

Disease-Specific Care Certification Review Process Guide 2021





The Joint Commission

Disease Specific Care Certification

Review Process Guide

January 2021

What's New in 2021

New or revised content for 2021 is identified by underlined text in the activities noted below.

Changes effective January 1, 2021

No changes.

Disease Specific Care

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Disease Specific Care Certification

Organization Review Preparation

The purpose of this activity guide is to inform organizations about how to prepare for the Disease Specific Care onsite certification review, including:

- Identifying ways in which the organization can facilitate the onsite review process
- Describing logistical needs for the onsite review

Important Reading

The Certification Review Process Guide describes each activity of a Joint Commission onsite certification review. Organizations should read through each of the following activity descriptions, which include:

- The purpose of the activity
- Descriptions of what will happen during the session
- Discussion topics, if applicable
- Recommended participants
- Any materials required for the session

These descriptions can be shared organization-wide as appropriate.

Pre-Review Phone Call

A Joint Commission account executive will contact your organization by phone shortly after receiving your application for certification. The purpose of this call is to:

- Confirm information reported in the application for certification, to verify travel planning information and directions to office(s) and facilities,
- Confirm your access to The *Joint Commission Connect* extranet site and the certification-related information available there (onsite visit agenda, Certification Review Process Guide, etc.), and
- Answer any organization questions and address any concerns.

Information Evaluated Prior to the Onsite Certification Review

The Joint Commission Certification Reviewer assigned to perform your organization's onsite visit will receive the following items presented with your organization's Request for Certification.

1. Demographic information, including identification of the disease-specific care service(s) undergoing certification review
2. The name and description of the clinical practice guidelines used for each disease program seeking certification – This information is entered into the Certification Measure Information Process form accessible from the organization's extranet site. It is important that the reviewer have the most complete information about the clinical practice guidelines being followed by the program, including the nationally recognized/published name, the population covered (adult or pediatric) by the guidelines, the year the guidelines were issued, the source of the guidelines (e.g., association, professional organization, literature-base upon which guidelines were established for the program) and any other identifying information that will assist the reviewer in locating the

guidelines being implemented by the program (see also page 12). Examples of CMIP entries include:

- Standards of Medical Care in Diabetes -2017. American Diabetes Association. Diabetes Care 2017;40(1):S4-S125.
 - ACC/AHA/HFSA Guideline: Yancy, Clyde W., et.al. 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. Circulation. 2017;
 - AHA/ASA Stroke Guidelines – 1) Jauch, Edward C., Saver, Jeffrey L., et al. Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke, 2013;44:870-947. 2) Powers, William J., Derdeyn, Colin P., et al. 2015 American Heart Association/American Stroke Association Docused Update of the 2013 Guidelines for the Early Management of Patients with Acute Ischemic Stroke Regarding Endovascular Treatment: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2015;46:3020-3035. 3) Hemphill III, J. Claude, Greenberg, Steven M., et al. Guidelines for the Management of Spontaneous Intracerebral Hemorrhage: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2015;46:2032-2060.
3. Stage I- Four non-standardized performance measures, including at least (2) clinically-focused measures; or Stage II – Standardized performance measures as defined by disease program
 - On Re-certification reviews, the reviewer will also receive measure-related data submitted by the program
 4. Performance improvement plan

Familiarizing a reviewer with your program before the onsite visit facilitates evaluation of your program's compliance with standards. Advance analysis makes the on-site review time more efficient, effective and focused.

Information Needed During On-site Review

Please note that it is not necessary to prepare documentation just for purposes of the certification review. The reviewer is interested in seeing the resources that staff reference in their day-to-day activity. These items need not be stand-alone documents; the items noted may represent sections contained within other documents.

Items Required for Reviewer Planning Session

The following is a list of items that reviewers **WILL NEED** to see during the Reviewer Planning Session of the onsite review.

- Composition of the program's interdisciplinary team
- Program's mission and scope of services
- An organization chart for the program, if one is available
- Emergency and medical equipment management plans
- Current list of patients being treated through the disease program

(NOTE: It is desirable to have the following information included in both the list of current and discharged patients: Primary diagnosis, admit date, discharge date, patient age, gender and ethnicity, if available.)

- A list of patients who accessed or progressed through the disease program in the
 - past four months for initial reviews and
 - past twelve months for recertification reviews

(NOTE: The above noted time frames can extend further back in order to increase the number of patients from which the reviewer can sample. Ten patients to select from is desired, but a lower number is acceptable in those programs that do not yet have experience with this number of patients)

- Order sets, clinical pathways, protocols, etc., that are used to implement selected clinical practice guidelines
- Education material for program patients
- Policy and procedures for patient confidentiality including staff authorization for access
- Policies on retention of health records and other data and information
- A written performance improvement plan
- Performance measure data collected and reported for the required four measures
- Continuous quality improvement reports (for previous 12-months for re-certification reviews)
- Performance improvement action plans that demonstrate how data have been used to improve program care and services, when available

Additional Items Required for Stroke Center Certification Reviews

In addition to the items noted above, the following documents **WILL BE NEEDED** for the Reviewer Planning Session:

- List of patients for the past 4-12 months with the following diagnoses or intervention:
 - Ischemic Stroke
 - Hemorrhagic Stroke – please indicate whether patient was diagnosed with ICH or SAH
 - TIA's
 - Administration of tPA
 - Mechanical thrombectomy for LVO

(NOTE: Ten patients to select from are desired, but a lower number is acceptable in those programs that do not yet have experience with this number of patients. The above noted time frames can extend further back in order to increase the number of patients from which the reviewer can sample.)

- List of stroke team members

Additional Items Required for Ventricular Assist Device Destination Therapy Review

In addition to the items noted above, the following documents **WILL BE NEEDED** for the Reviewer Planning Session:

- INTERMACS data

Additional Items Required for Advanced Certification for Total Hip and Total Knee Replacement Review

In addition to the items noted above, the following **WILL BE NEEDED** For the Reviewer Planning Session:

- List of patients having either a total hip or total knee replacement on either day of review

Items Reviewers May Request During On-site Review

Following is a list of items that reviewers **MAY REQUEST** to see during any onsite review.

