GLOBAL HEALTHCARE ACCREDITATION STANDARDS BRIEF 4.1

Pre-Publication Version

Disclaimer:

This document does not reflect the entire Pre-Publication GHA Standards Manual Version 4.1. Only portions of the manual are included to give interested parties a preliminary understanding of the structure and contents of the Pre-Publication GHA Standards Manual Version 4.1. Please note one chapter from each competency has been included in this dcoument and are as follows:

- **Patient-Focused Clinical Processes**
– Care Management (CM) Chapter
- **The Patient Experience**
– Cultural Competency (CC) Chapter
- **Sustainable Business Processes**
– Leadership and Risk Management (LR) Chapter

TABLE OF CONTENTS

INTRODUCTION

The Global Healthcare Accreditation (GHA) Program is an independent accrediting body that seeks to improve the patient experience and excellence of care received by patients who travel for their medical care and treatment, whether within their own country or internationally. GHA's goal is to share professional norms and set the standard for organizations serving medical travel patients. With a focus on the entire Medical Travel Care Continuum™, patient experience and sustainable business practices - we seek to provide both short term and long term value to our clients, whom we view as strategic partners.

Through its core competencies, categorized by Patient-Focused Clinical Processes, The Patient Experience, and Sustainable Business Processes, GHA Standards facilitate optimal management of the overall experience for a Medical Traveler.
Further, the standards' objectives are to validate the provider's provision of consistent, ethical, safe and transparent management practices. The assurance of quality and transparency in Medical Travel goes beyond the care delivered in the actual healthcare facility. It starts from the point of inquiry for the service, continues through arrival to the destination, admission, discharges post-service stay at a hospitality property, and includes follow up service once the patient returns home.

The intent and measurable elements of the standards include the engagement of patients respecting informed consent, transparency regarding the risk of procedure and cost of service, legal accountability, and whether the provision of service aligns with the culture and language of the patient. GHA strives to assure that the patient is actively engaged and that the organization is proactive in managing cultural sensitivities and communication at each touch point along this medical travel care continuum.

THE GHA MEDICAL TRAVEL CARE CONTINUUM™

The GHA Medical Travel Care Continuum™ (Image 001) is the foundation of the Global Healthcare Accreditation (GHA) Program. The Medical Travel Care Continuum™ (MTCC) denotes the entire scope and range of activities embodied by GHA for medical travel patients. The MTCC depicts the entire care continuum that must be integrated and managed to ensure good clinical outcomes, good patient experience and good business practices that positively impact an organization's performance. Our team of consultants and surveyors examines each critical component of the Medical Travel Care Continuum™, which is unique to each organization.*

*GHA acknowledges that certain stages in the MTCC may vary slightly based on the unique needs of patients and types of services being offered by the organization. The diagram below is used to provide a visual representation of the key stages as identified by most medical travel programs.

Image 001
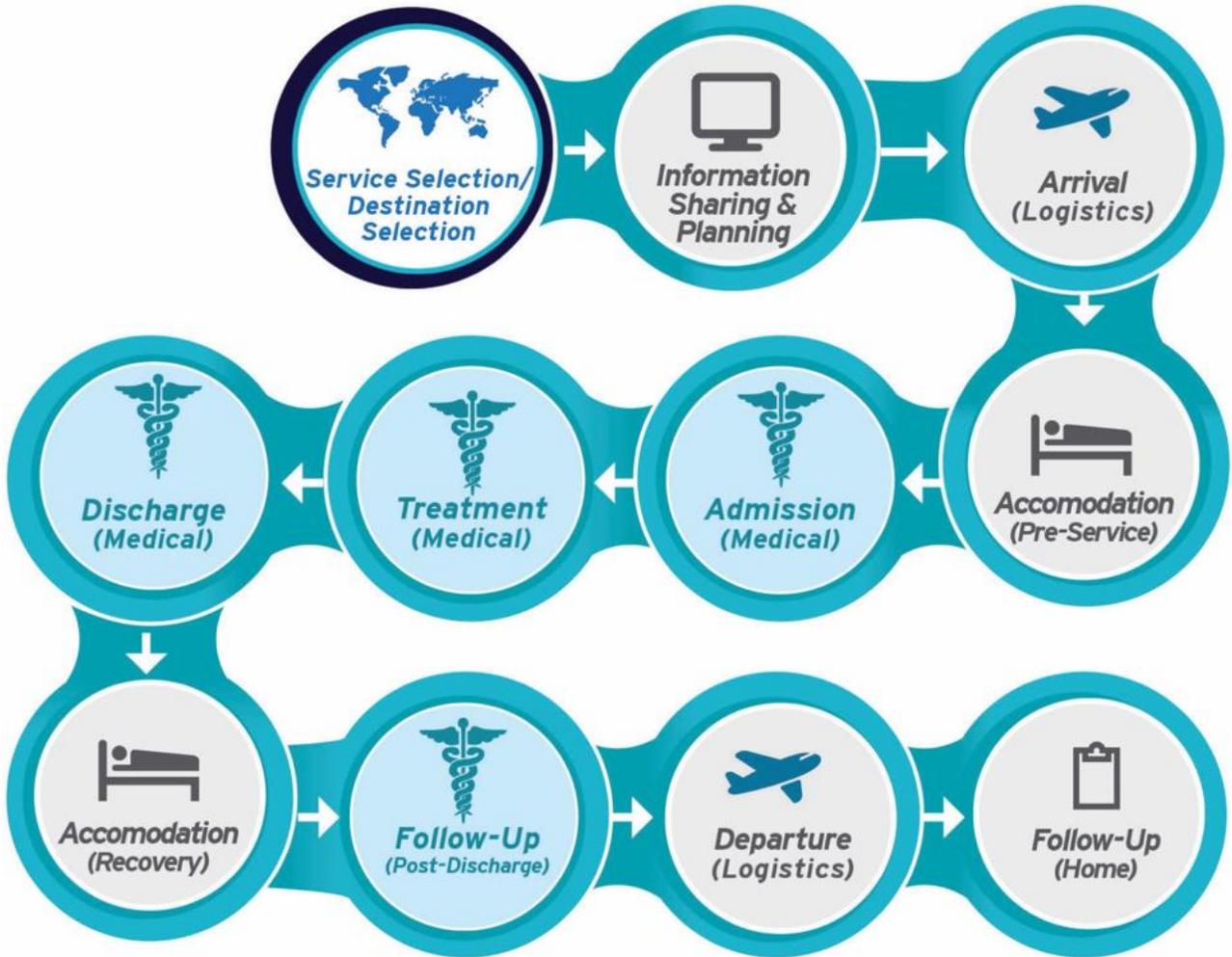
DEFINITION AND SCOPE OF MEDICAL TRAVEL PROGRAMS

