This is a blank copy of the reaccreditation application available in the OpenWater platform provided for informational purposes only. Once a signed Business Associate Agreement (BAA), Accreditation Program Agreement (APA), and fee have been submitted, applicants will be provided with a link to OpenWater to create their account and begin their application.

Adult Congenital Heart Association

Page: Introduction

The online application for the ACHA ACHD Accreditation Program is broken into two sections. The first section is for text entry of general information such as program location, outpatient locations, and provider information. This section also includes all of the CV, ACLS, and additional certification uploads required for the application. Each part of this section of the application is broken down by the criteria (Section A. ACHD Cardiologist(s)/B. ACHD Medical Program Director etc.).

The second part of the application is for the policy and procedure documentation and any additional files. This section is labeled "Policies/Procedures."

Please upload documents as PDFs and not word documents.

You do not have to answer sections of the applications or questions in order, but be sure to save your entered information at the bottom of the page.

If you move onto a different section and dont save your information, we are unable to recover the unsaved information and you will need to type it all again.

Page: Pre-Application Questions

The following questions are provided to allow an opportunity to indicate any changes within the program over the last five years. These questions help focus and expedite the review of your program's application, documentation and scheduling of a site visit.

Has the ACHD Program Medical Director changed in the last five years?

Have new ACHD Cardiologists joined the team in the last five years?

Does the program have at least 2 ACHD Board Certified/Eligible Cardiologists?

Has the ACHD APP changed in the last five years?

Has the ACHD RN changed in the last five years?

Has the Director of Congenital Cardiothoracic Surgery changed in the last five years?

Does the program have at least 2 CHD-Board Certified cardiothoracic surgeons?

Have there been any changes to the Heart Failure team that collaborate with the ACHD team in the last five years?

Have there been any changes to the Interventional Cardiology team that collaborate with the ACHD team in the last five years?

Have there been any changes to the Electrophysiology team that collaborate with the ACHD team in the last five years?

Have there been any changes in the imaging team (echocardiography, MRI, CT) in the last five years?

Have there been any changes to the Maternal Fetal Medicine team that collaborates with the ACHD team in the last five years?

Has the ACHD social worker changed in the last five years?

Please list any major structural changes (i.e. mergers, acquisitions) within the hospital(s) the ACHD program is associated with in the last five years?

Have there been any changes in institutional/ departmental leadership in the past five years? If yes, please indicate personnel below (check all that apply)

Page: Information Collection

Accreditation Contact (the person managing the application)

Role in Program

Email Address

Phone #

Address of ACHD Program

US

Closest / Most Convenient Airport

Program Structure

Page: A. ACHD Cardiologist(s) / B. ACHD Medical Program Director

A1. How many ACHD Board Certified or ACHD Board Eligible Cardiologists does your program have?

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

A2. Board certified / Board eligible in pediatric or internal medicine cardiology

A3. Board eligible for ACHD certification / Board certified in ACHD cardiology (per ABIM board certification)

A4. ACLS Certified

Examples should be within the past 5 years including lectures given and articles published.

A5(1). Describe how they educate professionals interested in learning more about the ACHD field.

A5(2). Provide links to their publications (please provide the last 5 publications related to ACHD).

A5(3). Describe their participation in CME ACHD education.

A5(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

CV

No File Uploaded

ACLS Certification

No File Uploaded

B1. ACHD Medical Program Director?

B3. Who from your organization attended the Adult Congenital Heart Association (ACHA) National Conference and/or Regional Conference/Legislative Conference in the last six years?

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

A2. Board certified / Board eligible in pediatric or internal medicine cardiology

A3. Board eligible for ACHD certification / Board certified in ACHD cardiology (per ABIM board certification)

A4. ACLS Certified

Examples should be within the past 5 years including lectures given and articles published.

(There are 2.5 years to implement this piece of criteria)

A5(1). Describe how they educate professionals interested in learning more about the ACHD field.

A5(2). Provide links to their publications (please provide the last 5 publications related to ACHD).

A5(3). Describe their participation in CME ACHD education.

A5(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

CV

No File Uploaded

ACLS Certification

No File Uploaded

B1. ACHD Medical Program Director?