- Disease management program-specific policies and procedures
- Staff orientation materials, with target audience identified
- Staff job descriptions
- Program specific physician credentials requirements, if applicable
- Written criteria for appointing or hiring practitioners
- In-service or conference calendars and attendance sheets for the past 12 months and for remainder of current year or next six months
- Policies and procedures for education and competency training
- Frequently used internal forms or documents related to the clinical practice guidelines (for example, assessment, intervention, additional algorithms)
- Performance improvement policies and procedures
- Policies and procedures for collecting, processing, and analyzing data
- A list of data elements collected for selected program performance measures, and other data collection instructions or documents
- Schedules and agendas of any classes, group meetings, seminars, etc. related to patient education
- Documents sent to patients about accessing the program's services, when applicable
- Any required business licenses
- Supporting policies and procedures related to ethical business and professional behavior
- Policies and procedures for identifying and managing unanticipated adverse events
- Enrollment requirements, if applicable

Logistics

- While onsite, the reviewer(s) will need workspace for the duration of the visit. A desk or table, telephone, 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 may request to see some closed records as well in order to verify performance with guidelines such as those that address patient discharge and post discharge follow-up.
- Your onsite review agenda template, similar to those presented later in this guide, will be posted to your *Joint Commission Connect* extranet site. The review agenda presents a suggested order and duration of activities. Discuss with the reviewer any changes to the agenda that may be needed at any time during the onsite visit.

Questions about Standards

If you have 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, Login to your organization's Joint Commission extranet site, *Connect*: <https://customer.jointcommission.org/TJCPages/TJCHomeEmpty.aspx> and click on Resources - Standards Interpretation, to submit your question. If you do not have access to *Connect*, please go to the Standards Interpretation Page: https://www.jointcommission.org/standards_information/jcfaq.aspx to submit a question.

Questions about the on-site review process, agenda, scheduling, etc. – Call your Joint Commission Account Executive.

Certification Review Notification and Postponement Policies

Notice of Initial Certification On-site Review

If this is your program's first time through the certification process you will receive a thirty (30) day advance notice of your on-site review date(s). Notice will be provided via e-mail to the individuals identified on your account as the Primary Certification Contact and CEO. Also thirty (30) days prior to your review, the Notification of Scheduled Events section on your organization's extranet site, *The Joint Commission Connect*, is populated with the event along with a link to the reviewer(s) name, biographical sketch and photograph.

Notice of Re-Certification On-site Review

Your organization will receive notice from The Joint Commission seven (7) business days prior to the first day of the scheduled review date(s) for Disease Specific Care re-certification. The notice will be emailed to the individuals identified on your account as the Primary Certification Contact and CEO and will include the specific review date(s) and the program(s) being reviewed. Additionally, at 7:30 a.m. in your local time zone on the morning of the review, the Notification of Scheduled Events section on your organization's extranet site, *The Joint Commission Connect*, is populated with the review event including a link to the reviewer(s) name, biographical sketch and photograph.

Review Postponement Policy

The Joint Commission may not certify a program if the Organization does not allow The Joint Commission to conduct a review. In rare circumstances, it may be appropriate to request a review postponement. An organization should direct a request for postponement to its Account Executive. A request to postpone a review may be granted if a major, unforeseen event has occurred that has totally or substantially disrupted operations, such as the following:

- A natural disaster or major disruption of service due to a facility failure
- The organization's involvement in an employment strike
- The organization's cessation of admitting or treating patients
- The organization's inability to treat and care for patients and its transference of patients to other facilities

The Joint Commission may, at its discretion, approve a request to postpone a review for an organization not meeting any of the criteria listed above.

Your organization's Certification Account Executive can answer questions about these policies, or put you in contact with other Joint Commission staff that can assist you.

Disease Specific Care Certification

Performance Measures

Non-Standardized

Disease specific care certification requires programs to self-select and collect and analyze data on four performance measures prior to their initial on-site review. At least two of the four measures should be related to clinical processes or outcomes related to or identified in the clinical practice guidelines being followed by the program. The other two performance measures may also be clinical or related to program activity (i.e. administrative or financial areas, health status, or patient satisfaction). The self-selected performance measures should be evidence based, relevant to the program, valid, and reliable. When selecting measures consider the type of data that is likely to reveal program performance and opportunities for improving the provision of care and services.

Standardized

The Joint Commission includes standardized sets of performance measures for specific programs (i.e. Primary Stroke Center and Advanced Certification in Heart Failure). These performance measures have precisely defined specifications, standardized data definitions, and standardized data collection protocols. These performance measures replace the non-standardized, self-selected performance measures when they are launched.

Quantity of Data

For initial certification, at least four months of data for each measure must be available at the time of the on-site review for both non-standardized and standardized performance measures. For re-certification, 12-24 months of program data must be available at the time of the on-site review. At least the last twelve months of program data should be available at the time of the Intra-cycle monitoring phone call with the reviewer.

What to Look for in a Good Measure

Consider the following guidelines when selecting or developing a non-standardized performance measure. Is the performance measure:

- Based on evidence
- Under the program/service and within provider control
- Related to current clinical practice guidelines
- Accompanied by defined measure specifications such as:
 - Rationale
 - Numerator and denominator statements
 - Description of measure type (process or outcome measure)
 - Direction of improvement
- Based on logical data collection calculations
 - Consistent with measure specifications and sampling protocols
- Useful to the disease-specific care program and the organization

For further information on performance measures and core measures, please visit The Joint Commission Performance Measurement Network Q&A Link:

<http://manual.jointcommission.org/bin/view/Manual/WebHome>

Sampling Methodology

Please refer the *Disease-Specific Care Certification Manual* for further information on sampling methodology.

Retirement of a Performance Measure

There are no set guidelines for retirement of a performance measure. Multiple data points are required to demonstrate that performance has not only been achieved but also sustained. A well-constructed measure can remain meaningful and useful for many years. At minimum, measures selected for certification purposes should be retained for the entire 2-year certification period (i.e. 24 monthly data points). Retirement of a non-standardized performance measure should be considered prior to the recertification visit; at which point a discussion should occur with the reviewer on potential new measures.

Retirement or measure modification may be needed when the evidence supporting the measure significantly changes, (e.g. “AMI-6, Beta-Blockers on Arrival”). Similarly, retirement or modification may be indicated when program performance has reached a plateau, and the opportunity for further improvement is considered marginal or “topped out”. In such situations, periodic data collection is advised to verify that the program maintains high performance over time. When standardized measures are developed by The Joint Commission for the certification program, (i.e. Primary Stroke Certification and Advanced Certification in Heart Failure), the non-standardized measures previously utilized by the program are retired and replaced with the standardized measure set.