As defined by GHA, a medical travel program (also referred to as international patient services or global patient services program) may be designed as a plan or system to facilitate medical/dental care and ancillary services for medical travel and/or international patients, with the ultimate goal of providing a safe and high-quality care and patient experience. This is achieved by creating standardized processes and procedures, along the Medical Travel Care Continuum™, that address the unique needs of traveling patient populations. By doing so, the organization is removing or reducing barriers and friction points that would normally occur if a traveling patient went through the local patient care pathway.

Day to day operations are usually managed through a department or office that interfaces with other departments (e.g. admission, lab, customer service) or individuals (such as physicians and nurses) within a hospital or ambulatory center as it coordinates care and advocates for the needs of medical travelers and their companions.

Medical travel programs vary in size and scope - from the majority of patients within the hospital or ambulatory center to a small fraction of the total patient population. The scope of services offered by the medical travel program vary from a single specialty such as cosmetic or dental services to a full scope of preventive, wellness, curative, surgical and non-surgical clinical services. The organizational structure of the medical travel program is appropriate for the size of the program and scope of services.

DEFINITION OF A MEDICAL TRAVEL PATIENT

A medical travel patient is defined as any individual who receives services from the medical travel program and for whom a patient record is created - including acceptance as a patient, evaluation and testing, second opinion and/or treatment, discharge and any indicated follow-up. Such individuals may include those who travel to the destination medical travel program from another country or from within the same country, expats living in the area, tourists who require medical services, or others who for reasons of language or cultural competency choose the medical travel program for care.

ORGANIZATION OF THE STANDARDS

The Global Healthcare Accreditation Program Standards are organized around the primary competencies of a successful Medical Travel Program. Those competencies areas are: The Patient-Focused Clinical Processes; The Patient Experience; and Sustainable Business Processes. Under each competency are sections of standards, organized by chapters that identify the structures, processes and outcomes that are necessary to excel in the competency area. The table below identifies the competency areas and the chapters of standards associated with that competency. Each chapter of standards contains sub-headings to assist in relating the particular standards to an important component of the requirements.

COMPETENCY AREAS AND ASSOCIATED STANDARDS

Patient-Focused Clinical Processes	The Patient Experience	Sustainable Business Processes
Care Management (CM)	Cultural Competency (CC)	Leadership and Risk Management (LR)
Infection Prevention & Control (IC)	Communication & Education (CE)	Business Ethics (ET)
Quality Improvement and Patient Safety (QI)	Patient Advocacy (PA)	Financial Transactions (FT)
Patient Rights (PR)	Physical Environment (PE)	Marketing (MK)
	Travel & Tourism (TT)	Supply Chain Management (SC)

Critical Standards

Within each of the three (3) core competency areas there are certain standards, and their measurable elements, with greater relevance and impact on achievement of full compliance with a specific competency (chapter). These standards are considered "Critical Standards" (CS) and are identified below and within the standards chapters (each identified with ** before the standard).

NOTE: Compliance with the Critical Standards alone does not indicate the medical travel program will be accredited – all standards are included in the final accreditation decision.

Patient-Focused Clinical Processes

CM.3   The medical travel program has implemented evidence-based clinical practice guidelines for the primary medical procedures and clinical services provided to medical travel patients.

CM.6   The medical travel program ensures that only properly licensed and trained personnel are providing medical, dental or other healthcare, assessment and treatment services to medical travel patients.

CM.7   The medical travel program ensures appropriate health professional staff are identified and trained to provide resuscitative services to the patients of the medical travel program.

CM.8   Patient medications are tracked and reconciled across the medical travel care continuum.

CM.10 Policies and procedures guide how medical emergencies are managed by the medical travel program.

CM.11   Qualified professionals provide sedation and anesthesia services to medical travel patients.

IC.1   There is a documented plan on how infection prevention and control is implemented in the medical travel program.

QI.1   There is a documented plan on how quality improvement and patient safety is implemented in the medical travel program.

PR.1   Patient Rights are defined by the medical travel program and communicated to all patients.
PR.2   The medical travel program has a uniform process for the granting of consent by patients.

The Patient Experience

CC.1   The leaders of the medical travel program support and implement cultural competence into all aspects of the medical travel care continuum.

CE.3   The medical travel program educates patients regarding the planned care and the care process at the destination.
CE.4   The medical travel program educates patients about the care processes in which they will participate.

PA.2   The medical travel program receives and uses complaint information to improve patient satisfaction, and to improve the medical travel care continuum.

PE.4   The medical travel program has a fire and smoke safety program to protect patients.

TT.1   Medical travel programs ensure a satisfactory travel experience to the destination and on the return home.

Sustainable Business Processes

LR.3   The medical travel program has a documented risk management plan.

ET.2   The medical travel program protects the privacy and confidentiality of identifiable personal medical information

FT.2   Payment processes are clear and transparent.

MK.2   The marketing media and materials of the medical travel program are accurate and transparent.

SC.1   The medical travel program ensures that quality supplies are available from reliable resources to meet medical travel patient needs.

STANDARDS THAT REQUIRE MONITORING

Monitoring processes and outcomes is a vital component of quality improvement in a medical travel program. The process consists of selecting what to monitor, defining how it will be monitored - what data needs to be collected, analyze the data and then use the information for improvements.

