Disease Specific Care Core and Advanced Certification Programs

Review Process Guide

January 2025

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Disease Specific Care
Core and Advanced Certification Programs

Review Process

"What's New in 2025"

New or revised content for 2025 is identified by underlined text in the activities noted below.

Changes effective January 1, 2025

Single guide for both reviewers and organizations.

The Review Process Guide (RPG) has been streamlined to more closely align with the revisions made in the DSC core standards.

New York State Stroke Specific Requirements - Updated the Vascular Imaging and Process and Outcomes Measures and Data Collection section contents for Primary Stroke Centers (PSC), Thrombectomy-Capable Stroke Centers (TSC) and Comprehensive Stroke Centers (CSC).

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Part I: Review Preparations

General Guidance and Overview

The purpose of the ***Review Process Guide (RPG)*** is to inform organizations and reviewers about the Disease Specific Care certification review process.

For all core and advanced certification programs, organizations are encouraged to download and review the agenda (as applicable to their program). The agendas can be obtained at the following website: Review Agenda | The Joint Commission

Or copy and paste this web address: https://www.jointcommission.org/jc-connect/review-agenda

The review process includes the program having knowledge of the DSC chapter requirements listed in the ***Comprehensive Certification Manual for Disease Specific Care*** **(DSC),** implementation of those requirements, and adherence to clinical practice guidelines.

Organizations should also be familiar with ***Perspectives*** articles which are posted monthly to the organization's *Connect* (extranet) site that provides any updates of new and/or revised DSC program requirements.

Pre-Review Outreach
A Joint Commission account executive will contact the organization by phone or email shortly after receiving the application for certification or recertification. The purpose of this call or email with the account executive is to:

- Confirm information reported in the application for certification or recertification
- Verify travel planning information and directions to office(s) and facilities, as applicable to the onsite review.
- Confirm access to The *Joint Commission Connect* extranet site and the certification-related information available there.
- Confirm accuracy of any program-specific eligibility requirements, such as any pertinent volumes and procedures performed. (see also, the *Comprehensive Certification Manual for Disease Specific Care-General Eligibility Requirements)*
- Confirm clinical practice guidelines used by the program and any audited registry requirements. (For DSC core programs, please see the *Comprehensive Certification Manual for Disease Specific Care-Table 2. Approved Clinical Practice Guidelines)*
- Answer any organization questions and address any concerns.

Logistics planning

For the onsite review, the account executive will confirm with the organization the following:

- The reviewer(s) will need workspace for the duration of the visit. A desk or table, access to an electrical outlet and the internet are desirable.
- Some review activities will require a room or area that will accommodate a group of participants. Group activity participants should be limited, if possible, to key individuals that can provide insight on the topic of discussion. Participant selection is left to the organization's discretion; however, this guide does offer suggestions.
- The reviewer will want to move throughout the facility or offices during Tracer Activity, talking with staff and observing the day-to-day operations of the organization along the way. The reviewer will rely on organization staff to find locations where discussions can

take place that allow confidentiality and privacy to be maintained and that will minimize disruption to the area being visited.
- While reviewers will focus on current patients being cared for by the program, they will also request to see some closed records as well in order to verify compliance with requirements such as those that address patient discharge and post discharge follow-up.

For the offsite (virtual) review, the account executive will confirm with the organization the following:
- Internet access/capabilities
- Video conference applications (such as Zoom or Microsoft Teams)
- Access to computer(s) with the ability to share screens and utilize camera functionalities
- Mobility of the camera-enabled computer to be used during tracer activity
- A dedicated space to privately discuss patient care, treatment, services

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Multiple Programs in Review

If one reviewer is evaluating multiple certification programs in the same day or across days, the account executive, with input of the reviewer, will develop an agenda that meets the needs of the program and organization leader's schedules.

Information Evaluated Prior to Certification Review

The Joint Commission Certification Reviewer(s) assigned to perform the organization's review will receive the following items presented with the organization's Request for Certification:

1. Demographic information, including identification of the disease-specific care service(s) undergoing certification or recertification review

2. The DSC program is required to enter data in the Certification Measure Information Process (CMIP) form which is accessible from the organization's *Connect* (extranet) site. The following information must be maintained in CMIP as follows:

    i. **Clinical Practice Guidelines**: The title of the current clinical practice guidelines and/or evidence-based practices. (see the section CPG below)

    ii. **Performance improvement (PI) plan**: Describes in writing the following elements of the program's PI plan:
    - Scope and activities of PI program
    - Composition of the multidisciplinary team
    - Current years for the PI goals and objectives of the program
    - Activities to meet the current years PI goals and objectives
    - The process for program's PI including how fits into organization's PI activities

iii. **Performance Measures:** The program enters their performance measures that are relevant to their scope of care, treatment, and services as follows:

Non-standardized performance measures are entered and must include at least (2) clinically focused measures

Standardized performance measures (as defined by the advanced disease program) are entered into the corresponding measure section

iv. **Data Submission:** All certified programs, including both advanced certification programs with standardized measures and programs collecting non-standardized measure data, are required to report performance measure data **quarterly** to The Joint Commission via CMIP.

3. The DSC program uploads program-specific documents based on the current document list available through the extranet site which must be completed by the due date listed on the "What's Due" section. The account executive will assist with the process in advance of certification review if needed.

Questions about Standards

If the organization has a question about a standard, element of performance, or any advanced certification requirement, please consider reviewing the Standards Interpretation FAQs page: https://www.jointcommission.org/standards_information/jcfaq.aspx prior to submitting a question.

To submit a question to Standards Interpretation Group,

- Login to the organization's Joint Commission extranet site, *Connect*: https://customer.jointcommission.org/TJCPages/TJCHomeEmpty.aspx and click on Resources - Standards Interpretation, to submit the question.
    - Or
- If personnel access is limited, please utilize *Connect*, and then go to the Standards Interpretation Page: https://www.jointcommission.org/standards_information/jcfaq.aspx to submit a question.

Clinical Practice Guidelines

A disease specific care program seeking Joint Commission certification must demonstrate that it is providing care, treatment, and services according to current clinical practice guidelines and/or evidence-based practice.

Clinical Practice Guidelines (CPGs) are statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

CPGs have two parts:

- The foundation is a systematic review of the research evidence bearing on a clinical question, focused on strength of the evidence on which clinical decision-making for that condition is based.
- A set of recommendations, involving both the evidence and value judgments regarding benefits and harms of alternative care options, addressing how patients with that condition should be managed, everything else being equal.

The organization may choose to utilize more than one clinical practice guideline to meet the needs of their patients; however, all clinical practice guidelines utilized by the program must be entered into the Certification Measure Information Process (CMIP) tool on the organization's *Joint Commission Connect* extranet site.

- **For core DSC programs**, please see the list of current CPGs listed in Table 2. Approved Clinical Practice Guidelines of the *DSC Comprehensive Certification Manual*.

- **For Advanced DSC programs**, the organization identifies which current clinical practice guideline(s) it has selected to implement that is specific to the care, treatment, and services it provides.

When entering the CPGs utilized by the program into CMIP, please enter or copy the cited reference that includes the date, author or professional organization(s), and title of the clinical practice guideline(s).

PART II: Agenda Specific Activities

Opening Conference

Objective
To gain a better understanding of the organization's program structure, scope of care, treatment, and services provided by the program, as well as discuss the structure of the review process and answer any questions.