Disease Specific Care Certification

Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are tools that describe a specific procedure or processes found, through clinical trials or consensus opinion of experts, to be the most effective in evaluating and/or treating a patient who has a specific symptom, condition, or diagnosis. CPGs function to direct care toward evidence-based practice, provide a standard of care for varied populations, and increase collaboration efficiency of team members.

An organization or program can choose to create their own CPGs or adopt or adapt CPGs from professional organizations or a clearinghouse. The risks and benefits should be weighed by the organization on whether creation or adoption of CPGs will work best for them. In March 2011, the Institute of Medicine (IOM) published a report that discusses how to identify a high quality CPG. This report can be used as a reference to guide the program leaders on distinguishing high quality CPGs for their program.

CPGs can be used as a means to accomplish program goals for care, treatment and services of the target population. Collaboration of all team members and front line staff is imperative when implementing a CPG. Post-implementation monitoring should occur to assure that the various aspects of the CPGs continue to be used with the original intent of achieving program goals for patients. The program can develop performance measures based on selected aspects of the CPG to monitor provider and staff adherence to, or variance from the CPG.

A disease specific care program seeking Joint Commission certification must demonstrate that it is providing care, treatment and services according to clinical practice guidelines or evidence-based practice. The review of compliance considers both The Joint Commission standards and the guidelines or evidence-based practices the program is following.

For your convenience, links have been provided to assist in development of a CPG or identifying an already published CPG for adoption or adaptation.

<https://guidelines.ecri.org/>

<http://www.healthquality.va.gov/>

Disease Specific Care Certification

Opening Conference and Orientation to Program

This session combines two activities into one 60-minute block of time. The breakdown of activities and suggested length for each follows.

Organization Participants

- Opening Conference – Program(s) administrative and clinical leadership and others at the discretion of the organization
- Orientation to Organization – Program(s) administrative and clinical leadership and others at the discretion of the organization

Materials Needed for this Session

- Organization chart, if applicable
- Disease specific care program organization chart, if applicable
- Roster or sign in sheet of the organization representatives attending this session (Note: This document is used as a reference by the reviewer throughout the visit and will be returned to the organization at the conclusion of the review.)

Overview of the Opening Conference (15 minutes)

Approximately 15-20 minutes in duration that includes:

- Reviewer introduction
- Introduction of organization review coordinator and leaders (Please note: Other staff can be introduced as the reviewer encounters them throughout the onsite visit);
- Overview of The Joint Commission and Disease Specific Care Certification
- Agenda review with discussion of any needed changes
- Overview of the SAFER™ portion of the Summary of Certification Review Findings Report
- Mention of the changes to the post-review Clarification process
- Questions and answers about the onsite review process.

Overview of the Orientation to the Program (45 minutes)

This 45-minute session is an exchange between the organization and reviewer about the disease management program(s) structure and scope of care and services. A brief, approximately 15-20 minute, summary presentation about the program is very helpful to the reviewer and often to organization staff participating in the review process. Additional discussion with the reviewer following the presentation will help clarify the documentation submitted by the program with their application for certification. The reviewer will facilitate the discussion and use the information as a base to build on while continuing their program review in other activities.

Program representatives participating in this session should be able to discuss topics such as:

- Program mission, goals and objectives
- Program structure
- Program leadership and management
- Program design
- Composition of the program's interdisciplinary team

- Scope of services/continuum of care
- Developing, implementing and evaluating the program
- Target population for the program
- Identified needs of the program population
- The selection and implementation of clinical practice guidelines
- Evaluation of clinical practice guideline use and appropriateness to target population
- Performance improvement process, including evaluation of the disease management program's efficacy

Disease Specific Care Certification

Reviewer Planning Session

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. Additionally, reviewers will identify personnel and credentials files that they will need for review during the Competence Assessment and Credentialing Process session.

Organization Participants

- Program representative(s) that will facilitate tracer activity
- Individual(s) responsible for obtaining clinical records

Materials Needed for this Session

- Current list of patients being treated through the disease program
- If there are no patients currently being treated, a list of patients who accessed or progressed through the disease program in the past 4-12 months
(NOTE: It is desirable to have the following information included in both the list of current and discharged patients: Primary diagnosis, admit date, discharge date, patient age, gender and ethnic origin, if available.)
- Order sets, clinical pathways, protocols, etc., that are used to implement selected clinical practice guidelines

Stroke Center Certification Additional Documents

- List of patients for the past 4-12 months with the following diagnoses or intervention
 - Ischemic Stroke
 - Hemorrhagic Stroke – please indicate whether patient was diagnosed with ICH or SAH
 - TIAs
 - Administration of tPA
 - Mechanical thrombectomy for LVO
- List of stroke team members

Ventricular Assist Device Destination Therapy Certification Additional Documents

- INTERMACS data

Planning Guidelines – Selecting Patients to Trace

1. Reviewers will describe to the program representatives the types of patients that they want to trace and request their assistance in identifying individuals who may fit the description. A list of active patients is needed for this activity, or the reviewer may proceed directly to a patient care area and ask the staff to help identify patients.

2. A minimum of five (5) patients will be selected
 - Patients selected should present the opportunity to trace care and services through as many of the potential departments, areas, sites, or services that support or participate directly in the disease specific care program.
 - Patients should have different characteristics, such as demographics, age, sex and other factors that would influence the program response, or impact the application of clinical practice guidelines.
 - a. **For Stroke Programs ONLY**—In addition to the above guidelines for patient tracer selection, within the five (5) patients selected the reviewer will want to include patients who experienced TIA, thrombosis or embolus, patients treated with intravenous tPA for a stroke, and patients who experienced a hemorrhagic stroke.
 - b. **For Advanced Certification for Total Hip and Total Knee Replacement ONLY**
A minimum of six (6) patients will be selected for tracer activity
 - A minimum of three (3) patients experiencing total hip replacement
 - A minimum of three (3) patients experiencing total knee replacement
 - At least one of the patient tracers performed must allow for the intraoperative observation
3. Reviewers will prioritize patients for tracer activity with the organization's assistance.