There are 22 required monitors in Version 4.1 GHA standards. These monitors are found in the 9 standards listed below:

CM.3.4- Monitor clinical practice guideline use
CM.4.4- Monitor protocol, procedure and pathway use
IC.1.3- Monitor infection risks and rates
QI.2.1- Monitor WHO patient identification implementation
QI.2.2- Monitor WHO safe surgical practices implementation
QI.2.3- Monitor Safe Medication practices implementation
QI.2.4- Select at least one monitor from each of the 14 chapters, in addition to the ones already identified in each chapter
QI.3.3- Monitor event data (sentinel, adverse, near miss), risk management data related to patient care, patient
          and staff satisfaction data, and patient complaints
QI.4.1- Monitor the implementation of quality improvements

Seven of these standards are specific as to the topic of the monitoring, e.g., IC.1.3 infection rates. The data points collected, the use of sampling and other data collection techniques, e.g., electronic or paper, are up to the medical travel program to decide. For the QI.2.4 requirement, the medical travel program will select one aspect of their program related to the standards in that chapter for monitoring. What is monitored should be meaningful and useful to the medical travel program and its patients.

Monitoring data is not submitted to GHA. Rather, the monitors, the data and use of the data and information will be a topic for discussion during the GHA survey.

IMPORTANT NOTE:
The collection and submission of KEY PERFORMANCE INDICATORS (KPIs) to GHA is not a current requirement. Submission of any monitors or KPIs to GHA will resume as consensus emerges as to the monitors most useful and important to the medical travel industry, and the infrastructure is ready to receive, validate and provide comparative reports to GHA accredited organizations.

SPECIAL CONSIDERATIONS
The on-site assessment process for the Global Healthcare Accreditation (GHA) Standards 4.1, and the recommended documents found at the end of each standards chapter, were developed for the assessment process of medical travel programs within a clinically accredited in-patient hospital or system, or within an accredited ambulatory center. This clinical accreditation can be from a recognized national or international accreditation agency and must be current. Without a current accreditation, the assessment process for the GHA standards will be extended beyond the medical travel program and into the in-patient hospital or system, or ambulatory center to better understand the key quality and patient safety issues that can may impact the care and safety of medical travel program patients. The time frame for this extended assessment will be determined by the information obtained by the application regarding the size, complexity of services and scope of the medical travel services program.

GHA

STANDARDS

Patient-Focused Clinical Processes

Care Management (CM)

Overview

Among the primary criteria used by those who travel for medical, dental and other services is the perceived quality of those services and the skills and knowledge of those providing the services. While the entire patient experience is very important, it is the results of the clinical services that will be the ultimate judge of the medical travel program and determine its success. Thus, it is appropriate that these standards for Medical Travel Programs start with standards that will support good clinical outcomes.

The standards for Care Management focus on reducing variation in how clinical services are provided and ensuring that those health professionals providing the services are appropriately qualified. The literature on quality and patient safety cite clinical process variation as a primary factor in outcomes that do not meet expectations or result in harm to the patient. Variation is reduced through the use of evidence-based guidelines and the standardization of all the other clinical processes associated with the care of patients.

To ensure that staff are qualified requires the careful and complete gathering of staff credentials, verifying those credentials and making work assignments consistent with the credentials.

How these important processes are carried out depends on the organizational structure of the medical travel program and the clinical services provided. Those medical travel programs that are part of a health care provider organization, such as a hospital, will frequently have ready access to evidence-based clinical practice guidelines and other standardized processes. These programs will also have access to the credentialing and privilege process used to evaluate and assign health professional staff. Medical travel programs based in an ambulatory center may need to develop the capacity to find and implement evidence-based clinical practices and to gather and verify the credentials of their health professional staff.

The type of services provided by the medical travel program also plays a part. For programs providing complex invasive procedures such as joint replacements, dental implants or organ transplants, evidence-based clinical guidelines are readily available and the qualifications of the health professionals team needed to deliver those services fairly defined. For medical travel programs that provide less invasive cosmetic and rehabilitative services, there may be little evidence-based clinical guidelines available. In these cases, professional practice standards may provide the available guidance and standardization, for example through peer review. Professional associations can also be a valuable resource in defining the qualifications of staff.

Standards

CM.1 The medical travel program has a standardized process for the collection of patient clinical data and information and reports prior to patient travel or on arrival.
Intent of standards CM.1 through CM.2.4

Once a medical travel patient has selected a particular organization for their care or treatment, its medical travel program begins the process of assessment to ensure the patient's needs can be met by the medical travel program. A component of this assessment is the review of relevant clinical and non-clinical data and information prior to the patient's arrival. A confidential, standardized process is used to request, receive and review the data and information from the patient or from their home country medical care provider. For example, the patient's medical profile indicates if they are at risk for deep vein thrombosis (DVT) or not during long trips. (See standard CE.3 for requirements related to such communications with a home provider). The availability or lack of certain necessary data will determine the additional tests and examinations that will be required when the patient arrives. When necessary, the patient is informed of tests or treatments they will need prior to travel. Such tests can help determine if the patient is fit for travel and treatment and if the medical travel program can meet the patient's needs on arrival. For example, a patient with uncontrolled diabetes may need to have the diabetes under control prior to travel and treatment. The medical travel program works to prevent unanticipated situations that will result in the patient being sent home prior to any treatment. Based on the pre-arrival data and information, patients accepted for treatment are provided a preliminary care plan (See standard CE.2.1 related to this communication).

CM.1.1 The medical travel program uses checklists or other standardized methods to collect clinical data and information from the patient or patient's home medical care provider.
CM.1.2 The process is confidential.
CM.1.3 The patient is informed of any additional required documents, test results or other clinical information needed by the medical travel program prior to the patient's arrival.
CM.1.4 The patient is informed of any related physical and/or healthcare requirements associated with the planned procedure or treatment.

CM.2   The medical travel program has a standardized process for the admission and continued assessment of the patient prior to arrival and upon arrival.

CM.2.1 The medical travel program has an efficient process for the admission of patients based on their needs and expectations.
CM.2.2 The physical assessment of the patient confirms those additional tests and examinations that are required.
CM.2.3 The patient is informed of the need to repeat, validate or confirm tests previously provided by the patient or home medical care provider.
CM.2.4 The patient is informed when the medical travel program care team would benefit from communication with the patient's home medical care providers.

**CM.3 The medical travel program works with appropriate staff to select and implement evidence-based clinical practice guidelines for the primary medical procedures and clinical services provided to medical travel patients.