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

A2. Board certified / Board eligible in pediatric or internal medicine cardiology

A3. Board eligible for ACHD certification / Board certified in ACHD cardiology (per ABIM board certification)

A4. ACLS Certified

Examples should be within the past 5 years including lectures given and articles published.

(There are 2.5 years to implement this piece of criteria)

A5(1). Describe how they educate professionals interested in learning more about the ACHD field.

A5(2). Provide links to their publications (please provide the last 5 publications related to ACHD).

A5(3). Describe their participation in CME ACHD education.

A5(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

CV

No File Uploaded

ACLS Certification

No File Uploaded

B1. ACHD Medical Program Director?

Add another ACHD Board Certified or ACHD Board Eligible Cardiologist

Page: C. Advanced Practice Nurse / Physician Assistant

C1. How many 1.0 FTE Advanced Practice Nurse / Physician Assistants do you have within your ACHD Program?

Name

Institution

Address

US

Type of advanced practice provider

Title

Medical License Number

Years Practicing ACHD

Type of provider

C2. Please indicate if the Advanced Practice Nurse / Physician Assistant are ACLS Certified.

Examples should be within the past 5 years including lectures given and articles published

C3(1). Describe how they educate professionals interested in learning more about the ACHD field

C3(2). Provide links to their publications (please provide the last 5 publications related to ACHD)

C3(3). Describe their participation in CME/CNE ACHD education

C3(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

Advanced Practice Nurse / Physician Assistant's CV

No File Uploaded

C2. ACLS certification

No File Uploaded

Do you want to add another Advanced Practice Nurse / Physician Assistant?

Name

Institution

Address

US

Type of advanced practice provider

Title

Medical License Number

Years Practicing ACHD

Type of provider

C2. Please indicate if the Advanced Practice Nurse / Physician Assistant are ACLS Certified.

Examples should be within the past 5 years including lectures given and articles published

(There are 2.5 years to implement this piece of criteria)

C3(1). Describe how they educate professionals interested in learning more about the ACHD field

C3(2). Provide links to their publications (please provide the last 5 publications related to ACHD)

C3(3). Describe their participation in CME/CNE ACHD education

C3(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

Advanced Practice Nurse / Physician Assistant's CV

No File Uploaded

C2. ACLS certification

No File Uploaded

Name

Institution

Address

US

Type of advanced practice provider

Title

Medical License Number

Years Practicing ACHD

Type of provider

C2. Please indicate if the Advanced Practice Nurse / Physician Assistant are ACLS Certified.

Examples should be within the past 5 years including lectures given and articles published

(There are 2.5 years to implement this piece of criteria)

C3(1). Describe how they educate professionals interested in learning more about the ACHD field

C3(2). Provide links to their publications (please provide the last 5 publications related to ACHD)

C3(3). Describe their participation in CME/CNE ACHD education

C3(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

Advanced Practice Nurse / Physician Assistant's CV

No File Uploaded

C2. ACLS certification

No File Uploaded

Do you want to add another Advanced Practice Nurse / Physician Assistant?

Page: D. Registered Nurse

D1. How many 1.0 FTE Registered Nurses do you have within your ACHD Program

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

D2. Please indicate if the Registered Nurses are ACLS Certified

Examples should be within the past 5 years including lectures given and articles published

D3(1). Describe how they educate professionals interested in learning more about the ACHD field

D3(2). Provide links to their publications (please provide the last 5 publications related to ACHD)

D3(3). Describe their participation in CME/CNE ACHD education

D3(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

Registered Nurse CV

No File Uploaded

D2. ACLS certification

No File Uploaded

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

D2. Please indicate if the Registered Nurses are ACLS Certified

Examples should be within the past 5 years including lectures given and articles published

(There are 2.5 years to implement this piece of criteria)

D3(1). Describe how they educate professionals interested in learning more about the ACHD field

D3(2). Provide links to their publications (please provide the last 5 publications related to ACHD)

D3(3). Describe their participation in CME/CNE ACHD education

D3(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

Registered Nurse CV

No File Uploaded

D2. ACLS certification

No File Uploaded

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

D2. Please indicate if the Registered Nurses are ACLS Certified

Examples should be within the past 5 years including lectures given and articles published

(There are 2.5 years to implement this piece of criteria)

D3(1). Describe how they educate professionals interested in learning more about the ACHD field

D3(2). Provide links to their publications (please provide the last 5 publications related to ACHD)

D3(3). Describe their participation in CME/CNE ACHD education

D3(4). Describe their time spent in the service of CHD/ACHD organizations (describe membership / leadership in organizations over the past 5 years).