Planning Guidelines – Selecting Competence and Credentials Files for Review

1. A minimum of (5) files will be selected per disease specific care program
2. At least one file per discipline (physician, nurse, social worker, dietitian, therapist, etc.) represented on the disease specific care program team will be reviewed.
3. The reviewer will select these files based on the individuals encountered during tracer activity, that is, those caring for or who cared for the patient being traced. Please let the reviewer know if there could be a delay in getting files for review.

Planning Guidelines – Contact with Discharged Patients

Reviewers will want to have some contact with the program's patients. If there are no active patients at the time of the review, the reviewer will request the program representatives to arrange for a phone call with one or more past patients.

Disease Specific Care Certification

Individual Tracer Activity

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 or service through the program
- Assess the impact of interrelationships among the program disciplines on patient care
- Assess the use of and 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

Materials Needed for this Session

Clinical records of selected patients

Overview of the Individual Tracer Activity

1. A significant portion of the agenda is designated for patient tracer activity. The number of patients traced during this time will vary. **NOTE:** *In-house patients take priority for tracer activity; however, there may be instances when reviewers will select a discharged patient upon which to conduct a tracer. This will occur when reviewers need to trace the care provided to a patient with a given diagnosis, for example patients experiencing an ischemic stroke or a TIA. This may also occur to evaluate the patient discharge/education process for a program.*
2. Tracer activity begins in the unit, clinic or outpatient setting in which the patient may be scheduled for a visit or where the patient is routinely receiving care, treatment and services, or in the case of a discharged patient, the location from which they were discharged.
3. The organization/program staff and the Joint Commission certification reviewer will use the patient's record to discuss and map out the patient's course of care, treatment and services. The number of staff participating in this stage of the tracer should be limited. The rationale for limiting the number of staff participating in this stage is to reduce any distraction that the review process may have on patient care.
4. Organization/program staff and the reviewer will follow their map, moving through the organization, as appropriate, visiting and speaking with staff in all the areas, programs, and services involved in the patient's encounter. There is no mandated order for visits to these other areas. Reviewers will speak with any staff available in the area. **NOTE:** *This activity will occur on in-house as well as discharged patients.*
5. Throughout tracer activity, reviewers
 - 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.

The tracer should lead the reviewer back to the starting point of care. Upon returning, the reviewer will follow-up on observations made either through additional record review or discussions with staff.

At the conclusion of the tracer, the reviewer communicates 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, and
- Issues that have the potential to result in Requirements for Improvement.

Individual Tracer in the Clinical Setting

Includes the following activities:

- Record review with staff
- Trace a patient's care and services from preadmission through post-discharge, as applicable to disease management program being certified
- Visit units, departments, programs and services involved in the patient's care
- Observe environment of care
- Observe the delivery of care and services
- Observe staff interaction with patients
- Speak with representatives of disciplines involved in patient's care, preferably with staff who interacted with the patient if available
- Interview patient and/or family member, in person or by phone
- Trace disease specific care post-acute care support programs including:
 - the scheduling of follow-up laboratory, clinic, or therapy appointments, home visits, patient self-monitoring and electronic reporting (e.g., blood glucose levels, blood pressure)
 - Review of records and logs the organization maintains on either direct contact with patients or on contact with clinical customers

Individual Tracer Activity when DSC Services Delivered Remotely

Includes the following activities:

- Record review with staff
- Trace a patient's care and services from preadmission through post-discharge, as applicable to disease program being certified
- Observe staff interaction with patients
- Speak with representatives of disciplines involved in patient's care, preferably with staff who interacted with the patient if available

- Interview patient and/or family member, in person or by phone
- Trace services provided to clinical settings based on contractual agreements
- Trace disease specific care post-acute care support programs including:
 - the scheduling of follow-up laboratory, clinic, or therapy appointments, home visits, patient self-monitoring and electronic reporting (e.g., blood glucose levels, blood pressure)
- Review of records and logs the organization maintains on either direct contact with patients or on contact with clinical customers

Disease Specific Care Certification

System Tracer- Data Use

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 weaknesses 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

Materials Needed for this Session

- Performance measure data reports
- Action plans demonstrating the program's use of and response to data

Overview of the Data Use System Tracer

During the session, the reviewer(s) and organization will discuss:

- The basics of data gathering and preparation, including:
 - Selection of performance measures
 - Data collection, including validity and reliability
 - Data analysis and interpretation
 - Dissemination /transmission
 - Data use and actions taken on opportunities for improvement
 - Monitoring performance/improvement
- 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.
- Techniques used to protect confidentiality and security of all types of patient data.

Use of data for all aspects of the program, including medication management and infection control, as applicable, should be discussed during this session.

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. This discussion may include a review of:

- Actions taken as a result of using data
- Selection and prioritization of performance improvement activities
- Dissemination of findings and staff involvement
- Data reporting – when it occurs and to whom
- Type of analyses being conducted – approach to trending data over time, comparing data to an expected level of performance, and looking at data in combination for potential cause and effect relationships.

Disease Specific Care Certification

Competence Assessment & Credentialing Process

The purpose of this session is to discuss how the program meets the need for qualified and competent practitioners.

Organization Participants

- Program leaders
- Clinical leaders
- Organization representatives responsible for human resources processes
- Organization representatives responsible for credentialing processes, if different from above
- Individuals with authorized access to, and familiar with the format of files
- Others at the discretion of the organization

Materials Needed for this Session

Personnel or credentials files for individuals identified by the reviewer

- A minimum of five (5) files will be selected
- At least one file per discipline (physician, nurse, social work, dietician, therapist, etc.) represented on the disease specific care program team will be reviewed

Note: The reviewer will select these files based on the individuals encountered during tracer activity, that is, those caring for or who cared for the patient being traced. Please let the reviewer know if there could be a delay in getting files for review.