Intent of standards CM.3 through CM.5.4

Patients who travel to receive medical, dental, rehabilitation and other clinical and restorative services base their choice of health care provided primarily on their perception of the quality of those services and their cost. The international literature on quality of care cites "variation" in the delivery of services as the primary cause of poor quality and patient safety risk. Thus, reducing variation in the clinical services provided will be the primary concern of the successful program. Standardizing how services are provided is the primary strategy to reduce variation. Standardization of surgical and other clinical services is best achieved by the adoption and use of international or national guidelines. Such clinical practice guidelines are based on research evidence as to the best practices from diagnosis to follow-up that will produce consistent quality results. The "strength" of the evidence behind clinical practice guidelines can vary from rigorous clinical trials to consensus statements and case reports. It is always best to seek and use guidelines with the strongest level of evidence. See NOTE below.

These evidence-based clinical practice guidelines should guide the primary surgical procedures and other clinical services provided by the medical travel program. The evidence-based clinical practice guidelines should be developed by or endorsed by the relevant authoritative source, such as a professional association or public agency. For effective implementation, the health professional staff that will be using the guideline should carefully review guideline details, indicating any necessary alternative drug or dosage, or alternative diagnostic or monitoring technology or possibly alternative clinical practices. Any alternative must be acceptable within the parameters of the clinical guideline to ensure the guideline will continue to be evidence-based and not need re-review by the authoritative source. Alternatives may be necessary when certain drugs or dosage levels are not available within the country or when national standards of practice vary from that of the guideline. To be effective in reducing variation, the evidence-based clinical practice guideline should be used by all the relevant practitioners, and clinical outcomes monitored as a component of the healthcare provider's quality improvement program. It is important to note that those medical travel programs within an organization, such as an in-patient hospital or ambulatory center, will work closely with the relevant practitioners to ensure consistent use of evidence-based practices in all settings, including for medical travel patients. It is also important to note that when the medical travel program provides services for which evidence-based clinical guidelines are not available, consensus professional standards of practice are followed. These may be in a format such as a protocol or pathway.

While the use of evidence-based clinical practice, guidelines will standardize the care process, and reduce unwanted or unintended variation, there are other tools that will also contribute to consistent high-quality patient care outcomes. These tools standardize associated patient care processes. These processes can include, for example, the insertion of IV lines or catheters, the use of sedation, or the proper method to change a surgical dressing to prevent infections or how to prepare a patient for a treatment. These tools are usually called "protocols" or "procedures" and they identify the correct steps to be taken to provide the clinical service. "Pathways" are also helpful as they standardize the sequence of events in the care process. It is important to note that the terms "protocols", "procedures" and "pathways" can also be used for operational, or non-clinical processes such as patient registration, laundry management or the disinfection of a patient room.

As the clinical services provided by the medical travel program may change over time, patient needs change, and the science supporting the delivery of clinical services advances, it is important to regularly review all the tools that help to standardize clinical care and reduce variation. This is important when data gathered by the appropriate staff show

that the tools are not being used, are not consistently implemented or are not achieving the desired results. Review related to such situations is a component of the quality improvement process in the medical travel program.

NOTE: Evidence-based medicine (EBM) was introduced in the early 1990's and is about finding evidence and using that evidence to make clinical decisions. There are several approaches in use currently to "grade" the levels of evidence and the "strength" of recommendations based on the evidence. Evidence is considered stronger if it represents systematic reviews of research such as from randomized controlled clinical trials, and is considered weaker if it is based mostly on expert opinion and case reports.

Many organizations offer guidance on how to evaluate the evidence such as the Cochrane Consumer Network and the USA Agency for Health Care Research and Quality (AHRQ). Other rating or grading systems include Grades of Recommendation Assessment, Development and Evaluation (GRADE), Strength of Recommendation Taxonomy (SORT), and others that are used by various professional clinical specialty societies.

In the evaluation and scoring of CM.2, GHA evaluators will discuss with the appropriate staff the "evidence" supporting the procedures and treatments provided to patients, the "strength" of that evidence, and any other approaches used to standardize care.

CM.3.1 The medical travel program identifies the primary medical procedures and clinical services provided to medical travel patients.

CM.3.2 Evidence-based clinical practice guidelines, endorsed by relevant authoritative sources, are identified for those procedures and clinical services.

CM.3.3 The guidelines are evaluated by the medical staff, any acceptable necessary alternatives identified (such as a drug substitution) and then approved for implementation.

CM.3.4 The guidelines are implemented, use is monitored, and the clinical outcomes related to use or non-use are tracked as part of the program's quality improvement processes.

CM.4 Standardized protocols, procedures or pathways have been instituted that support the use of evidence-based clinical practice guidelines and support other processes critical for patient safety and quality clinical services.

CM.4.1 Clinical care processes critical for patient safety and quality clinical services have been identified.

CM.4.2 Standardized protocols, procedures or pathways are developed or adopted for those clinical care processes.

CM.4.3 Staff are educated on the standardized protocols, procedures or pathways.

CM.4.4 The standardized protocols, procedures or pathways are implemented and use and clinical outcomes are monitored as part of the program's quality improvement processes.

CM.5 The medical travel program, along with its in-patient hospital or ambulatory center setting, at least annually, reviews all evidence-based clinical practice guidelines, and the protocols or procedures related to critical clinical processes to ensure they are current and represent best practices.

CM.5.1 The evidence-based clinical practice guidelines are reviewed when use is low, or when there are implementation problems, or when variation in outcomes continues, or at least annually when issues are not present that would indicate a shorter review cycle.

CM.5.2 The protocols or procedures that support safe, quality clinical care are reviewed when use is low, or when there are implementation problems, or when variation in the processes continue, or at least annually when issues are not present that would indicate a shorter review.

CM.5.3 Monitoring data and information and known best practices are used in the review and updating of the evidence-based clinical practice guidelines, protocols and procedures.

CM.5.4 Those who use the evidence-based clinical practice guidelines, and the protocols and procedures participate in the review and approve any modifications.

**CM.6 Only properly licensed and trained personnel are providing medical, dental or other healthcare, assessment and treatment services to medical travel patients.