Organization Participants
- Program(s) administrative and clinical leadership, individual or individuals that will provide the Safety Briefing to the reviewer(s), and others at the discretion of the organization.
- Program(s) administrative and clinical leadership and others at the discretion of the organization
- If applicable, pre-hospital providers
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session
- A prepared presentation (such as a PowerPoint)
- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity when presenting at opening conference

Opening Conference
- Reviewer(s) will begin this session with a few remarks and introduction of themselves, followed by an introduction of the program staff
- The organization is requested to provide the reviewer(s) with a Safety Briefing (informal, no more than five minutes) sometime during this activity. The purpose of this briefing is to inform the reviewer(s) of any current organization safety or security concerns and how Joint Commission staff should respond if the safety plans are implemented while they are on site. Situations to cover include:
  - Fire, smoke, or other emergencies
  - Workplace violence events (including active shooter scenarios)
  - Any contemporary issues the reviewer may experience during the time they are with the organization (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)
- Next, hospital and/or program leadership will present an overview (PowerPoint) of their disease-specific care program. Topics to be covered include:
  - Program leadership
  - Program interdisciplinary team composition
  - Program design and integration into hospital
  - Program mission, vision, and goals of care
  - Population characteristics/demographics and needs (such as a community needs assessment)

    - Diversity, equity, inclusion, and belonging program efforts
    - Program selection and implementation of Clinical Practice Guidelines (CPGs)
    - Overall program improvements implemented and planned
- The reviewer will clarify if questions can be asked during the presentation or following the presentation.
- Reviewer will end session with:
    - Overview of agenda and objectives
    - Dialogue about what the reviewer can do to help make this a meaningful review for the program

Reviewer Planning Session

Objective

During this session, the reviewer(s), in conjunction with disease specific care program representatives, will identify the patients that they would like to follow during tracer activity and may ask to review additional documents (such as order sets, clinical pathways, protocols, etc., that are used to implement selected clinical practice guidelines).

Organization Participants

- Program representative(s) that will facilitate tracer activity
- Individual(s) responsible for obtaining clinical records
- Individuals who can readily patient information in the electronic medical record
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

The following is a list of items that reviewers **WILL NEED** to have available during the Reviewer Planning Session.

1. A current list of patients being treated in the disease specific care program that includes the following information:
    - Patient age, gender, and ethnicity, if available
    - Unit/service admitted to (if applicable)
    - Primary diagnosis related to the disease-specific care program
    - Admission and discharge date (if not currently an inpatient)
    - Disposition status (home, SNF, home with home care, acute rehab, etc.)
2. A list of patients who accessed or progressed through the disease specific care program as follows:
    - For initial reviews only, the past four (4) months
    - For recertification, the past twelve (12) months

NOTE: For some Advanced DSC programs (such as stroke, cardiac, heart failure, total hip, and total knee) see Patient List Requirements in the next section

Selecting Patients to Trace

- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity for sharing the list of active patients, closed records to review, list of staff who are working on the day of the review (for selecting files for the Competency and Credentialing session) and any other documents that may be requested by the reviewer.

- From the patient lists provided, the reviewers will begin selecting patients they want to trace and may request program representative's assistance in identifying patients who may fit the description.
- The reviewer will prioritize patients for tracer activity with the organization's assistance.
- If there are no current patients available to trace on the day of the review, the reviewer will select files from the discharge list provided.

Patient list Requirements for Advanced DSC Programs

STROKE PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Comprehensive Stroke Centers (CSC)
A list of stroke patients that is separated by diagnosis, date of admission, discharge location, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no intervention
- AIS with thrombolytic therapy
- AIS with endovascular therapy
- ICH
- SAH
- Surgical intervention for AIS
- Stroke log (including inpatient stroke codes)
- Current stroke patients in-house

For Thrombectomy Capable Centers (TSC)
A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no intervention
- AIS with thrombolytic therapy
- AIS with endovascular therapy
- ICH (as applicable)
- SAH (as applicable)
- Surgical intervention for AIS (as applicable)
- Stroke log (including inpatient stroke codes)
- Current stroke patients in-house

For Primary Stroke Centers (PSC)
A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no treatment
- AIS with IV thrombolytic therapy
- ICH (as applicable)
- SAH (as applicable)

For Primary Stroke Centers (PSC) that perform mechanical thrombectomy

A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no intervention
- AIS with thrombolytic therapy
- AIS with endovascular therapy
- ICH (as applicable)
- SAH (as applicable)
- Stroke log (including inpatient stroke codes)
- Current stroke patients in-house

For Acute Stroke Ready Hospitals (ASRH)
A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients includes patients (as applicable to services provided by the program):
- TIA
- AIS no treatment
- AIS with IV thrombolytic therapy
- ICH (as applicable)
- SAH (as applicable)

CARDIAC PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Acute Heart Attack Ready (AHAR), Primary Heart Attack Center (PHAC), and Comprehensive Heart Attack Center (CHAC)
A list of heart attack patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients includes (as applicable to services provided by the program):
- ST-elevated myocardial infarction (STEMI)
- Non-ST-elevated myocardial infarction (NSTEMI)
- Acute Coronary Syndrome/chest pain (Unstable angina, angina (INOCA, SCAD)
- Cardiogenic shock with advanced therapies (as applicable)
- Cardiac arrest with ROSC, TTM, & other therapies
- Cardiac rehabilitation

For Advanced Heart Failure (HF) Programs
A list of heart failure patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:

- A list of current admitted patients with heart failure diagnosis
- A list of discharged patients with heart failure diagnosis
- A list of heart failure clinic patients currently receiving care, treatment, and services

For Ventricular Assist Device (VAD) Program
A list of VAD patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- Implanted VADs (long term devices)
- Planned VAD placement
- Emergent VAD placement
- Inpatient and outpatient activity

SURGICAL PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Advanced Certification for Spine Surgery (ACSS) Programs
A list of spine surgery patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- Patients having spine surgery on either day of review (including name, time, type of procedure, anesthesia)
- Patients currently in hospital or ambulatory surgery center on review days
- A list of discharged patients who received care, treatment, and services from the spine surgery team.

For Advanced Total Hip and Total Knee (THKR) Certification Programs
A list of total hip and total knee patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- Patients having either a total hip or total knee replacement on either day of review
- A minimum of six (6) patients will be selected by the reviewer for tracer activity
  - A minimum of three (3) patients experiencing total hip replacement
  - A minimum of three (3) patients experiencing total knee replacement

NOTE: At least one of the patient tracers performed must allow for the intraoperative observation

OTHER Advanced DSC PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Advance Lung Volume Reduction Surgery (LVRS) Programs

A list of LVRS patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:

- Patients admitted or scheduled for lung volume reduction surgery
- Discharged patients who had lung volume reduction surgery as their primary or secondary diagnosis

For Advanced Inpatient Diabetes Center (IDC) Programs

A list of diabetes patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:

- Patients admitted with:
  - Patients with Type 1, Type 2, and Gestational diabetes
  - Patients with insulin pumps, if applicable to organization
  - Patient using insulin pen while hospitalized, if applicable to organization
- Discharged patients with diabetes as their primary or secondary diagnosis

Individual Tracer Activity

Objectives

The individual tracer activity is a review method used to evaluate an organization's provision of care, treatment and services using the patient's experience as the guide. During an individual tracer, the reviewer(s) will:

- Follow a patient's course of care, treatment, and service through the program
- Assess the patient's active involvement in managing their disease
- Assess the impact of interrelationships among the program disciplines on patient care
- Assess the use, adherence, and diversion from clinical guidelines in the patient's care, treatment, or service
- Evaluate the integration and coordination of program and organization services in the patient's care

Organization Participants

- Program staff and other organization staff who have been involved in the patient's care, treatment, or services

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- Access to clinical records of selected patients
- For a review that is being conducted offsite (virtually), the organization must utilize a mobile webcam for this activity

Individual Tracer Activity

- A significant portion of the agenda is designated for individual tracer activity.

- Organization/program staff and the reviewer will move through the organization, as appropriate, visiting and speaking with staff in all the areas, programs, and services involved in the patient's encounter.

- Tracer activity follows the patient's course of care, treatment, and services. Tracer activity may vary by location of where services are provided (such as inpatient, outpatient, or remote)
  NOTE: *Clinical areas or units to be visited are based on the disease-specific needs of the patient population.*

- The organization/program staff and the reviewer will use the patient's record to discuss and map out the patient's course of care, treatment, and services.
  NOTE: *The number of staff participating in tracer activity should be limited. The rationale for limiting the number of staff participating is to reduce any distraction that the review process may have on patient care.*

- Throughout tracer activity, the reviewer(s) will:
  - Observe program staff and patient interaction
  - Observe the care planning process
  - Observe medication processes, if applicable
  - Consider the impact of the environment on individual safety and staff roles in minimizing environmental risk
  - Speak with staff about the care, treatment, and services they provide
  - Speak with patients or families, if appropriate, and permission is granted by the patient or family. Discussion will focus on the course of care and other aspects of the program(s) being evaluated for certification.
    NOTE: *If the patient being traced is already discharged, the reviewer may ask the program to see if a phone call with the patient/family is feasible and can be arranged.*
  - Look at procedures or other documents, as needed to verify processes or to further answer questions that still exist after staff discussions.