Overview of the Competence Assessment and Credentialing Process Session

During the session, the reviewer and organization representatives will:

- Discuss the following competence assessment and credentialing topics as they relate to the program seeking certification:
 - How the program fits into any organization-wide competence and credentialing processes, if applicable
 - Hiring criteria unique to the program
 - Selection of disease management team members
 - Program-specific competence and credentials requirements
 - Processes for obtaining team member credentials information
 - Program-specific credentials evaluation criteria
 - Orientation and training process for disease management program team
 - Methods for assessing competence of practitioners and team
 - Unique orientation, on-going education, training and in-service requirements for the program
- Participate in a facilitated review of selected files for:
 - Relevant education, experience and training or certification

- Current licensure that has been verified through the primary source prior to expiration
- Competence
- Evidence reflecting completion of any required continuing education
- Appointment letters for medical staff
- Evidence of medical staff privileging
- Evidence of FPPE/OPPE in applicable files

Individuals attending this session should be prepared to explain the program's approach to credentialing and competency assessment. Additionally, the organization should be prepared to address any program-specific credentials and competence requirements if this is certification for an advanced disease management program. These requirements exist for:

- Acute Stroke Ready Hospitals
- Primary Stroke Centers
- Thrombectomy-capable Stroke Centers
- Comprehensive Stroke Centers
- Lung Volume Reduction Surgery
- Ventricular Assist Device
- Management of Patients with Diabetes in the Inpatient Setting
- Chronic Kidney Disease

These advanced program requirements can be identified in the Disease Specific Care Certification standards manual.

Disease Specific Care Certification

Issue Resolution

Issue resolution time is an opportunity for the reviewer to follow-up on potential findings that could not be resolved in other onsite activities. This is also time for the organization to present any information that they believe the reviewer may have missed during the day or that may not have been immediately available upon the reviewer's request.

Organization Participants

Will vary depending upon the issue

Materials Needed for this Session

Will vary depending upon the issue

Preparation for Issue Resolution

None required

Overview of the Issue Resolution Session

The reviewer may have identified issues during individual tracer activity or other sessions that require further exploration or follow-up with staff. This follow-up may include a variety of activities such as:

- Review of policies and procedures
- Review of human resources files
- Review of performance improvement data
- Discussions with selected staff

The reviewer will work with the program's certification review coordinator to organize and conduct all issue resolution activity.

If there are no issues to resolve and the reviewer does not need any additional information, this activity will not need to occur. The reviewer will proceed with Report Preparation activity.

Disease Specific Care Certification **Team Meeting & Planning Session**

This activity only takes place on multi-day, multi-reviewer certification on-site visits. Reviewers use this session to debrief on the day's observations and plan for upcoming review activities.

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

Organization Participants

None

Logistical Needs

The suggested duration for this session is 30 minutes.

Disease Specific Care Certification

Daily Briefing

Reviewers will use this time to provide organization representatives with a brief summary of survey activities of the 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.

Duration

15-30 minutes

Participants

- Program administrative and clinical leaders
- Others at the discretion of the program

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.
- 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.

Disease Specific Care Certification

Reviewer Report Preparation

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

Private work space with access to an electrical outlet and internet connection, if available

Overview of the 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 Summary of Certification Review Findings report and plan for the Exit Conference.

Disease Specific Care Certification

Program Exit Conference

The Program Exit Conference is the final onsite activity when the organization receives a preliminary report of findings from the reviewer. In addition, reviewers will

- Review the the Summary of Certification Review Findings 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

Materials Needed for this Session

Copies of the Summary of Certification Review Findings report—if it is being distributed to staff

Preparation for the Program Exit Conference

None required

Overview of the Program Exit Conference

This is a 30-minute activity that takes place at the completion of a program review. Administrative and clinical program leaders, and other organization staff, as invited, will hear a verbal report of observations, review findings, requirements for improvement, and where these are appearing on the SAFER™ matrix. The Summary of Certification Review Findings Report is shared with participants in the Exit Conference ONLY with the permission of the CEO. All reports left onsite are preliminary and subject to change upon review by Joint Commission central office staff.

NOTE: In those instances 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.

Disease Specific Care Certification

Intra-cycle Evaluation Process

All organizations participating in the certification process are required to collect, report, and monitor their performance relative to standardized and non-standardized measures on an ongoing basis. The Certification Measure Information Process (CMIP) tool assists certified organizations with the data collection, reporting and monitoring requirements associated with performance measures. The CMIP tool is available on your organization's secure extranet site, The Joint Commission *Connect*. The Performance Measure (PM) Data Report portion of the CMIP tool is available for all Disease Specific Care programs to perform an annual analysis of their performance relative to each performance measure.

A mid-point (intra-cycle) evaluation of the performance measurement activities and standards compliance will be conducted via conference call with a Joint Commission reviewer.

Prior to the Intra-cycle Event

Your organization will receive an automated email to the primary certification contact and the CEO approximately 90 days in advance of the anniversary date of your last certification review. You 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 your performance improvement plan 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, your organization will receive an email reminder to submit the tool or risk having your certification decision changed.

If your organization is using a vendor to submit your standardized performance measure data, there will be no data in CMIP. Please be prepared to discuss and respond to questions from the reviewer regarding your performance measures and be able to provide current data.

Intra-cycle Evaluation Logistics

This call will take place as close as possible to the one year mid-point of the current two year certification cycle. The call 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. Participation in the intra-cycle conference call is mandatory for all Disease Specific Care programs.

Organization Participants

- Staff involved in data collection and analysis
- Program leaders that implement performance improvement plans

Overview of the Intra-cycle Evaluation Process

During the conference call, the reviewer will discuss

- The results of your organization's performance against the performance measures (monthly data),
- Your analysis of your performance (PM Data Report),
- Your organization's ongoing approach to performance improvement (PI Plan), and
- Your questions regarding compliance with Joint Commission standards.

This call is your organization's opportunity to have an interactive discussion with the Joint Commission reviewer to assure you are 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 your organization has not actively engaged in performance measurement and improvement activities since the time of the most recently completed initial or recertification review.

Addendum for Comprehensive Stroke Center (CSC) Certification

Introduction

Included in this CSC addendum is supplemental information to the *Certification Review Process Guide (RPG)*. Organizations preparing for the CSC certification will need to review the *Certification Review Process Guide* as well as the information in this addendum. The CSC addendum includes important information that is specific to CSC certification.

The CSC certification review occurs over two days. Therefore, time frames for agenda items in the *Certification Review Process Guide* are not applicable to the CSC certification review. The CSC agenda reflects the correct time frames for the CSC review as does this addendum. Keep in mind that the time frames mentioned are flexible, and may be revised by the reviewers as necessary based on organizational need.