Intent of standards CM.6 through CM.7.4

Patients traveling to an organization to receive clinical procedures or treatments rely on the medical travel program to provide only licensed and trained professional staff. The qualifications of the health professional staff may appear on the medical travel program website or be made known to prospective patients by other means. The medical travel program thus has a very high accountability to ensure that the credentials and experience of the professional staff is accurate and has been verified. Appropriate staff gather all the credentials, education, training, licensure, certifications, and experience of the professional staff member and verify this information from the primary source.

All the credentials of the health professional staff must be current and retained in a file for each professional staff member. Based on the credentials of a health professional staff member, they are permitted by the organization to provide certain patient procedures or treatments that are within the scope of their competency. These conditions also apply to those outside physicians who seek temporary or short-term permission to provide clinical care to a particular patient or provide a particular clinical procedure. Many patient safety incidents can be traced to health professional staff who provide clinical services at the margins of their competency or outside of their documented competency areas.

An important area of professional staff competency is certification in resuscitative care. All staff with direct patient contact should be trained and certified. At least one individual trained in Advanced Cardiac Life Support should be available at all times when patients are being treated in addition to other staff trained in Basic Cardiac Life Support. Designated staff identify the individuals who should be trained and documents that their training is current. The organization supports resuscitative services with necessary equipment and supplies (e.g., crash carts) appropriate to the age and types of patients provided services.

Health professional staff includes physicians, dentists, nurses, physical therapists and others who have completed formal professional training and are licensed or permitted to practice. Those licensed health professionals who are permitted by law and the organization to practice independently - such as physicians, and dentists - are given privileges to provide certain services. Others, such as nurses, dental hygienists, therapists, who provide services under supervision have a job description which identifies the services they are permitted to provide to patients of the medical travel program.

CM.6.1 The credentials of all health professional staff are gathered and kept within the staff members file.

CM.6.2 The credentials of all health professional staff are verified from the primary source when possible.

CM.6.3 The licenses of licensed health professional staff are current and a copy in the staff members file

CM.6.4 The medical travel program or appropriate staff identify what services each health professional is permitted to provide to patients and document this in the staff members file.

**CM.7 Appropriate health professional staff are identified and trained to provide resuscitative services to the patients of the medical travel program.

CM.7.1 All health professional staff to be trained and certified to provide resuscitative services, either basic or advanced, are identified.

CM.7.2 The organization determines the number and training level of staff to be present when patients are receiving services.

CM.7.3 The certification of staff is kept current.

CM.7.4 The certification is documented in the staff members file.

**CM.8 Patient medications are tracked and reconciled across the medical travel care continuum.

Intent of standards CM.8 through CM.8.4

Medications form an important part of patient care around the world. For medical travel patients, the medication management issues are both significant and potentially complex. In addition to the medical and health information collected in advance (See CM.1) the medical travel program requests a complete list of all the patient's current medications, both prescription and non-prescription (over-the-counter), including the brand or generic name, the dosage amount and frequency. From this list, the medical travel program advises the patient on which medications to bring with them to use, and which medications will need to be new prescriptions on arrival. The patient is also informed if any of their medications have different names and dosages at the destination country in the event they need to refill those medications, and if any of the patient's medications will not be permitted through customs on entry or departure. Patients are given guidance on the number of doses to bring with an understanding that there may be travel delays and potential delays in treatment and recuperation. The patient's health care record list all the medications the patient is taking, and those medications added, deleted or changed as the result of the care provided by the medical travel program. At the time of discharge, the patient is given a list of all the medications they are to continue to take and are advised as to the medications and doses to take for the travel home. The medical travel program considers international guidelines on antibiotic stewardship.

CM.8.1 A list of all the patient's medications (names, dose, frequency) is obtained as part of the assessment process prior to travel.

CM.8.2 Patients are advised on which medications to stop or modify the dose, on the quantity of each medication they should bring, and which medications will need to be newly prescribed by the medical travel program, and any limitations or restrictions on bringing medications into the destination country and any restrictions on bringing medications back into the patient's home country.

CM.8.3 The patient's care record contains an up-to-date list of all medications being taken by the patient during care.

CM.8.4 At discharge, the patient is informed as to what continuing or new medications to take and when any medications related to their care can be discontinued.

CM.9 The planned clinical care for each medical travel patient is documented in a plan of care.

Intent of standards CM.9 through CM.9.4

Planning the care for a medical travel patient begins prior to the patient leaving their home and can continue after the patient's arrival at the destination. Medical travel patients may receive a preliminary plan of care to review prior to travel and a final plan of care after arrival and the completion of any diagnostic studies and examinations. Patients are informed as to when and how they will be expected to indicate their acceptance of the plan of care.

The plan of care is a documented description of the multidisciplinary clinical care continuum for the patient. The plan of care for the medical travel patient can be a single integration of medical, nursing, rehabilitation and other services planned by the patient's care team, or it can be separate plans from each member of the team. Any recuperative and follow-up care prior to departure or in the patient's home country is included. The plan of care reflects any unique needs or special considerations that reflect patient values, beliefs and preferences during the care and treatment process. If changes in the plan of care occur, the plan is updated.

> CM.9.1 The care identified for the medical travel patient is documented in a plan of care that is an integration of all procedures, treatments and services to be delivered over the medical travel care continuum.
> CM.9.2 The patient receives a copy of the plan of care in advance or on arrival and agrees to the plan.
> CM.9.3 The plan of care reflects any unique needs or preferences of the patient such as family involvement, religion or faith implications of care choices, learning preferences and recuperation preferences.
> CM.9.4 The plan of care is updated as needed during the care process, and at discharge medical travelers are provided with a copy of their medical records.

**CM.10 Policies and procedures guide how medical emergencies are managed.

Intent of standards CM.10 through CM.10.4

Patient medical emergencies, while not common, require a quick, efficient, and appropriate response by designated staff. Patients may have an emergent situation unrelated to the planned care or may have unexpected complications from the care process. These can occur while receiving care or during the night at the hotel. Policies and procedures are required to guide the response and staff are educated on the policies and procedures including education on the signs of a patient with an emerging problem so an emergency situation can be prevented. For those medical travel programs within an in-patient hospital, the procedures include responsibility for quickly engaging the emergency services of the hospital, including a crash team and use of the emergency department. For ambulatory centers, the procedures include contacting emergency assistance and transport to a facility that can provide the needed critical care. These types of arrangements are planned in advance and may be in a cooperative agreement between the medical travel program or the organization and the critical care site. In all cases, equipment and supplies are readily available to resuscitate and stabilize the patient until emergency help and transport arrives.