- Throughout the tracer activity, the reviewer will communicate to the program leaders and care providers any:
  - Specific observations made
  - Issues that will continue to be explored in other tracer activity
  - Need for additional record review
  - Issues that have the potential to result in Requirements for Improvement
  - Identify staff files needed for the Competency and Credentialing Session

Intraoperative Tracer Activity

This intraoperative tracer activity **only** applies to Advanced Total Hip and Total Knee (THKR) and Advanced Certification in Spine Surgery (ACSS)

What to expect and/or plan for:

- Flexibility and clear communication for the intraoperative tracer activity is imperative.
  NOTE: *The organization and reviewer should confirm the timing for this activity as soon as possible since this is a* ***mandatory*** *activity for advanced THKR/ACSS certification.*

- Reviewers will change/dress per organization policy for intraoperative tracer activity

- Dependent on the volume of **scheduled cases** the observations may occur with more than one patient and at different times during the two-day review
  NOTE: *Reviewers most likely will not observe the entire surgical procedure*

- The reviewer will interact with anesthesia, nursing, and other healthcare providers responsible for preoperative preparation of the patient and may inquire about their roles and responsibilities (such as involvement in obtaining informed consent, assessing NPO status, continuing patient education, helping to manage the patient's pain)

- The intraoperative tracer activity will also include:

  - Observation of preoperative process
  - Observe communication and collaboration between team members and patient, observe consistency of information being exchanged
  - Observe hand-offs (e.g., registration-to preoperative RN, preoperative RN-to anesthesia, preoperative RN-to-surgeon, surgeon-to-anesthesia, anesthesia-to surgeon, preoperative RN-to-Operating Room RN, Operating Room RN-to surgeon, surgeon-to-Operating Room RN, etc.)
  - Observe patient transition from preop to the operating room
  - Also, observe transition from OR to PACU

System Tracer- Data Use Session

Objectives

This session is focused on the program's use of data in improving safety and quality of care for their patients. The reviewer and the organization will:

- Identify strengths and opportunities in the organization's use of data, areas for improvement, and any actions taken or planned to improve performance.
- Identify specific data use issues requiring further exploration as part of subsequent review activities.

Organization Participants

- Program administrative and clinical leaders
- Others at the discretion of the organization
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- Presentation of data (such as a PowerPoint)
- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity when presenting their data

Data Use System Tracer

All organizations participating in a Joint Commission core or advanced DSC certification are required to collect, analyze, report, and monitor their performance relative to standardized and/or non-standardized measures (as applicable to their program requirements) at least quarterly.

The Certification Measure Information Process (CMIP) tool is available for all Disease Specific Care programs and assists certified organizations with the data collection, analysis, reporting, and monitoring requirements associated with performance measures.

During the data use session, the reviewer(s) and organization will discuss the performance measure data report that includes:

- Selection of performance measures (core DSC programs only)
- Standardized performance measures (advanced DSC programs only)
- Data collection, including validity and reliability
- Data analysis and interpretation
- Dissemination /transmission
- Data use and actions taken on opportunities for improvement
- Monitoring performance/improvement
- Action plans demonstrating the program's use of and response to data

- The performance measures selected to evaluate the processes and outcomes specific to the program, including how the selections were made (committee consensus, clinical staff voting, etc.) and measure implementation
- Performance improvement plan
- How clinical and management data is used in decision-making and in improving the quality of care and patient safety
- How patient satisfaction and perception of care data is used in decision-making and improving quality of care and patient safety
- Data variances as it pertains to clinical practice guidelines
- Strengths and weaknesses in the processes used to obtain data and meet internal and external information needs.
- Processes to ensure confidentiality and security of all types of patient data

The reviewer(s) will want to know about the program's priorities for performance improvement activities and how these fit into the organization's overall performance improvement processes.

Competence Assessment & Credentialing Process

Objectives

The purpose of this session is to discuss how the program meets the need for qualified and competent practitioners. The reviewer and the organization will discuss and review the following:

- Processes for obtaining team members' credentials information
- Orientation and training process for the disease management program team
- Methods for assessing competence of practitioners and team members
- In-service and facility-defined education and training activities provided to program team members
- Personnel records based on various team members and staff encountered or referred to throughout the day

NOTE: *File reviews are not the primary objective for this session. The file reviews are an opportunity to confirm that the program/organization is following its processes or procedures for staff credentialing, onboarding, competency, and initial and ongoing education, etc. This is not an audit.*

Organization Participants

- Program leaders
- Clinical leaders
- Organization representatives responsible for human resources processes
- Organization representatives responsible for orientation and ongoing education
- Organization representatives responsible for credentialing processes, if different from above
- Individuals with authorized access to, and familiar with the format of files
- Others as applicable to the care delivery within the disease-specific program
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

Personnel or credentials files for individuals identified by the reviewer

- A representative sample of staff (physician, advanced practice provider, nurse, social work, dietician, therapist, registrar, etc.) that are involved or impact the disease-specific care program
- The reviewer will select files based on the individuals encountered during tracer activity, that is, those caring for or who cared for the patient being traced. The organization does not need to pull files for every person the reviewer encounters during tracers. Additionally, please let the reviewer know if there could be a delay in getting files for review.
- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity when presenting personnel or credentials files

Competence Assessment and Credentialing Process Session

The session begins with an overview and discussion of orientation and training processes for the staff involved in disease-specific program including:

- The development and implementation of the annual educational plan
- Methods for assessing competence of practitioners and team members
- Inservice and other education and training activities provided to program team members

During the session, the reviewer and organization representatives will then review a sampling of the staff involved in the program that include the following:

Provider Files

- Licensure
- DEA Licensure
- Most recent reappointment letter
- Board certification
- Privileges and applicable supporting documents
- OPPE or FPPE (two most recent, as applicable)
- CME or attestation for program-specific CME requirements

Staff Files

- Licensure (if applicable)
- Certification (if applicable)
- Job description
- Most recent performance evaluation
- Program Specific Orientation Education/Competencies
- Program Specific Ongoing Education/Competencies

Reviewer Planning Session/Team Meeting

Note: This section only applies if there are two or more scheduled review days

Objectives

The reviewer(s) will use this session to reflect and debrief on any observations that occurred during the first day's activities. This time may also be used for any follow-up activity that could not be completed earlier in the day. They may also use this time to review and plan for the next day's activities.

Before leaving the organization, reviewer(s) will return any organization documents to the program's coordinator or liaison. If reviewers have not returned documentation, the organization is encouraged to ask reviewers for the documents prior to their leaving for the day.

Organization Participants

- Program's review coordinator or liaison, as requested by the reviewer
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- None

Daily Briefing

Note: This section only applies if there are two or more scheduled review days

Objectives

Reviewers will use this time to provide organization representatives with a brief summary of survey activities of the current or previous day and relay observations and note examples of strengths and possible vulnerabilities in performance. This session only takes place on multi-day certification on-site visits.

May take place at the end of Day 1 or be the first activity on Day 2. Reviewers will work with the organization to adjust the agenda as needed.

Participants

- Program administrative and clinical leaders
- Others at the discretion of the program
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- None

Overview

Reviewers will:

- Briefly summarize review activities completed on the previous day. Discuss at a high-level some of the patterns and trends they are seeing.
- Reviewers may show the current safer matrix to allow for clarification and discussion of current findings
- Ask the program representatives to clarify or help them understand what they have been hearing and observing.
- Answer questions and clarify comments when requested.
- Review the agenda for the day.
- Make necessary adjustments to plans based on program needs or the need for more intensive assessment
- Confirm logistics for the day, sites that will be visited, transportation arrangements, and meeting times and locations for any group activities
- Reviewers may ask to extend the Daily Briefing if necessary. However, they will be considerate of staff time. They will **not** make all program representatives stay for a discussion that is specific to a small group of individuals.