Registered Nurse CV

No File Uploaded

D2. ACLS certification

No File Uploaded

Do you want to add another Registered Nurse?

Page: E. Cardiothoracic Surgery and Cardiothoracic Intensive Care Unit

E4. How many CHD surgeons are there in your program?

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

E4. Board Certified as a Congenital Heart Surgeon by the American Board of Thoracic Surgery

E2. Please indicate if the CHD surgeon is ACLS certified

E1. ACHD Surgical Director?

Surgeon Letter

No File Uploaded

CV

No File Uploaded

E2. ACLS Certification

No File Uploaded

Add another CHD surgeon

First Name

Last Name

Title

E4 Does your facility have 24/7 ACHD surgical availability?

E7 Does your program have cardiac transplantation available for transfer to a center that performs cardiac transplantation?

E8. Does your institution’s definition of CHD Surgery include, but is not limited to:

Page: F. Heart Failure, Heart Transplant, Heart / Lung Transplant

F1. How many Heart Failure Cardiologists do you have in your program?

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

F1. Board Certified Heart Failure Cardiologist.

F1. Board Eligible Heart Failure Cardiologist.

CV

No File Uploaded

Do you want to add another Heart Failure Cardiologist?

Page: G. Interventional Cardiac Catherization

G1. How many invasive cardiologists work with the ACHD program?

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

Number of ACHD cases over the past 12 months

CV

No File Uploaded

ACLS Certification

No File Uploaded

Training narrative

No File Uploaded

Would you like to add another invasive cardiologist?

First Name

Last Name

Title

CV for the head of adult interventional cardiology

No File Uploaded

First Name

Last Name

Title

CV for the head of pediatric interventional cardiology

No File Uploaded

G2/G3. Confirm you have uploaded or will upload documentation within CT Surgery (Section E) criteria stating that there is 24/7 surgical availability

G4. Does your facility have 24/7 emergency access to an operating room?

G5. Does your facility have access and availability of CT surgery, open chest resuscitation, ECMO?

Page: H. Interventional Electrophysiology

H1. How many EP specialists work with the ACHD program?

Name

Institution

Address

US

Title

Medical License Number

Years Practicing ACHD

Type of provider

CV

No File Uploaded

ACLS Certification

No File Uploaded

Add another EP specialist

H3. Confirm your institution has 24/7 ACHD Surgical availability including Mechanical Circulatory Support

H4. Confirm 24/7 emergency access to the operating room

H5. Confirm availability and access to ACHD CT surgery, open chest resuscitation, ECMO and IABP

Page: I. Inpatient Services

Where are ACHD patients seen on the inpatient side

I2. Do you have access to ACHD imaging, invasive cardiac procedures, CT surgery while inpatient?

First Name

Last Name

Title

Page: J. Outpatient Services

How many half-day clinic sessions does your program have per week?

How many outpatient facilities do you see ACHD patients at?

Site Name

Which ACHD cardiologists work at this location?

Address

US

Type of facility

Site Name

Which ACHD cardiologists work at this location?

Address

US

Type of facility

Site Name

Which ACHD cardiologists work at this location?

Address

US

Type of facility

Site Name

Which ACHD cardiologists work at this location?

Address

US

Type of facility

Add another outpatient facility

Briefly describe a typical clinic week for your ACHD program. (Max 1000 words)

J3. Please provide the URL for your ACHD Program website

Plan to develop a website if necessary

No File Uploaded

Phone number

J4. Does your program have the availability for an initial appointment within 4 weeks for new patients

J5. Are urgent patients evaluated by the ACHD team within 48 hours?

J6. Do office notes or the electronic medical records have an indication that communication to the referring physician has been complete?