> CM.10.1 Policies and procedures guide the timely response to patient emergencies.
> CM.10.2 Emergency equipment and supplies needed to resuscitate and stabilize patients prior to transport are readily available.
> CM.10.3 The relationship between the medical travel program or the organization and the critical care site are planned and documented.
> CM.10.4 Staff are trained on the procedures to ensure early identification of patients with an emerging problem and the timely and appropriate response to any patient emergencies.

**CM.11 Qualified professionals provide sedation and anesthesia services to medical travel patients.

Intent of standards CM.11 through CM.11.4

Medical travel programs frequently facilitate clinical services to patients that require some level of anesthesia. The organization complies with any requirements for licensure of permits to provide anesthesia services. In some instances, patient comfort is achieved with a local injected anesthesia such as for most dental procedures and some

cosmetic surgery procedures. In other, more complex and lengthy procedures, such as multiple dental extractions or extensive cosmetic procedures, the patient may also be sedated through conscious sedation. In the most invasive and complex procedures, such as joint replacement, the patient will be unconscious through general anesthesia. As all these anesthesia modalities can be very dangerous, they should only be used by qualified individuals, usually qualified dentists, physicians and anesthesiologists. As conscious sedation can slowly move to deep sedation and deep sedation to general anesthesia, it is essential that the patient be monitored. Monitoring should not be done by the practitioner providing the procedure - it should be done by a qualified individual with this responsibility. For general anesthesia, this responsibility is given to an anesthesiologist, certified nurse anesthetist or an equivalently trained and certified individual.

The more complex the anesthesia the more equipment is needed to ensure adequate oxygen, and monitor body temperature, blood oxygenation, and vital signs. Equipment required by laws or regulations or national norms is available. Anesthesia patients have adequate time and monitoring in a "recovery" area to ensure they are ready to be moved to an in-patient unit or to a pre-discharge unit. Patients are educated on the anesthesia relevant to their care and are assessed as to readiness for anesthesia in cases such as a recent onset of an upper respiratory infection or cold which could delay the use of anesthesia.

CM.11.1 Selection of appropriate sedation or anesthesia is based on the assessment of the patient and the planned procedure and any licensure or other requirements.

CM.11.2 Administration of sedation and anesthesia is performed by qualified individuals.

CM.11.3 Patients are monitored during sedation and anesthesia by a qualified individual.

CM.11.4 Patients are monitored during recuperation from sedation and anesthesia and criteria are used for decisions to move the patient to an in-patient care unit or to a pre-discharge unit.

THE FOLLOWING DOCUMENTS ARE RECOMMENDED AS EVIDENCE OF COMPLIANCE WITH THE CARE MANAGEMENT STANDARDS AND SHOULD BE AVAILABLE FOR THE GHA ASSESSMENT TEAM TO EVALUATE ON-SITE

Reference Standard	Suggested Documents and other sources of evidence to demonstrate standards compliance
CM.1	Any document that is used to standardize the collection of pre-arrival clinical information
CM.2	Any document that is used to standardize the admission process and continued patient assessment post-arrival
CM.3	Copies of the evidence-based clinical practice guidelines for the primary clinical procedures and services provided
CM.4	Copies of any protocols or procedures used to standardize other clinical processes
CM.5	Monitoring data on the use of evidence-based clinical practice guidelines
CM.6	Copies of policies and procedures used to assess the qualifications of health professional staff
CM.7	Any policies or procedures on resuscitative services and staff training
CM.8	Any policies, procedures, forms, etc., used to ensure safe medication management from pre-arrival to discharge
CM.9	Copies of clinical plans of care showing patient acceptance, any special considerations, updating, etc.
CM.10	Copies of policies and procedures that guide the care of patients with medical emergencies

CM.10	Documentation of arrangements with critical care sites for emergency needs of medical travel program patients
CM.11	The staff records of those qualified to administer sedation or general anesthesia
CM.11.3	The protocol for monitoring patients undergoing sedation or general anesthesia

The Patient Experience

Cultural Competency (CC)

Overview

Culture can be defined as "the beliefs and behaviors shared by members of a group." Culturally competent care is essentially patient-centered care. It is an ongoing process of evaluating beliefs, practices, structures and policies in order to plan for and incorporate cultural and linguistic competency within the medical travel program.

The leaders of the organization need to consider the importance of:

- Incorporating a diverse workforce reflecting target patient populations as much as possible;
- Incorporating cultural competency into all policies and procedures;
- Making language assistance available for patients based on the patient's preferred language;
- Offering ongoing staff training regarding delivery of culturally and linguistically appropriate services; and
- Tracking quality of care and patient perception of care across language, racial, ethnic, and cultural subgroups.

Cultural sensitivity is especially important within the context of medical travel, where patients from many cultural backgrounds are traveling for healthcare away from their home.   Cultural sensitivity and awareness breaks down barriers, reduces the potential for errors and ultimately promotes better outcomes. According to the National Center for Cultural Competence, "Cultural competence requires that healthcare providers and their personnel have the capacity to: (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of individuals and communities served."

Standards

**CC.1 The leaders of the medical travel program support and implement cultural competence into all aspects of the medical travel care continuum.

Intent of standards CC.1 through CC.1.4

Cultural competency comes about through leadership, relevant policies and procedures, and staff commitment and training. Competency is expressed in many ways such as recognizing how diverse populations access services, prefer to learn and be educated, choose the treatment times and schedule, involve family and travel companions in their choices, observe religious and other traditions during the day, value traditional healers and treatments, dietary choices and beliefs about outcomes and healing, and provide consent for care and services. For example, in some cultures an adult relative signs consent forms on the patient's behalf. Even infection control policies need to consider cultural beliefs such as the use of alcohol in disinfection procedures. Cultural competency is expressed in all phases of the medical travel care continuum.

CC.1.1 The values, beliefs, spirituality, language, diet and other preferences of the target populations served by the medical travel program are identified.

CC.1.2 The identified cultural preferences are supported by leadership and respected by all staff.

CC.1.3 The clinical and operational policies and procedures of the medical travel program are designed to support culturally and linguistically appropriate services and processes.