Summary Discussion

Objectives

This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference.

Organization Participants

- Program Leadership
- Others at Program's discretion
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- Will vary depending upon the review

Summary Discussion Description

Topics that may be discussed include:

- Any issues not yet resolved (IOUs)
- The identified Requirements for Improvement (RFIs)
- What made the review meaningful to the team
- Sharing best practices to inspire quality improvement and/or outcomes
- Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs)
- Did I meet the goals of your team today?

Reviewer Report Preparation

Objectives:
The reviewer uses this time to compile, analyze and organize the data he or she has collected into a summary report of observations made throughout the review.

Organization Participants
- None required, unless specifically requested by the reviewer

Materials Needed for this Session
- None; private workspace for the reviewer with access to an electrical outlet and internet connection, if available
- For a review that is being conducted offsite (virtually), the reviewer will be off camera during this activity and will advise when they will resume for the next session

Reviewer Report Preparation Session
The reviewer uses this time to enter their observations that reflect standards compliance issues. If organization interruptions can be kept to a minimum during this time, it will help the reviewer remain on schedule and deliver a report at the appointed time. The reviewer will be using their tablet to prepare the Preliminary Certification Report and plan for the Exit Conference.

Program Exit Conference

Objectives:
The Program Exit Conference is the final activity when the organization receives a Preliminary Certification Report of findings from the reviewer.

In addition to the preliminary report, the reviewers will:
- Review the Preliminary Certification Report, including the SAFER™ matrix feature
- Discuss any standards compliance issues that resulted in Requirements for Improvement (RFIs)
- Allow the organization a final onsite opportunity to question the review findings and provide additional material regarding standards' compliance
- Mention the post-review Clarification process
- Review required follow-up actions as applicable

Organization Participants
- Program leaders
- Clinical leaders
- Other staff at the discretion of the organization
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials needed for this Session
- None required

Program Exit Conference
This activity takes place at the completion of a program review. The reviewer(s) will provide a summary of their observations, review any findings, requirements for improvement, and where these are appearing on the SAFER™ matrix.

During the exit conference or at the close of day, the reviewer will post to the organization's *Joint Commission Connect* extranet site the Preliminary Certification Report.

The Final Certification Report and certification decision is made by central office within 10 days of the review and will be posted on the *Joint Commission Connect* secure extranet site.

NOTE: When more than one disease specific care program is being reviewed in a day, the reviewer(s) may coordinate with the organization to conduct a combined Program Exit Conference at the end of the day to discuss each program. Please inform the reviewer(s) during the Opening Conference if this arrangement is not agreeable to the organization.

PART III- Post Review Activities

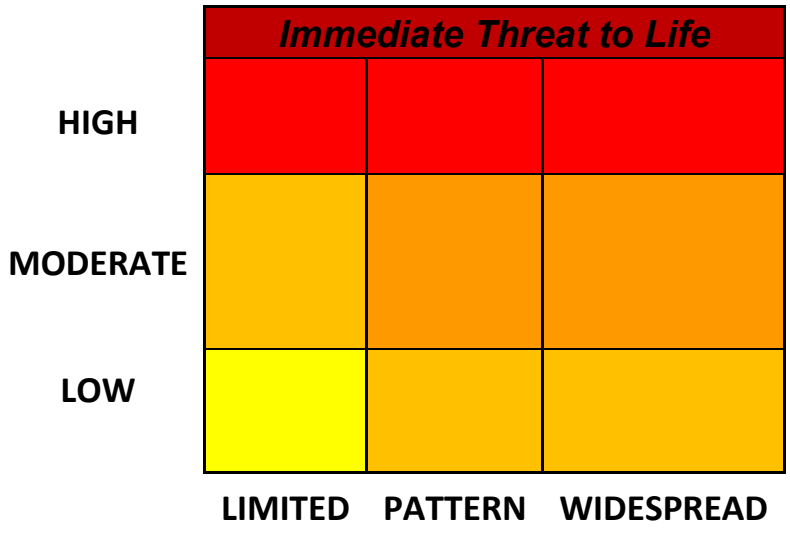
Evidence of Standards Compliance

Objectives:
All noncompliant EPs will be cited as a Requirement for Improvement (RFI) and will be placed on the SAFER® Matrix, illustrated below, as determined by the risk level associated with each RFI.

SAFER® is the Survey Analysis for Evaluating Risk® process, a scoring approach used for the DSC program review of health care organizations. SAFER is a transformative approach for identifying and communicating risk levels associated with deficiencies cited during the review.

All observations of noncompliance will be documented within the SAFER Matrix and require implemented corrective actions that are submitted within the Evidence of Standards Compliance (ESC). The amount of information required within an ESC is reflective of the risk-level and associated SAFER placement of each RFI.

All RFIs must be addressed via the Evidence of Standards Compliance (ESC) submission process. The time frame for completing the ESC submission is within sixty (60) calendar days. The organization should work with their account executive to ensure that these submissions are submitted timely. For assistance, please contact your account executive.



Intra-cycle Evaluation Process

Objectives:
All certified organizations who are participating in a Joint Commission core or advanced DSC certification program are required to participate in the intra-cycle conference meeting.

The intra-cycle meeting is the organization's opportunity to have an interactive discussion with the Joint Commission reviewer to assure the organization is on the right track relative to performance measurement and ongoing performance improvement and standards compliance.

There are no negative outcomes to the intra-cycle event unless the reviewer identifies that the organization has not actively engaged in performance measurement and improvement activities since the time of the most recently completed initial or recertification review.

Prior to the Intra-cycle Event

- The organization will receive an automated email to the primary certification contact and the CEO approximately 90 days in advance of the mid-point of the program's cycle (Approx. 12 months after the review).

- The program will have 30 days to enter any missing monthly data points for any of the performance measures, complete the performance measure (PM) data report for each measure, and review the performance improvement plan and CPGs for any updates. Once everything has been entered or updated, please use the submission checklist section of the CMIP tool to formally submit the CMIP tool to The Joint Commission for the intra-cycle event. If the tool is not submitted on time, the organization will receive an email reminder to submit the tool or risk having the certification decision changed.

- If the organization is using a vendor to submit the standardized performance measure data, there may be a delay in data submitted to CMIP. Please be prepared to discuss and respond to questions from the reviewer regarding the performance measures and be able to provide current data.

Intra-cycle Evaluation Logistics
This virtual meeting will take place as close as possible to the one-year mid-point of the current two-year certification cycle.

The virtual meeting will be completed by a Joint Commission reviewer who will contact the person identified in the "Intra-cycle Conference Call Contact Information" section of the CMIP tool for a time that is convenient to both parties involved.

Organization Participants

- Staff involved in data collection and analysis
- Program leaders that implement performance improvement plans
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials needed for this Session

- Prior 12-24 months data

Intra-cycle Evaluation Process

During the intra-cycle conference meeting, the reviewer will start with introductions and will then begin a discussion of the following topics:

- Review the total number of patients the program served in the past year
- Discuss any changes to the program/organizational leadership who support the program
- Discuss any changes in the scope of the program (such as new technology or new procedures being utilized)
- Discuss any additions/deletions of the selected Clinical Practice Guidelines
- Review of the program's data collection and IRR processes and discuss data and ongoing approaches to performance improvement
- Review any additional performance measures implemented by the program
- Review any new/revised patient education
- Review any new/revised and/or completion of staff education
- Review data related to patient's perception of care
- Answer any questions regarding compliance with Joint Commission standards or performance measures

Part IV: New York State's Stroke-specific Requirements

New York State Stroke Services Certification – Primary Stroke Centers (PSC)

Introduction
In 2019, the Commissioner of Health in New York State began delegating the review of stroke certifications to nationally recognized accrediting organizations. New York state's eligibility and program requirements differ slightly from what is currently required by The Joint Commission. The Joint Commission is unable to have more than one set of program requirements for a particular stroke program in its database. Since New York State's program eligibility and requirements are not applicable to other states, this supplement was created to outline those differences for organizations applying for certification. Organizations applying for certification with The Joint Commission will be held accountable for the requirements listed in this supplement in addition to the eligibility and program requirements that can be found in The Joint Commission's Comprehensive Certification Manual for Disease-Specific Care relevant to Primary Stroke Center certification. New York State recognizes three levels of stroke centers: Primary Stroke Center, Thrombectomy-Capable Stroke Center, and Comprehensive Stroke Center.