J12. Do you have a verifiable database (e.g. method of documentation) of ACHD patients and services?

J12. What is your verifiable database used to document ACHD patients and services and what are the limitations?

J13. Appropriate facilities and equipment for adult patients?

First Name

Last Name

Title

Page: K. Transitional Services

Please refer to the Policies/Procedures section of the application to upload policies and procedures or additional files associated with this part of the application

Page: L. Patient-Centered Care

L1. Does your program integrate patient centered care into the program mission statement?

L2. Do you have policies to promote PCC?

First Name

Last Name

Title

L4. Does your team team's participate in training programs/educational sessions designed to promote PCC?

L5. Confirm you have a Patient and Family Advisory Council (PFAC) and have provided or will provide documentation of structure of PFAC and improvements in quality of care in the Policies/Procedures section.

L6. Confirm you collect patient feedback, experience and satisfaction for the ACHD program and have provided or will provide documentation of how tools/methods have been used to improve quality care in the Policies/Procedures section.

L7. Do you have a written strategy for healthcare providers to partner with, educate, and engage patients/families in all stages of care delivery.

Page: M. Echocardiography

M1. Do you have access to 24/7 echocardiography (echo)?

M2. How many CHD sonographers work with the ACHD program?

Name

Institution

Address

US

Title

Certifications (i.e. RDCS)

Years Practicing as a CHD sonographer

CV

No File Uploaded

Additional certifications

No File Uploaded

Add another sonographer

First Name

Last Name

Title

Name

Institution

Address

US

Title

How long have they been performing and interpreting echo's

CHD team member who specializes in echocardiography’s CV

No File Uploaded

Additional certifications for CHD team member specialized in echocardiography’s CV

No File Uploaded

First Name

Last Name

Title

M4. Confirm echo team meets with ACHD program at least once a year to review performance and quality. Documentation has been provided or will be provided in Policies/Procedures section that outlines quality improvement metrics and changes to policies/procedures as a result of performance and quality review meetings.

Page: N. Cardiac Magnetic Resonance Imaging (MRI)

N1. Do you have access to cardiac magnetic resonance imaging?

N2. Radiologist(s) and/or cardiologist(s) experienced in CHD

Name

Institution

Address

US

Title

Medical License Number

CV

No File Uploaded

Additional certifications

No File Uploaded

Add another radiologist(s) and/or cardiologist(s) experienced in CHD

N3. Confirm MRI team meets with ACHD program at least once a year to review performance and quality. Documentation has been provided or will be provided in Policies/Procedures section that outlines quality improvement metrics and changes to policies/procedures as a result of performance and quality review meetings.

First Name

Last Name

Title

Page: O. Cardiac Computed Tomography

O1. Do you have access to Cardiac Computed Tomography (CT) scan?

O2. Radiologist(s) and/or cardiologist(s) experienced in CHD

First Name

Last Name

Title

Add another radiologist(s) and/or cardiologist(s) experienced in CHD

O3. Confirm CT team meets with ACHD program at least once a year to review performance and quality. Documentation has been provided or will be provided in Policies/Procedures section that outlines quality improvement metrics and changes to policies/procedures as a result of performance and quality review meetings.

First Name

Last Name

Title

Page: P. Pulmonary Arterial Hypertension

Name

Institution

Address

US

Title

Medical License Number

Years Practicing as an ACHD provider

First Name

Last Name

Title

Confirm PAH team meets with ACHD program at least once a year to review performance and quality. Documentation has been provided or will be provided in Policies/Procedures section that outlines quality improvement metrics and changes to policies/procedures as a result of performance and quality review meetings.

CV for PAH consultant

No File Uploaded

Page: Q. Exercise Testing and Cardiac Rehabilitation

Access and onsite availability to the following equipment and
testing:
a. Exercise test
b. Metabolic cardio-pulmonary testing
c. Stress imaging (nuclear, MRI, echo)
d. Standardized Six minute walk test

Q1(a). Do you have access and onsite availability to exercise tests?

Q1(b). Do you have access and onsite availability to metabolic cardiopulmonary testing?

Q1(c). Do you have access and onsite availability to stress imaging (nuclear, MRI, echo)?