CC.1.4 The medical travel program or a designated department makes available surgical and procedural consent forms, patient rights statements, and other key documents in the patient's language of choice.

CC.2 The clinical and non-clinical workforce of the organization are culturally competent.

Intent of standards CC.2 through CC.2.4

True cultural competence for a medical travel program is expressed by the staff who interact with patients and families on a daily basis. This essential staff attribute comes about from the recruitment and orientation through daily support and on-going training. As the target patient populations of the medical travel program may change, or even the preferences of existing patient populations may change over time, the training will need to continuously evolve. Cultural competencies are incorporated into recruitment materials, job descriptions, as well as performance reviews. As medical travel programs cannot be culturally competent in the needs and preferences of every population group, the program has identified external or internal resources for translation and interpretation services when required or requested.

CC.2.1 The organization employs, or contracts for, a diverse, culturally, and linguistically competent clinical and non-clinical workforce.

CC.2.2 The medical travel program or a designated department provides cultural competency training as a component of a comprehensive education and training program for all staff, including new staff orientation, ongoing in-service training and professional development.

CC.2.3 The organization incorporates cultural competence into position descriptions and performance evaluations for all clinical and non-clinical staff.

CC.2.4 The medical travel program makes available professional interpreters for patients based on patient needs or upon request.

THE FOLLOWING DOCUMENTS ARE RECOMMENDED AS EVIDENCE OF COMPLIANCE WITH THE CULTURAL COMPETENCY STANDARDS AND SHOULD BE AVAILABLE FOR THE GHA ASSESSMENT TEAM TO EVALUATE ON-SITE.

Reference Standard	Suggested Documents and other sources of evidence to demonstrate standards compliance
CC.1.1	A description of the target populations served by the medical travel program
CC.1.3	An example or two of a policy or procedure that reflects the influence of cultural preferences
CC.1.4	Consent forms, patient rights, or other documents in the language of target populations
CC.2.1	Any data on the diversity of the medical travel program workforce
CC.2.2	An example of a staff education that includes cultural competency training
CC.2.3	An example of a job description that include cultural competency expectations
CC.2.3	An example of a performance review that includes an assessment of cultural competency
CC.2.4	A list of available interpreters

Sustainable Business Processes

Leadership and Risk Management (LR)

Overview

Strong, proactive leadership is the basis of good business health in a medical travel program. The GHA Program defines business health as the ability of an organization to identify, maintain and continuously improve its ability to manage daily operations and proactively minimize risks to patients and the medical travel program over time. The GHA Program recognizes business health as a foundational component of building a sustainable medical travel program. Whether the medical travel program's focus is on domestic, regional, or international patients, the overall ability of the medical travel program to maintain a broad understanding of the needs of a medical traveler as well as to proactively mitigate risks, is a set of competencies that any medical travel program must acquire.

Standards

Leadership

LR.1 The leaders of the medical travel program are accountable for maintaining the business health of the program.

Intent of standards LR.1 through LR.2.4

Leadership is an important factor in the development, implementation and continued ability to operate a medical travel program as an independent business initiative or as a business unit within a healthcare organization such as an in-patient hospital or ambulatory center. Whatever the size of the medical travel program, strong leadership and business skills are essential. The accountabilities of leaders need to be clearly identified and the organizational structure appropriate for the size and services provided. One example of accountability is to ensure compliance with all applicable laws and regulations for the medical travel program. The leaders need to be qualified and then supported with information on the medical travel industry so the program can be competitive and sustained over time.

LR.1.1 The medical travel program has identified leaders and has an effective management structure for the size and activity level of the program.

LR.1.2 The leaders are accountable for strategic and operational planning and financial performance goals, as well as the monitoring of the performance of any contracted vendors (eg, ground transportation, hospitality, translation services, etc) which support the goals and objectives of the medical travel program.

LR.1.3 The leaders are accountable for the development and approval of the mission and vision statements, and the code of conduct.

LR.1.4 The leaders are accountable for the continuous improvement of the quality and patient safety of the medical travel program.

LR.2 The leaders of the medical travel program are qualified through education, experience and current knowledge of the medical travel industry.

LR.2.1 The education and experience of the clinical and managerial leaders of the medical travel program are appropriate for the size and services of the program.

LR.2.2 The leaders have the knowledge and experience to create and maintain a sustainable business model for the medical travel program.

LR.2.3 The leaders have access to the resources required to align the medical travel program with global healthcare trends and be competitive in the medical travel market.

LR.2.4 The leaders provide in-service education to staff related to the various staff roles in the medical travel care continuum.

Risk Management

**LR.3 The organization has a documented risk management plan for the medical travel program.

Intent of standards LR.3 through LR.4.4

Traditionally, risk management has been a process for identifying, assessing, and prioritizing risks of different kinds. The multiple components of the medical travel care continuum add a new dynamic to traditional risk management. For example: the logistics in travel add patient health and travel interruption risks; the communications between healthcare professionals in two different countries can increase the risk of misunderstandings and increase clinical risks, and hotel arrangements may not be as expected and the risk of poor patient and companion satisfaction increases.

In addition, there is the risk that the patient's personal medical information may not be complete or may not be kept confidential; and the risk that a dissatisfied patient may seek legal recourse.
Medical travel programs need to identify all such areas of risk and determine how they can best limit their exposure through risk mitigation, including risks to patients in services managed by contracted vendors. Risk mitigation is about understanding risks that can impact patient care and treatment, can impact a medical travel program's reputation, or can impact the business health of the medical travel program. Medical travel programs can use many strategies to mitigate and manage these types of risks. Examples of risk mitigation strategies for medical travel patients include:

- Ensure that there are immediately accessible individuals who can communicate with the patient in the language of their choice to mitigate circumstances in which language and understanding is critical;
- Ensure there are criteria in place for accepting medical travel patients;
- Ensure there is a process to determine when medical travel patients are fit to return home after surgery or treatment;
- Ensure protocols are in place for managing clinical emergencies during recuperation and for follow-up care in the patient's home country.
- Ensure protocols are in place to reduce the risk of medical complications on airline flights.
- Implement tourism safety guidelines and acceptable tourism venues to visit to limit risks in the destination community or country.
- Ensure that all employees and visitors are appropriately identified and the physical facility is secure.