Note: Requirements Assessed at Application: The term “eligibility criteria” is no longer used for CSC certification. The replacement term is “CSC Requirements Assessed at Application”. Reviewers will not be reviewing these CSC requirements at the opening conference. The Requirements Assessed at Application will be reviewed **at application** for organizations seeking CSC for the first time. For organizations seeking CSC recertification, these requirements will be addressed throughout the CSC review. The following CSC requirements will be assessed on application for organizations seeking initial CSC review:

- DSPM.1, EP 5, a, b, c, d: Volume requirements
- DSPR.3, EP 4, a and b.: Advanced Imaging Capabilities
- Post hospital care coordination (such as: DSDF.4, EP 4; DSDF.5 EP 1, a, b; DSDF.6, EP 1, a; DSDF.6, EP 2, a; DSDF.6, EP 3; DSSE.1, EP 3, a, b., DSSE.3, EP 5, a, b, c, d).
- DSPR.3 EP 4, d: Dedicated neuro-intensive beds for complex stroke patients
- DSPR.5, EP 1, a, b: Research and written research protocol
- DSPM.1, EP 2, b: Interdisciplinary program level review and peer review
- DSPM.1, EP 5, e: Performance measures

Other eligibility:

To be eligible for CSC certification, an organization must have performed mechanical thrombectomy and post-procedure care for at least 15 patients with ischemic stroke in the past 12 months or at least 30 patients over the past 24 months.

Additionally, all neurointerventionists who perform mechanical thrombectomy at the organization that is applying for CSC certification, must have performed 15 mechanical thrombectomies over the past 12 months or 30 over the past 24 months. In evaluating the number of mechanical thrombectomies performed by an individual physician, procedures performed at hospitals other than the one applying for certification can be included in the physician’s total.

CSC Patients

The Comprehensive Stroke Center certification (CSC) focuses on the complex stroke patient receiving care in an organization, including emergency care, advanced imaging, ICU/critical care, post-critical care, acute rehabilitation, and transitions into the home or another setting. According to the Brain Attack Coalition: “Complex stroke patients often require **advanced diagnostic and treatment procedures** directed by specially trained physicians and other health care professionals” (Alberts et al., 2005, p. 1598).

DAY ONE

(All activities noted below have detailed descriptions earlier in this guide. Please consult the table of contents.)

Opening Conference and Orientation to Program (90 Minutes)

Organization Participants

- Disciplines representing the care needs of the complex stroke patient based on the CSC requirements.

Opening Conference (15 Minutes)

- Overview of CSC certification by reviewers

Orientation to the Program (60-75 Minutes)

- The organization should be prepared to discuss or provide a 20-30 minute presentation, that includes:
 - A broad overview of the process of care for CSC patients implemented at the organization which may include: Scope of stroke services emergency care; advanced imaging; availability to perform interventions twenty four hours a day, seven days a week; ICU/critical care (dedicated neuro ICU beds); post ICU care; rehabilitation care; referral process; and, transitions of care to home or extended care.
 - The following subjects specific to the CSC program: (Note: This list contains subjects identified earlier in the *Orientation to the Program* activity, as well as some additional subjects specific to CSC. A combined list is provided here to minimize confusion.)
 - Program mission, goals, and objectives
 - Program structure
 - Program leadership and management,,
 - Program design
 - Stroke team composition
 - Developing, implementing, and evaluating the program
 - Target population for the program
 - Identified needs of the program population
 - The selection, implementation, and evaluation of clinical practice guidelines
 - Model of neuro-ICU care
 - Evaluation of clinical practice guidelines use and appropriateness to the target population
 - Performance improvement process, including evaluation of the disease management program's efficacy
 - Community relationships
 - Telemedicine (if in use)

Reviewer Planning Session and Protocol Review Session (30 Minutes)

This session combines two activities: the reviewer planning session and review of CSC protocols.

Materials Required for the Reviewer Planning Session:

- Current list of complex stroke patients (including those with ischemic and hemorrhagic stroke [ICH and SAH indicated]) from at a minimum the last 4 months, who received emergent care, advanced imaging, and interventions such as clipping for aneurysm, coiling for aneurysms, stenting of the extracranial carotid(s), mechanical thrombectomy for LVO, or medication therapy such as IV/IA tPA. Patients should be separated by diagnosis and date of admission.
- List of stroke team members and their credentials
- CSC protocols for care

Selecting Patients for Individual Tracers and Protocol Review (30 Minutes)

- From the list of current complex stroke patients, the reviewers in conjunction with program representatives will identify a minimum of 5 patients for tracing. Reviewers will also begin to identify personnel and credential files that they will need for review during the Competence Assessment, Credentialing Process, and Education session.
- The CSC certification has numerous requirements for protocols that focus on clinical care.
- Based on the patients chosen for the initial individual patient tracer, the reviewers may choose to review the organization's CSC protocols related to the patient's specific care, treatment, and services, as required by The Joint Commission's CSC requirements.

These protocols include:

- Activation of stroke team
- Process for obtaining EMS records
- EMS protocols including rapid assessment and rapid communication between emergency department
- Meeting the concurrent emergent needs of two or more complex stroke patients
- Medical stabilization of patient en route to the emergency department by EMS staff
- Care of complex stroke patients in an emergency situation
- Acute workup of ischemic/hemorrhagic stroke patients
- Informed consent for stroke interventions
- Use of IV tPA
- Implementation of endovascular procedures
- Use of therapeutic hypothermia
- Reduction of complications
- Nursing care through the continuum of care
- Receiving stroke patient transfers
- Transferring stroke patients to another hospital/facility
- Evaluating the receiving organization's ability to meet the individual patient's needs
- Transitions of care for patients within the organization (internal) and post hospitalization (external)
- Referral process when the CSC does not provide post acute, inpatient rehabilitation services

- Circumstances under which the organization would not accept transferred complex stroke patients for surgical procedures/advanced treatment (i.e. the hospital is on lock down)
- The review of the protocols will continue throughout the review and they should remain available and easily retrievable. The reviewers will compare care provided during individual patient tracer activity to protocols utilized by the stroke program.

Emergency Department Review (30 Minutes)

Organization Participants include:

- Emergency Department Medical Director
- Emergency Department Nurse Director/Manager
- Emergency department licensed independent practitioners and staff as determined by the organization

Before initiating the first individual patient tracer, the reviewers conduct an evaluation of the organization's emergency department (ED). The organization is to provide a high level, brief overview of how care is provided to CSC patients in the ED.