Eligibility
There is no additional eligibility for New York State Stroke Services Certification. PSC applicants will be expected to meet the eligibility criteria for The Joint Commission's Primary Stroke Center certification.

Stroke Coordinator
The organization identifies an administrative leader (stroke coordinator) who acts as a liaison with EMS in coordinating and evaluating pre-hospital care related to stroke services. The stroke coordinator is a full-time member of the hospital staff (but can be concurrently assigned to another role in the hospital). The stroke coordinator ensures timely and accurate data submission to EMS as requested and complies with and monitors programs established by regional EMS providers. The stroke coordinator is also responsible for collecting, storing, and reporting data collection and for quality improvement of the stroke program. Additionally, the stroke coordinator is responsible for coordinating quality improvement of the stroke program, including analysis and interpretation of the program's stroke data to drive quality improvement of the stroke program.

Medical Director
The organization identifies a physician leader with sufficient knowledge in cerebrovascular disease and experience caring for stroke patients. This person shall be a physician on the hospital staff, licensed in New York State, and Board Certified in Family Medicine, Internal Medicine, Emergency Medicine, Neurology, Neuroradiology, or Neurosurgery.

The medical director or designee shall be available 24 hours per day, 7 days per week to provide leadership and deal with difficult medical, logistical, and administrative issues. There should be a call schedule available for the designee when the director is unavailable.

Pre-hospital Services/EMS feedback
The organization tracks that EMS notified the ED of all potential incoming stroke patients and then provides education and feedback to EMS at a predetermined frequency.

Acute Stroke Team
The acute stroke team must be at the bedside within 15 minutes of patient arrival/activation.

Neurologist
A neurologist must be available in person or via telemedicine within 15 minutes of the request for initial assessment and/or for treatment decisions.

Primary Stroke Centers may designate a physician who has experience in the treatment and diagnosis of ischemic stroke when a board-certified neurologist is not available.

Diagnostic Radiologist
A diagnostic radiologist with complex stroke experience and/or a physician to interpret CT, CTA, and MRI of the brain must be available 24/7.

Stroke Unit Nursing Care
Nursing staff on the stroke unit (monitoring stroke beds) are under the clinical direction of a Registered Nurse who by education, training, and experience is qualified to direct nursing care to the stroke population.

Nurse Case Managers/Social Workers
Nurse case managers and social workers with expertise in neurology/stroke care, care coordination, different levels of rehabilitation, and community resources are available.

Transfer Agreement
Primary Stroke Centers should at a minimum have a transfer agreement with a Comprehensive Stroke Center. If there is an accessible TSC, the PSC may wish to have a transfer agreement with the TSC for timely endovascular services in addition to the agreement with a CSC.

At a minimum, the transfer agreement should address:

- 24/7 emergency contact information of acute stroke team and/or the receiving team at the receiving facility authorized to accept transfers
- The ability to transfer the patient 24/7, the ability of the receiving facility to accept the patient 24/7
- The ability to affect a transfer in a timely manner as appropriate for patient needs (target timeframe for transfer should be identified in the transfer agreement for other neurosurgical and endovascular services)
- Clinical criteria for transfer and processes for obtaining consultation for transfer decisions
- Expectations/criteria for advanced imaging prior to transfer, including CTA/CTP or other imaging modalities, and timeframe for diagnostic service completion and image sharing processes (images at sending facility must be shared with receiving facility before or upon transfer)
- Plans for the triage and transport of suspected stroke patients including, but not limited to, those patients who may have an emergent large vessel occlusion to an appropriate facility within a specified time.

The transfer agreement shall clearly delineate responsibility related to which center will perform a CTA and the agreement shall identify under which circumstances patients should receive a CTA at the sending facility prior to transfer. The agreement shall clearly articulate imaging

capabilities of the sending facility. In all cases, the transfer agreement shall address the rapid imaging and appropriate treatment of the suspected stroke patient.

The stroke center has a contract with a transportation vendor that covers expeditious transfer by both ground ambulance and air ambulance transfer options as applicable.

Vascular Imaging

Neuroimaging is initiated within 25 minutes of patient arrival and read by a diagnostic radiologist or physician privileged to interpret CT neuroimaging within 45 minutes of patient arrival.

NYSDOH Stroke Designation Program requires that the Primary Stroke Center have the ability to perform a CTA of the arch to vertex (head and neck) to assess for a large vessel occlusion and identify candidates for endovascular therapy. CTA should not delay the administration of IV thrombolytic. CTA imaging must be reviewed by a diagnostic radiologist or physician privileged to interpret CTA for a large vessel occlusion in order to identify candidates for endovascular therapy within 45 minutes of patient arrival. Expectations for CTA prior to transfer for endovascular intervention should be clarified with the receiving facility.

Other Imaging
TTE must be available when clinically indicated at PSCs.

Laboratory
Laboratory studies must be obtained, run, resulted, and communicated to the requesting practitioner within 45 minutes of patient arrival. Laboratory capability must include, but is not limited to complete blood count, blood glucose, coagulation studies (International Normalized Ratio, Prothrombin Time, Activated Partial Thromboplastin Time), troponin, blood chemistries, pregnancy test, and drug toxicology, as clinically indicated.

Staff Education
The following staff must complete 8 hours of stroke-focused education on an annual basis:

- Members of the Acute Stroke Team (or any staff anticipated to serve as a member of the acute stroke team)
- Nurses in the stroke unit
- Stroke Medical Director
- Stroke Coordinator

*The CEO/CMO or other individual able to bind the organization may attest to staff completion of education as evidence of satisfying this requirement.

The PSC may determine the content and objectives of the education. Educational content should improve stroke care and may include, but is not limited to:

- Health system or hospital specific educational components
- Review of new literature
- Evidence-based practices
- Hospital-based quality improvement initiatives related to stroke

Patient Education
Stroke education for patients and/or their family/caregivers must address all of the following: Risks and benefits of IV thrombolytic, personal risk factors, warning signs for stroke, activation of emergency medical system, need for follow-up after discharge, and medications prescribed.

Quality Improvement
Internal QI group specific to stroke care to meet at least monthly with recorded minutes. This group is minimally expected to review stroke quality benchmarks, indicators, evidence-based practices, patient outcome data (i.e., mortalities, etc.), delays in patient care and take actions, as necessary. The PSC must have an interdisciplinary team with a peer review process that includes the medical director, stroke coordinator and a quality facilitator charged with conducting quality reviews.

Process and Outcome Measures & Data Collection
PSCs are required to collect and report data on a quarterly basis. Please have data available to share with the reviewer during the data session of the on-site visit. Data are used to demonstrate ongoing performance improvement efforts.

NOTE: *Performance Measures (for those performance measures that are not STK measures, please have data available for the reviewers during the data session of the on-site visit)*
NYS PSC 1: VTE Prophylaxis
NYS PSC 2: Discharge on Antithrombotic Therapy
NYS PSC 3: Anticoagulation Therapy for AFIB/Flutter
NYS PSC 4: Thrombolytic Therapy (arrive by 3.5 hours, treat by 4.5 hours)
NYS PSC 5: Antithrombotic Therapy by the end of Hospital Day Two
NYS PSC 6: Discharged on Statin Medication
NYS PSC 7: Stroke Education
NYS PSC 8: Smoking Cessation
NYS PSC 9: Assessed for Rehabilitation
NYS PSC 10: Dysphagia Screening
NYS PSC 11: Initial NIHSS Reported
NYS PSC 12: mRS on Discharge
NYS PSC 13: Pre-Notification: Percent of cases of advanced notification by EMS for patients transported by EMS from scene
NYS PSC 14: EMS Pre-Hospital Stroke Scale: Percent of patients arriving via EMS who had pre-hospital stroke scale performed
NYS PSC 15: Pre-Notification Content:

- Last Known Well communicated
- Stroke scale findings communicated

NYS PSC 16: Stroke Team Activated Prior to Arrival: Percent of patients arriving via EMS for whom the stroke team was activated prior to patient arrival based upon EMS pre-notification