Medical travel programs may be within regions or cities with social disorder, war, street protests and other conflicts. Such situations can occur in any place around the world without advance warning. All organizations, even those in lower risk environments, need to reduce risks that individuals enter the program's facility for reasons of theft or disturbance. Adequate facility security and identification badges for all staff and visitors is an important risk mitigation step. In addition, the medical travel program needs to determine its level of transparency to the medical travel patient about any actual or potential conflicts or social disorder that may occur in the region or country, and the safety and security measures in place in the program's facility to increase the patient's sense of wellbeing or affect the medical travel program's ability to successfully treat the patient.

Because of the many phases of the medical travel care continuum and the complexity of travel for care and treatment to frequently new and unfamiliar destinations, the medical travel program or a designated department needs to identify probable risks and mitigation strategies in a documented plan. The risk management plan for the medical travel program may be a component of the in-patient hospital's overall plan or a component of the ambulatory center's plan.

LR.3.1 There is a documented risk management plan that identifies risks to patients and environmental risks.
LR.3.2 The risk management plan sets priorities for risk identification, management and mitigation throughout the medical travel care continuum.
LR.3.3 There is a system for the identification and collection of patient-specific risk data such as medical or dental patient or family medical histories, past history of surgical or procedure complications, or allergies to medications and foods.
LR.3.4 There are protocols or procedures for the further screening of those patients that fit within the overall risk tolerance of the medical travel program, including screening for current medical conditions such as diabetes, high blood pressure or communicable diseases.

LR.4 Patient engagement and risk mitigation are components of the risk management plan.

LR.4.1 Effective communication mechanisms are used with patients as a means of mitigating risk and reducing potential liability exposure.
LR.4.2 There are protocols or procedures for addressing treatment complications that occur once the patient has returned home.
LR.4.3 The organization takes responsibility and has appropriate insurance related to complications that occur as a result of error or negligence on the part of the program, the hospital or ambulatory center if appropriate, or the licensed care provider.
LR.4.4 An adverse incident reporting system is maintained that incorporates the unique vulnerabilities of medical travel patient services.

Human Resources

LR.5 There are transparent processes to manage human resources in the medical travel program.

Intent of standards LR.5 through LR.5.4

Understanding how to appropriately scale up and maintain a competent workforce within a medical travel program is crucial to creating a sustainable business model. Key clinical and non-clinical staff may work full time or be shared with other healthcare organizations. For example, an ambulatory medical travel program may contract with a local hospital

for anesthesia support or for surgical support. Medical travel programs within a hospital may have access to all the health professional staff in the hospital.

As many potential medical travel patients select a particular program based on the credentials of the professional staff, the medical travel program makes available the profiles of key staff, such as the credentials of the surgeon, dentist, therapist, etc. The profile includes education and training, experience and accomplishments. Valid outcome data is included when available. This information may be on the website of the medical travel program or provided directly upon request of the potential patient.

Whatever the source of the staff, they need to be aware of and support the unique needs of the medical travel patient. This is accomplished through an orientation and training program. Additionally, all clinical and non-clinical staff of the medical travel program or who commonly treat or serve medical travelers, have an annual performance review. Finally, the medical travel program participates in the review of those staff who also provide services to medical travel program patients.

LR.5.1 Physician and other health professional profiles are available, including their education and training, experiences and accomplishments and outcome data when available and validated.

LR.5.2 Policies and procedures are developed and adopted that support the recruitment, education, orientation and management of staff responsible for medical travel program care continuum.

LR.5.3 Staff working directly with medical travel patients during the medical travel care continuum receive appropriate orientation.

LR.5.4 Performance reviews are conducted at least annually, for all staff of the medical travel program.

LR.6 The leaders of the medical travel program are accountable for the assessment and use of technology in the medical travel care continuum.

Intent of standards LR.6 through LR.6.4

Globally, more hospitals, dental practices and other specialties are using medical technology such as electronic medical records, interactive websites, mobile devices and social media to educate and communicate with patients and with other providers. Physicians, dentists and other specialists, while on the job can now have access to any type of information they need – from drug information, research and studies, patient history or records, and more – within mere seconds. Internet applications can aid in identifying potential health threats and examining digital information like x-rays and CT scans for the medical travel patient.

The wise and effective use of new technologies and the application of the technologies to the medical travel care continuum is the responsibility of the leaders of the medical travel program. One such responsibility is to ensure the availability of technology training and support for the medical travel program.

LR.6.1 The leaders of the medical travel program or a designated department are accountable for evaluating new and existing technologies in the context of the overall medical travel care continuum, including clinical, patient experience and business processes.

LR.6.2 The leaders of the medical travel program or a designated department provide guidance to the professional staff for the acceptable use of technology in the patient care management process.

LR.6.3 The medical travel program or a designated department ensures appropriate use of technology by providing technology information and resources in a language that can be understood by users, patients and staff.

LR.6.4 The medical travel program or a designated department provides or contracts for timely technology support to ensure continuous, effective and appropriate education and use.

THE FOLLOWING DOCUMENTS ARE RECOMMENDED AS EVIDENCE OF COMPLIANCE WITH THE LEADERSHIP AND RISK MANAGEMENT STANDARDS AND SHOULD BE AVAILABLE FOR THE GHA ASSESSMENT TEAM TO EVALUATE ON-SITE.

Reference Standard	Suggested Documents and other sources of evidence to demonstrate standards compliance
LR.1.1	The program organizational chart showing leaders and management structure
LR.1.2	The strategic, operational and financial plans of the medical travel program
LR.1.3	The mission, vision statements and code of conduct for the medical travel program
LR.2.1, 2.2	The credentials of the leaders
LR.2.4, LR.5.3	Documentation of staff education
LR.3.1, LR.3.2	The document describing the risk management program and priorities
LR.3.4	The protocol for risk screening of patients
LR.4.2	The protocol or procedure to manage the situation when complications arise
LR.5.1	Profiles of key professional staff
LR.5.2	Policies and procedures for staff recruitment and management
LR.5.4	Samples of staff performance reviews
LR.6.1	Description of the technology assessment process
LR.6.2	Documents describing the acceptable use of technology in patient care
LR.6.4	Arrangements for technology training and support