- This activity is designed to assist the reviewer's understanding of how CSC care is initiated in your organization. **This departmental review does not require a formal slide presentation.**

Be prepared to:

- Tell your story about providing care for acute complex stroke patients in the ED setting.
- Describe how your organization is able to care for more than one complex stroke patient simultaneously.
- Discuss your ED's infrastructure including staff, licensed independent practitioners, equipment, and materials (including medications) that are required to care for acute complex stroke patients.
- Discuss your organization's process for obtaining EMS records documenting care provided during the transfer to the facility.

Individual Patient Tracer Activity- Day 1 (Morning Session, 2 Hours)

Organization Participants

Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patients, including staff who have been involved in the patient's care. This may include:

- Emergency licensed independent practitioners and staff
- Imaging licensed independent practitioners and staff
- Surgical/procedural licensed independent practitioners and staff
- ICU licensed independent practitioners and staff
- Speech therapist(s), physical therapist(s), and occupational therapist(s)
- Discharge planner(s) and case manager(s)
- Other licensed independent practitioners and staff providing stroke care at the discretion of the organization
- Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology staff

Materials Needed for This Session

- Clinical record of selected patient

Overview of the Individual Patient Tracer Activity

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

- Follow a patient's course of care, treatment or service through the program:
 - Individual patient tracer activity usually begins on the unit the patient is currently being treated or the location from which they were discharged
 - Program staff and reviewers will follow the patient movement through the organization, as appropriate, visiting and speaking with staff in all the areas, programs, and services involved in the patient's encounter
 - Evaluation of the care provided to the patient including emergency services, advanced imaging, surgical and endovascular interventions, neuro-ICU care, post ICU care, rehabilitation care, patient family education, referral, and transferring/discharge procedures
- Assess the impact of interrelationships among the program disciplines on patient care:
 - The specific disciplines for CSC include, but are not limited to, stroke team members, physicians including neurosurgeons, radiologists, ED physicians, interventionalists etc.: advanced practice nurses, registered nurses, imaging technicians, rehabilitation therapists, social workers, case managers/discharge planners, pharmacists, and other clinical and ancillary staff
- Assess the use and adherence to and diversion from clinical practice guidelines in the patient's care, treatment, or service
- Evaluate the integration and coordination of program and organization services in the patient's care

On Day 1: All tracers over the course of the review will be conducted separately by the reviewers. Plan for sufficient staff and licensed independent practitioners to accommodate the two reviewers conducting tracer activity in the organization. Also, plan for space to accommodate reviewers conducting interviews during individual patient tracers so as not to interfere with patient care. If your organization utilizes electronic medical records/documentation, please plan to provide computer access for the reviewers during individual patient tracers. This can be done in a conference room or on the patient care unit. The number of staff participating in the individual patient tracer activity should be limited. The rationale for limiting the number of staff participating in this activity is to reduce any distraction that the review process may have on patient care.

At the conclusion of each tracer, the reviewers will communicate to the program representatives and care providers any:

- Specific observations made
- Issues that will be continued to be explored in other tracer activity
- Need for additional record review
- Issues that have the potential to result in requirements for improvement

Closed Chart Review: During individual patient tracers, the reviewers may request closed patient records for review. The purpose of the closed patient records review is to evaluate the care provided throughout the continuum of care and also the discharge/transitions care provided to complex stroke patients. Reviewers will also request information about the follow-up call if applicable.

Individual Patient Tracer Activity- Day 1 (Afternoon Session, 2 ½ Hours)

Plan to have sufficient staff and licensed independent practitioners to accommodate the two reviewers that will be conducting patient tracer activity throughout the organization. All aforementioned information pertaining to individual patient tracers is applicable to the Day 1 afternoon tracer. See the CSC agenda for specific tracer activities.

Reviewer Summary Session/Special Issues Resolution - End of Day 1 (1 Hour)

Organization Participants

Program representatives who can facilitate patient selection for Day Two tracer activity and an individual responsible for obtaining clinical records should be available. Other staff also, as designated by the organization.

Overview of Reviewer Summary Session/Special Issues Resolution

This session is for the reviewers to confer at the end of the first day, and plan for Day Two of the review. During this time the reviewers will:

- Address any special issues for resolution with the organization
- Select patients for the Day Two individual tracers.

The reviewers will also communicate a summary of the first day's observations to the program representatives and will determine if additional information will be needed the following day.

Day Two

Daily briefing with the organization (30 minutes)

Reviewers will review with the organization:

- Provide a summary of Day One activities
- Follow-up on any unresolved issues from Day One
- Obtain any outstanding documents

Individual Patient Tracer Activity- Day 2 (Morning Session 2 ½ Hours)

Plan to have sufficient staff and licensed independent practitioners to accommodate two reviewers that will be conducting patient tracer activities throughout the organization. All aforementioned information pertaining to individual patient tracers is applicable to the Day 2 individual patient tracers.

System Tracer--Data Use (2 Hours)

Organization Participants

- Program administrative and clinical leaders
- Individual(s) responsible for performance improvement processes within the program
- Individual(s) responsible for stroke research and processes within the program

- Others at the discretion of the organization

Materials Needed

- Performance measurement data addressed in requirements
- Action plans demonstrating the program's use of and response to data collection

During the session, the reviewers and program representatives will discuss:

- The basics of data gathering and preparation, including data collection, analysis, interpretation, and actions taken on opportunities for improvement
- Strengths and opportunities for improvement in the processes used to obtain data and meet internal and external information needs
- How clinical, management, and patient satisfaction data is used in decision-making and in improving patient safety and quality

Overview of the Data Use System Tracer

The system tracer session is focused on the program's use of data to improve care, treatment, and services, as well as the safety and quality of care for complex stroke patients. Specific areas of focus for CSC certification will include:

- Use of a defined performance improvement methodology including plans, action plans, and resulting improvements
- Volumes of procedures and interventions
- Annual aneurysm clipping and coiling mortality rates
- Complication rates
- Current stroke performance measure data
- Percentage of complex stroke patients that receive a follow-up phone call by a member of the organization's stroke team within seven days of discharge (Note: Applicable only to CSC patients who are discharged home)
- Public reporting of outcomes per requirements
- Interdisciplinary program review and peer review process
- Use of the stroke registry
- Patient satisfaction data specific to complex stroke patient population
- CSC research which must be patient-centered and approved by the Institutional Review Board (IRB). Also have your written research protocols available for review.
- Review of the program's stroke team log
 - Organizational Data:
 - For CSC requirements that call for organizational data (such as, complication rates), the organization must provide data from the four months prior to the review date. This is applicable to organizations that currently have PSC certification and those that do not.
 - For organizations that are transitioning from PSC to CSC, the organization must provide one year of data for the PSC data requirements (including the PSC Stroke Performance measures data).