NYS PSC 17: Door to MD/DO/NP/PA Assessment (10 minutes)
NYS PSC 18: Door to Stroke Team (15 minutes)
NYS PSC 19: Door to Brain Image Initiated (25 minutes)
NYS PSC 20: Door to Brain Image Read (45 minutes)
NYS PSC 21: Door to IV thrombolytic (60 minutes) – 85%
NYS PSC 22: Door to IV thrombolytic (45 minutes) – 50%
NYS PSC 23: Door-in-door-out time at first hospital prior to transfer for acute therapy (</= 90 minutes)
NYS PSC 24: NIHSS Reported

New York State Stroke Services Certification – Thrombectomy-Capable Stroke Centers (TSC)

Introduction
In 2019, the Commissioner of Health in New York State began delegating the review of stroke certifications to nationally recognized accrediting organizations. New York state's eligibility and program requirements differ slightly from what is currently required by The Joint Commission. The Joint Commission is unable to have more than one set of requirements for a particular stroke program in its database. Since New York State's program eligibility and requirements are not applicable to other states, this supplement was created to outline those differences for organizations applying for certification. Organizations applying for certification with The Joint Commission will be held accountable for the requirements listed in this supplement in addition to the eligibility and program requirements that can be found in The Joint Commission's Comprehensive Certification Manual for Disease-Specific Care relevant to Thrombectomy-Capable Stroke Center certification. New York State recognizes three levels of stroke centers: Primary Stroke Center, Thrombectomy-Capable Stroke Center, and Comprehensive Stroke Center.

Eligibility
- All primary neurointerventionists who routinely take call to perform emergency mechanical thrombectomy must meet the following criteria:
    - Have performed 15 mechanical thrombectomies, as the primary operator, over the past 12 months (or 30 over the past 24 months); procedures performed at organizations other than the one applying for certification may be counted in the total.
    - Must be CAST certified or meet all of the following criteria:
        - Completed an ACGME-accredited or equivalent residency in neurosurgery, neurology, or radiology;
        - For neurologists: completed a stroke or neurocritical care fellowship supervised by the ACGME, CAST, UCNS, or other equivalent oversight body;
        - For radiologists: completed a neuroradiology subspecialty fellowship supervised by the ACGME, CAST, UCNS, or other equivalent oversight body; and
        - Completed neuroendovascular procedure training in a CAST-accredited program or similar training program.

Stroke Coordinator
The organization identifies an administrative leader (stroke coordinator) who acts as a liaison with EMS in coordinating and evaluating pre-hospital care related to stroke services. The stroke coordinator is a full-time member of the hospital staff (but can be concurrently assigned to another role in the hospital). The stroke coordinator ensures timely and accurate data submission to EMS as requested and complies with and monitors programs established by regional EMS providers. The stroke coordinator is also responsible for collecting, storing, and reporting data collection and for quality improvement of the stroke program. Additionally, the stroke coordinator is responsible for coordinating quality improvement of the stroke program, including analysis and interpretation of the program's stroke data to drive quality improvement of the stroke program.

Medical Director

The organization identifies a physician leader with extensive experience in cerebrovascular disease and experience caring for stroke patients. This person shall be a physician on the hospital staff, licensed in New York State, and Board Certified in Neurology, Vascular Neurology, Critical Care, Neuro-Critical Care, Interventional Neuroradiology, or Neurosurgery.

The medical director or designee shall be available 24 hours per day, 7 days per week to provide leadership and deal with difficult medical, logistical, and administrative issues. There should be a call schedule available for the designee when the director is unavailable.

Pre-hospital Services/EMS feedback
The organization tracks that EMS notified the ED of all potential incoming stroke patients and then provides education and feedback to EMS at a predetermined frequency.

Acute Stroke Team
The acute stroke team must be at the beside within 15 minutes of patient arrival/activation.

Neurologist
A neurologist must be available in person or via telemedicine within 15 minutes of the request for initial assessment and/or for treatment decisions.

Vascular Neurologist
The Thrombectomy-Capable Stroke Center must have a fellowship-trained vascular neurologist available 24/7.

Endovascular Team
The team is to consist of at least one endovascular RN, one endovascular catheterization laboratory technician, and a physician privileged to perform mechanical thrombectomy. The endovascular team (including the interventionist) should be onsite within 30 minutes of activation.

Neurosurgeon
The Thrombectomy-Capable Stroke Center has 24/7 general neurosurgery coverage to respond to complications of mechanical thrombectomy.

Emergency Medicine Physicians/Nurses
The organization assures that 100% of emergency department physicians, mid-levels, and nursing staff have been trained on evidence-based acute stroke assessment and recognition (signs and symptoms of stroke) as well as how to activate the acute stroke team per hospital protocol and on the administration and monitoring of IV thrombolytics.

Diagnostic Radiologist
A diagnostic radiologist with complex stroke experience and/or a physician to interpret CT, CTA, and MRI of the brain must be available 24/7.

Stroke Unit Nursing Care
Nursing staff on the stroke unit (monitoring stroke beds) are under the clinical direction of a Registered Nurse who by education, training, and experience is qualified to direct nursing care to the stroke population. Nurses on the stroke unit or ICU for complex stroke patients are knowledgeable in NIHSS.

Telemedicine
If used for consultation, telemedicine is available 24/7 and able to connect within required time parameters. Telemedicine is defined as two-way audio and visual communication when there is a need to view the patient for the initial assessment or to make treatment decisions. Otherwise, telemedicine can be via audio communication only.

Transfer Agreement
Thrombectomy-Capable Stroke Centers should at a minimum have a transfer agreement with a Comprehensive Stroke Center.

At a minimum, the transfer agreement should address:

- 24/7 emergency contact information of acute stroke team and/or the receiving team at the receiving facility authorized to accept transfers
- The ability to transfer the patient 24/7, the ability of the receiving facility to accept the patient 24/7
- The ability to affect a transfer in a timely manner as appropriate for patient needs (target timeframe for transfer should be identified in the transfer agreement for other neurosurgical and endovascular services)
- Clinical criteria for transfer and processes for obtaining consultation for transfer decisions
- Expectations/criteria for advanced imaging prior to transfer, including CTA/CTP or other imaging modalities, and timeframe for diagnostic service completion and image sharing processes (images at sending facility must be shared with receiving facility before or upon transfer)
- Plans for the triage and transport of suspected stroke patients including, but not limited to, those patients who may have an emergent large vessel occlusion to an appropriate facility within a specified time

The transfer agreement shall clearly delineate responsibility related to which center will perform a CTA and the agreement shall identify under which circumstances patients should receive a CTA at the sending facility prior to transfer. The agreement shall clearly articulate imaging capabilities of the sending facility. In all cases, the transfer agreement shall address the rapid imaging and appropriate treatment of the suspected stroke patient.

The stroke center has a contract with a transportation vendor that covers expeditious transfer by both ground ambulance and air ambulance transfer options as applicable.

Vascular Imaging

The TSC is required to have the following radiology staff 24/7:

- Diagnostic radiologist with complex stroke experience and/or a physician privileged to interpret CT, CTA, and MRI of the brain.
- Radiology technician(s) able to perform CT/CTA and MRI/MRA/CA

Neuroimaging is initiated within 25 minutes of patient arrival and read by a diagnostic radiologist or physician privileged to interpret CT neuroimaging within 45 minutes of patient arrival.

NYSDOH Stroke Designation Program requires that the Thrombectomy-capable stroke center have the ability to perform a CTA of the arch to vertex (head and neck) to assess for a large

vessel occlusion and identify candidates for endovascular therapy. CTA should not delay the administration of IV thrombolytic. CTA imaging must be reviewed by a diagnostic radiologist or physician privileged to interpret CTA for a large vessel occlusion in order to identify candidates for endovascular therapy within 45 minutes of patient arrival.

The Thrombectomy-Capable Stroke Center must also be able to perform and read MRI/MRA, CA, and CTP 24/7.

Other Imaging
TTE must be available when clinically indicated at TSCs.

