Standard B-17-FH would require

background checks to be completed prior to employing an individual as well as require a National Practitioner Data Bank check for applicable individuals.

Scorers must be either certified or registered for both in-center tests and HSATs. Scoring personnel must be one of the following: RST, RPSGT, CPSGT, CRT-SDS, RRT-SDS or an interpreting clinician.

STANDARDS SECTION F: DATA ACQUISTION, SCORING AND REPORTING

Subcontracted HSAT services must be provided by an AASM-accredited entity unless directed by the payer or insurer to use a specific supplier. As many accredited facilities contract HSAT services from third-party suppliers, the AASM must ensure that these suppliers also meet AASM Standards. To ensure this, if the facility subcontracts HSAT services, these must be supplied by an AASM-accredited entity. Recognizing that many payers and insurers direct accredited facilities to use a specific supplier to receive payment for HSAT services, the facility may contract with a non-accredited entity in these instances but must document this in the medical record. (Proposed Standard F-10-H)

Subcontracted scorers must meet all applicable scoring personnel standards. If the facility subcontracts scoring, the scorers must meet all applicable standards as any other scorer would. The facility must have a written agreement with the subcontractor and must assess the performance of the subcontractor at least annually. (Proposed Standard F-11-F)

STANDARDS SECTION H: PATIENT RECORDS

PAP Assessment must include both the subjective response to therapy and the device download. Under proposed standard H-2-FH, PAP assessment must include both the device download confirming response to therapy and the subjective response to therapy (such as a questionnaire or face-to-face encounter). Inadequate response to therapy requires that a follow-up visit be offered to the patient.

Raw data must be stored for a minimum of 5 years. Raw data (excluding video) from all sleep tests must be maintained for a minimum of 5 years or longer (if required by law).

STANDARDS SECTION I: EMERGENCY PROCEDURES

Annual emergency drills must be conducted and documented. Under proposed Standard I-3-FH, annual drills of emergency procedures must be conducted on an annual basis, including, at minimum, cardiopulmonary emergency procedures.

The facility must have an automated external defibrillator (AED) or access to an on-site emergency response team. (Proposed Standard I-4-FH)

STANDARDS SECTION J: QUALITY ASSURANCE

Facility and HSAT Quality Assurance Programs must incorporate process and outcome measures related to the range of sleep disorders. The facility QA program must incorporate a process and outcome measure for OSA and an outcome measure for another sleep disorder, as well as ISR. The HSAT QA program must incorporate two process measures and one outcome measure. These measures may be chosen from the previously published AASM Quality Measures. (Proposed Standards J-1-F and J-2-H)

STANDARDS SECTION K: SAFETY

The entity must comply with all applicable construction standards, fire safety and building codes, OSHA requirements and hazardous material requirements. Proposed Standard K-1-FH requires the physician facility to meet all applicable construction, fire safety and building codes that are applicable in the jurisdiction where the facility is located. Under proposed Standard K-2-FH, the entity must also be in compliance with applicable OSHA requirements, including but not limited to access to Safety Data Sheets, availability of personal protective equipment and eyewash stations, when required. The entity must also dispose of hazardous materials in compliance with manufacturer recommendations and applicable regulations (Proposed Standard K-3-FH).

The entity must complete a patient safety risk analysis at least every 5 years, which is reviewed annually. The facility must complete an analysis of safety risks to patients in relation to the facility and sleep program and implement policies and procedures to mitigate risks that are identified.

The entity must define and document significant adverse events and perform an analysis of any significant adverse events that occur. The facility must define events to be considered adverse events, including, at a minimum, the events listed in proposed standard K-5-FH. When an event occurs, a root cause analysis and investigation must be conducted.

Policies and procedures must be implemented to minimize the risk of assault or allegations of inappropriate behavior in the sleep facility. Recognizing the unique vulnerability of patients and staff in a sleep testing environment, the facility must have policies and procedures in place to minimize these risks. Examples are listed in proposed Standard K-7-F.

STANDARDS SECTION L: PATIENTS' RIGHTS

A patients' bill of rights must be maintained and supplied to patients. A facility may maintain its own organization's bill of rights or adopt the bill of rights included in proposed Standard L-1-FH.