Q1(d). Do you have access and onsite availability to standardized six minute walk test?

Q2. Do you have access and availability to cardiopulmonary rehabilitation programs?

Q3. Do you have ACHD team members available for collaboration with medical staff performing and interpreting exercise testing and cardiopulmonary rehab?

First Name

Last Name

Title

First Name

Last Name

Title

Q4. ACLS certification for the provider who oversees exercise testing for ACHD patients.

No File Uploaded

Page: R. Reproductive Services

R5(b). Do ACHD providers have consulting privileges in the obstetrical unit where ACHD patients are admitted?

First Name

Last Name

Title

R8: Are women with ACHD AP classification IB-D, IIA-D, and IIIA-D managed collaboratively during pregnancy by ACHD cardiologists, MFM obstetricians, and OB anesthesiologists and in consultation with cardiac anesthesiologists for AP classification I-D, and IIC-D and IIIC-D?**

Page: S. Psychology and Social Work

How many Licensed Social Workers/Care Managers work with the ACHD Program

Name

Institution

Address

US

Title

Medical License Number

Years Practicing as an LSW

Social Worker / Care Manager's CV

No File Uploaded

Name

Institution

Address

US

Title

Medical License Number

Years Practicing as an LSW

Social Worker / Care Manager's CV

No File Uploaded

Name

Institution

Address

US

Title

Medical License Number

Years Practicing as an LSW

Social Worker / Care Manager's CV

No File Uploaded

Would you like to add another Social Worker / Care Manager?

Page: T. Cardiac Anesthesia

T1. Is perioperative anesthesia support provided by or in consultation with a cardiac anesthesiologist either trained, and/or with experience* in CHD for adult congenital patients with AP classification IC-D, and IIA-D and IIIA-D patients undergoing cardiac intervention (CT surgery, interventional cardiac catheterization, electrophysiologic procedure) or non-cardiac procedure?

T2. Is perioperative anesthesia support provided by a cardiac anesthesiologist either trained, and/or with experience* in CHD for adult congenital patients with AP classification I-D, and IIC-D and IIIC-D patients undergoing elective cardiac interventions (CT surgery, interventional cardiac catheterization, electrophysiologic procedure) or non-cardiac procedure?

Page: Policies/Procedures

B2.

No File Uploaded

Any additional files (not required)

No File Uploaded

Any additional files (not required)

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Any additional files (not required)

No File Uploaded

E3.

No File Uploaded

E4.

No File Uploaded

E6.

No File Uploaded

E6.

No File Uploaded

Any additional files (not required)

No File Uploaded

F2.

No File Uploaded

F3.

No File Uploaded

F4.

No File Uploaded

Any additional files (not required)

No File Uploaded

G1.

No File Uploaded

G2.

No File Uploaded

Any additional files (not required)

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H1.

No File Uploaded

H2.

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H2.

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Any additional files (not required)

No File Uploaded

I1.

No File Uploaded

I3.

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I3.

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I4.

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I5.

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Any additional files (not required)

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J2

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J4.

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J7.

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J8.

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J9.

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J10.

No File Uploaded

J11.

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J14.

No File Uploaded

Any additional files (not necessary)

No File Uploaded

K1.

No File Uploaded

K2.

No File Uploaded

K3.

No File Uploaded

Any additional files (not necessary)

No File Uploaded

L1.

No File Uploaded

L2.

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L4.

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L5.

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L6.

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L7.

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Any additional files (not necessary)

No File Uploaded

M1.

No File Uploaded

M4.

No File Uploaded

Any additional files (not required)

No File Uploaded

N3.

No File Uploaded

Any additional files (not required)

No File Uploaded

O3.

No File Uploaded

Any additional files (not required)

No File Uploaded

P2.

No File Uploaded

Any additional files (not required)

No File Uploaded

R1.

No File Uploaded

R2.

No File Uploaded

R3.

No File Uploaded

R4.

No File Uploaded

R5.

No File Uploaded

R6.

No File Uploaded

Any additional files (not required)

No File Uploaded

S1.

No File Uploaded

S2.

No File Uploaded

Any additional files (not required)

No File Uploaded

Any additional files (not required) (2)

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