Laboratory
Laboratory studies must be obtained, run, resulted, and communicated to the requesting practitioner within 45 minutes of patient arrival. Laboratory capability must include, but is not limited to complete blood count, blood glucose, coagulation studies (International Normalized Ratio, Prothrombin Time, Activated Partial Thromboplastin Time), troponin, blood chemistries, pregnancy test, and drug toxicology, as clinically indicated.

Staff Education
The following staff must complete 8 hours of stroke-focused education on an annual basis:

- Members of the Acute Stroke Team (or any staff anticipated to serve as a member of the acute stroke team)
- Nurses in the stroke unit
- Stroke Medical Director
- Stroke Coordinator

*The CEO/CMO or other individual able to bind the organization may attest to staff completion of education as evidence of satisfying this requirement.

The TSC may determine the content and objectives of the education. Educational content should improve stroke care and may include, but is not limited to:

- Health system or hospital specific educational components
- Review of new literature
- Evidence-based practices
- Hospital-based quality improvement initiatives related to stroke

Patient Education
Stroke education for patients and/or their family/caregivers must address all of the following: Risks and benefits of IV thrombolytic, personal risk factors, warning signs for stroke, activation of emergency medical system, need for follow-up after discharge, and medications prescribed.

Quality Improvement
Internal QI group specific to stroke care to meet at least monthly with recorded minutes. This group is minimally expected to review stroke quality benchmarks, indicators, evidence-based practices, patient outcome data, delays in patients care and takes actions, as necessary. The TSC must have an interdisciplinary team with a peer review process that includes the medical director, stroke coordinator and a quality facilitator charged with conducting quality reviews.

Process and Outcome Measures & Data Collection

TSCs are required to collect and report data on a quarterly basis. Please have data available to share with the reviewer during the data session of the on-site visit. Data are used to demonstrate ongoing performance improvement efforts.

NOTE: *Performance Measures (for those performance measures that are not STK or CSTK measures, please have data available for the reviewers during the data session of the on-site visit)*

NYS PSC 1: VTE Prophylaxis
NYS PSC 2: Discharge on Antithrombotic Therapy
NYS PSC 3: Anticoagulation Therapy for AFIB/Flutter
NYS PSC 4: Thrombolytic Therapy (arrive by 3.5 hours, treat by 4.5 hours)
NYS PSC 5: Antithrombotic Therapy by the end of Hospital Day Two
NYS PSC 6: Discharged on Statin Medication
NYS PSC 7: Stroke Education
NYS PSC 8: Smoking Cessation
NYS PSC 9: Assessed for Rehabilitation
NYS PSC 10: Dysphagia Screening
NYS PSC 11: Initial NIHSS Reported
NYS PSC 12: mRS on Discharge
NYS PSC 13: Pre-Notification: Percent of cases of advanced notification by EMS for patients transported by EMS from scene
NYS PSC 14: EMS Pre-Hospital Stroke Scale: Percent of patients arriving via EMS who had pre-hospital stroke scale performed
NYS PSC 15: Pre-Notification Content:

- Last Known Well communicated
- Stroke scale findings communicated

NYS PSC 16: Stroke Team Activated Prior to Arrival: Percent of patients arriving via EMS for whom the stroke team was activated prior to patient arrival based upon EMS pre-notification
NYS PSC 17: Door to MD/DO/NP/PA Assessment (10 minutes)
NYS PSC 18: Door to Stroke Team (15 minutes)
NYS PSC 19: Door to Brain Image Initiated (25 minutes)
NYS PSC 20: Door to Brain Image Read (45 minutes)
NYS PSC 21: Door to IV thrombolytic (60 minutes) – 85%
NYS PSC 22: Door to IV thrombolytic (45 minutes) – 50%
NYS PSC 23: Door-in-door-out time at first hospital prior to transfer for acute therapy (</= 90 minutes)
NYS PSC 24: NIHSS Reported
NYS TSC 1: mRS at 90 days: documented
NYS TSC 2: mRS at 90 days: following mechanical endovascular reperfusion therapy, favorable outcome
NYS TSC 3: Hemorrhagic transformation (overall rate)
NYS TSC 4: Mechanical Endovascular Reperfusion Therapy for Eligible Patients with Ischemic Stroke
NYS TSC 5: Thrombolysis in Cerebral Infarction (TICI post treatment reperfusion grade)
NYS TSC 6: NIHSS at Discharge
NYS TSC 7: Timeliness of reperfusion: arrival time to TICI 2B or higher (120 minutes)
NYS TSC 8: Timeliness of reperfusion: skin puncture to TICI 2B or higher (60 minutes)
NYS TSC 9: Door to Puncture Time
NYS TSC 10: Imaging to Puncture Time

New York State Stroke Services Certification – Comprehensive Stroke Center (CSC)

Introduction
In 2019, the Commissioner of Health in New York State began delegating the review of stroke certifications to nationally recognized accrediting organizations. New York state's eligibility and requirements differ slightly from what is currently required by The Joint Commission. The Joint Commission is unable to have more than one set of program requirements for a particular stroke program in its database. Since New York State's program eligibility and requirements are not applicable to other states, this supplement was created to outline those differences for organizations applying for certification. Organizations applying for certification with The Joint Commission will be held accountable for the program requirements listed in this supplement in addition to the eligibility and program requirements that can be found in The Joint Commission's Comprehensive Certification Manual for Disease-Specific Care relevant to Comprehensive Stroke Center certification. New York State recognizes three levels of stroke centers: Primary Stroke Center, Thrombectomy-Capable Stroke Center, and Comprehensive Stroke Center.

Eligibility
- All primary neurointerventionists who routinely take call to perform emergency mechanical thrombectomy must meet the following criteria:
    - Have performed 15 mechanical thrombectomies as the primary operator over the past 12 months (or 30 over the past 24 months); procedures performed at organizations other than the one applying for certification may be counted in the total.
    - Must be CAST certified or meet all of the following criteria:
        - Completed an ACGME-accredited or equivalent residency in neurosurgery, neurology, or radiology;
        - For neurologists: completed a stroke or neurocritical care fellowship supervised by the ACGME, CAST, UCNS, or other equivalent oversight body;
        - For radiologists: completed a neuroradiology subspecialty fellowship supervised by the ACGME, CAST, UCNS, or other equivalent oversight body; and
        - Completed neuroendovascular procedure training in a CAST-accredited program or similar training program.
- Provide care to 20 or more patients per year with a diagnosis of subarachnoid hemorrhage (does not have to be aneurysmal).

Stroke Coordinator
The organization identifies an administrative leader (stroke coordinator) who acts as a liaison with EMS in coordinating and evaluating pre-hospital care related to stroke services. The stroke coordinator is a full-time member of the hospital staff (but can be concurrently assigned to another role in the hospital). The stroke coordinator ensures timely and accurate data submission to EMS as requested and complies with and monitors programs established by regional EMS providers. The stroke coordinator is also responsible for collecting, storing, and reporting data collection and for quality improvement of the stroke program. Additionally, the stroke coordinator is responsible for coordinating quality improvement of the stroke program, including analysis and interpretation of the program's stroke data to drive quality improvement of the stroke program.

Medical Director
The organization identifies a physician leader with extensive experience in cerebrovascular disease and experience caring for stroke patients. This person shall be a physician on the hospital staff, licensed in New York State, and Board Certified in Neurology, Vascular Neurology, Critical Care, Neuro-Critical Care, Interventional Neuroradiology, or Neurosurgery. The Medical Director may not be concurrently a Stroke Medical Director at another hospital.

Pre-hospital Services/EMS feedback
The organization tracks that EMS notified the ED of all potential incoming stroke patients and then provides education and feedback to EMS at a predetermined frequency.

Acute Stroke Team
The acute stroke team must be at the beside within 15 minutes of patient arrival/activation.

Neurologist
A neurologist must be available in person or via telemedicine within 15 minutes of the request for initial assessment and/or for treatment decisions.

Vascular Neurologist
The Comprehensive Stroke Center must have a fellowship-trained vascular neurologist available 24/7.

Endovascular Team
The team is to consist of at least one endovascular RN, one endovascular catheterization laboratory technician, and a physician privileged to perform mechanical thrombectomy. The endovascular team (including the interventionist) should be onsite within 30 minutes of activation.

Emergency Medicine Physicians/Nurses
The organization assures that 100% of emergency department physicians, mid-levels, and nursing staff have been trained on evidence-based acute stroke assessment and recognition (signs and symptoms of stroke) as well as how to activate the acute stroke team per hospital protocol and on the administration and monitoring of IV thrombolytics.

Stroke Unit Nursing Care
Nursing staff on the stroke unit (monitoring stroke beds) are under the clinical direction of a Registered Nurse who by education, training, and experience is qualified to direct nursing care to the stroke population.

Physical and Occupational Therapy
Physical therapy and occupational therapy are available 6 days a week and on-call the 7th day to perform patient assessments during the acute stroke phase.

Rehabilitation Services
The rehabilitation services of a Comprehensive Stroke Center are directed by a physician with expertise and experience in neurorehabilitation.

Telemedicine

Transfer Agreement

The CSC has a transfer agreement with referring TSCs and PSCs within their catchment area for intake purposes.

The transfer agreement shall clearly delineate responsibility related to which center will perform a CTA and the agreement shall identify under which circumstances patients should receive a CTA at the sending facility prior to transfer. The agreement shall clearly articulate imaging capabilities of the sending facility. In all cases, the transfer agreement shall address the rapid imaging and appropriate treatment of the suspected stroke patient.

At a minimum, the transfer agreement should address:

- 24/7 emergency contact information of acute stroke team and/or the receiving team at the receiving facility authorized to accept transfers
- The ability to transfer the patient 24/7, the ability of the receiving facility to accept the patient 24/7
- The ability to affect a transfer in a timely manner as appropriate for patient needs (target timeframe for transfer should be identified in the transfer agreement for other neurosurgical and endovascular services)
- Clinical criteria for transfer and processes for obtaining consultation for transfer decisions
- Expectations/criteria for advanced imaging prior to transfer, including CTA/CTP or other imaging modalities, and timeframe for diagnostic service completion and image sharing processes (images at sending facility must be shared with receiving facility before or upon transfer)

The Comprehensive Stroke Center identifies another Comprehensive Stroke Center that they will transfer to when case complexity determines that further specialized care is needed, or high volume exceeds resources dictating a need for transfer. This can be identified through a policy document such as a surge policy and does not need to be in the form of a transfer agreement.

The stroke center has a contract with a transportation vendor that covers expeditious transfer by both ground ambulance and air ambulance transfer options as applicable.

Vascular Imaging

The CSC is required to have the following radiology staff 24/7:

- Diagnostic radiologist with complex stroke experience and/or a physician privileged to interpret CT, CTA, and MRI of the brain.
- Radiology technician(s) able to perform CT/CTA and MRI/MRA/CA

Neuroimaging is initiated within 25 minutes of patient arrival and read by a diagnostic radiologist or physician privileged to interpret CT neuroimaging within 45 minutes of patient arrival.

NYSDOH Stroke Designation Program requires that the Comprehensive Stroke Center have the ability to perform a CTA of the arch to vertex (head and neck) to assess for a large vessel occlusion and identify candidates for endovascular therapy. CTA should not delay the administration of IV thrombolytic. CTA imaging must be reviewed by a diagnostic radiologist or physician privileged to interpret CTA for a large vessel occlusion in order to identify candidates for endovascular therapy within 45 minutes of patient arrival.

The Comprehensive Stroke Center must also be able to perform and read MRI/MRA, CA, and CTP 24/7.

Laboratory
Laboratory studies must be obtained, run, resulted, and communicated to the requesting practitioner within 45 minutes of patient arrival. Laboratory capability must include, but is not limited to complete blood count, blood glucose, coagulation studies (International Normalized Ratio, Prothrombin Time, Activated Partial Thromboplastin Time), troponin, blood chemistries, pregnancy test, and drug toxicology, as clinically indicated.

Staff Education
The following staff must complete 8 hours of stroke-focused education on an annual basis:

- Members of the Acute Stroke Team (or any staff anticipated to serve as a member of the acute stroke team)
- Nurses in the stroke unit
- Stroke Medical Director
- Stroke Coordinator

*The CEO/CMO or other individual able to bind the organization may attest to staff completion of education as evidence of satisfying this requirement.

The CSC may determine the content and objectives of the education. Educational content should improve stroke care and may include, but is not limited to:

- Health system or hospital specific educational components
- Review of new literature
- Evidence-based practices

Hospital-based quality improvement initiatives related to stroke

Patient Education

Stroke education for patients and/or their family/caregivers must address all of the following: Risks and benefits of IV thrombolytic, personal risk factors, warning signs for stroke, activation of emergency medical system, need for follow-up after discharge, and medications prescribed.

Quality Improvement
The Comprehensive Stroke Center must have a quality representative that has the responsibility for monitoring requirements of the CSC program. The CSC must have an interdisciplinary team with a peer review process that includes the medical director, nurses stroke coordinator, and a quality facilitator charged with conducting quality reviews. There must be a written document defining quality review processes, how the CSC will measure objectives and goals and how the CSC will engage PSCs and TSCs in regional quality improvement initiatives.

Process and Outcome Measures & Data Collection
CSCs are required to collect and report data on a quarterly basis. Please have data available to share with the reviewer during the data session of the on-site visit. Data are used to demonstrate ongoing performance improvement efforts.

NOTE: *Performance Measures (for those performance measures that are not STK or CSTK measures, please have data available for the reviewers during the data session of the on-site visit)*
NYS PSC 1: VTE Prophylaxis

NYS PSC 2: Discharge on Antithrombotic Therapy
NYS PSC 3: Anticoagulation Therapy for AFIB/Flutter
NYS PSC 4: Thrombolytic Therapy (arrive by 3.5 hours, treat by 4.5 hours)
NYS PSC 5: Antithrombotic Therapy by the end of Hospital Day Two
NYS PSC 6: Discharged on Statin Medication
NYS PSC 7: Stroke Education
NYS PSC 8: Smoking Cessation
NYS PSC 9: Assessed for Rehabilitation
NYS PSC 10: Dysphagia Screening
NYS PSC 11: Initial NIHSS Reported
NYS PSC 12: mRS on Discharge
NYS PSC 13: Pre-Notification: Percent of cases of advanced notification by EMS for patients transported by EMS from scene
NYS PSC 14: EMS Pre-Hospital Stroke Scale: Percent of patients arriving via EMS who had pre-hospital stroke scale performed
NYS PSC 15: Pre-Notification Content:

- Last Known Well communicated
- Stroke scale findings communicated

NYS PSC 16: Stroke Team Activated Prior to Arrival: Percent of patients arriving via EMS for whom the stroke team was activated prior to patient arrival based upon EMS pre-notification
NYS PSC 17: Door to MD/DO/NP/PA Assessment (10 minutes)
NYS PSC 18: Door to Stroke Team (15 minutes)
NYS PSC 19: Door to Brain Image Complete (25 minutes)
NYS PSC 20: Door to Brain Image Read (45 minutes)
NYS PSC 21: Door to IV tPA (60 minutes) – 85%
NYS PSC 22: Door to IV tPA (45 minutes) – 50%
NYS PSC 23: Door-in-door-out time at first hospital prior to transfer for acute therapy (</= 90 minutes)
NYS PSC 24: NIHSS Reported
NYS TSC 1: mRS at 90 days: documented
NYS TSC 2: mRS at 90 days: following mechanical endovascular reperfusion therapy, favorable outcome
NYS TSC 3: Hemorrhagic transformation (overall rate)
NYS TSC 4: Mechanical Endovascular Reperfusion Therapy for Eligible Patients with Ischemic Stroke
NYS TSC 5: Thrombolysis in Cerebral Infarction (TICI post treatment reperfusion grade)
NYS TSC 6: NIHSS at Discharge
NYS TSC 7: Timeliness of reperfusion: arrival time to TICI 2B or higher (120 minutes)
NYS TSC 8: Timeliness of reperfusion: skin puncture to TICI 2B or higher (120 minutes)
NYS TSC 9: Door to Puncture Time
NYS TSC 10: Imaging to Puncture Time

NYS CSC 1: Severity measurement for SAH and ICH
NYS CSC 2: Nimodipine Treatment within 24 Hours