Education, Competence Assessment, and the Credentialing Process Session (2 Hours)

Organization Participants:

- Individual(s) familiar with program-specific requirements for team members such as supervisors, managers, and leaders
- Clinical or medical director(s)

Overview of the Competence Assessment, Credentialing Process, and Education Session

This session is focused on:

- The process to provide ongoing education and training of practitioners
- The requirement addressing public education classes (2) offered by the CSC program/organization
- Others at the discretion of the organization

The reviewers will discuss the following education, competence assessment, and credentialing topics as they relate to CSC:

- Orientation
- Competence assessment for staff caring for complex stroke patients
- Contract personnel competence assessment and education (if contract staff is used)
- Core stroke team members required to have 8 hours of stroke education annually
- Reason and rationale related to which nurses were identified to receive the 8 hours of education
- Continuing education: staff involved in care of stroke patient to have stroke education annually without specific hour requirement
- On-going education, training, and in-service requirements for the program. Job descriptions for select:
 - Nursing Staff
 - Medical Staff
 - Other Staff who cared for patients identified during the patient tracers
- Additional job descriptions for the:
 - Medical Director of Stroke Program
 - Stroke Coordinator
 - Director of Rehabilitation Services
 - Advanced Practice Nurse
- Documentation of at least two educational programs focused on stroke prevention/care provided for the public

The reviewers will participate in a facilitated review of selected personnel and credential files requested during the tracer activities for evidence reflecting completion of any required annual continuing education:

- 8 hours of continuing education for the core stroke team members
- 8 hours of neurovascular disease and stroke continuing education for registered nurses caring for complex stroke patients, as identified by the organization
- 2 hours of continuing education per year on cerebrovascular disease, including acute stroke care for registered nurses in the emergency department, as identified by the organization
- 2 hours of continuing education per year on cerebrovascular disease, including acute stroke care for other emergency department staff members, as identified by the organization
- A minimum of 1 or more registered nurses providing stroke care is required to attend 1 regional or national meeting/seminar every other year, as identified by the organization

- Evidence that the 1 or more registered nurses who attended the regional or national meeting/seminar provide education to the organization's CSC stroke nurses and other professional staff
- Licensed independent practitioners and staff members prepare and present 2 or more education courses per year to staff within and outside of the CSC
- Licensed independent practitioners and staff members who prepare and present are identified by the organization

Stroke Education for Nurses:

- Every individual nurse who provides care to complex stroke patients **does not** require 8 hours of education per year.
- The organization is to determine/identify the nurses providing complex stroke care who require the 8 hours of education. (CSC Requirement DSDf. 1, EP 7 a, provides examples of the type of nurses providing stroke care who may require this education.)
- Education can be counted on a "rolling" year basis as determined by the organization (e.g. July 2016 through July 2017).
- During the initial CSC review if all education is not yet completed, the organization can describe how the remaining education will be accomplished during the rest of the rolling year.
- After the initial review, the plan is to review CSC education ongoing through the organization's intracycle phone call.

Issue Resolution and Reviewer Report Preparation (1 Hour)

This session combines two activities. The activities are broken down as the following:

Issue Resolution

- This follow-up session may include the following activities, but is not limited to:
 - Review of policies and procedures
 - Review of human resources files
 - Review of performance improvement data
 - Discussion with selected staff
- The reviewers will work with program representatives to organize and conduct all issue resolution activities.

Reviewer Report Preparation

- The reviewers will use this time to compile, analyze, and organize the data he or she has collected into a summary report of observations made throughout the review.

Program Exit Conference (30 minutes)

- Reviewers will provide a summary of findings from the CSC review.

Disease Specific Care Certification Comprehensive Stroke Center Certification (CSC) Agenda Template

DAY 1

Time	Activity	Organization Participants
8:00-9:30 a.m.	Opening Conference and Orientation to Program	<p>Program clinical and administrative leadership</p> <p>Stroke team members</p> <p>Others at the discretion of the organization representing the disciplines providing complex stroke care</p>
9:30-10:00 a.m.	Reviewer Planning Session & Protocol Review Session <ul style="list-style-type: none"> - A list of comprehensive stroke patients for tracer selection separated by diagnosis, with date of admission -If inpatients are not available for a particular diagnosis, provide a list of all patients with that diagnosis for the previous 90 days - CSC protocols available for review for each stroke diagnosis - Job Description for the Stroke Program Coordinator and Medical Director - 2 copies of your stroke alert process - On-call schedules for neurosurgeons and IR physicians for the previous 90 days - Transfer policies/protocols 	<p>Program representatives who can facilitate patient selection and tracer activities</p>
10:00-10:30 a.m.	Emergency Department Review <p>The organization is to provide a high level, brief overview of how care is provided to CSC patients in the emergency department.</p> <p>Note: This activity is designed to assist the reviewer's understanding of how CSC care is initiated in your organization. This departmental review does not require a formal slide presentation.</p> <p>Be prepared to:</p> <ul style="list-style-type: none"> -Tell your story about providing care for acute complex stroke patients in the ED setting. -Describe how your organization is able to care for more than one complex stroke patient simultaneously. -Discuss your ED's infrastructure including staff, licensed independent practitioners, equipment and materials (including medications) that are required to care for acute complex stroke patients. -Discuss your process for obtaining EMS records documenting care provided during the transfer to the facility. -Discuss transfer protocols 	<p>Emergency Department Medical Director</p> <p>Emergency Department Nurse Director/Manager</p> <p>Emergency department licensed independent practitioners and staff as determined by the organization</p>
10:30-12:30 p.m.		

Disease Specific Care Certification Comprehensive Stroke Center Certification (CSC) Agenda Template

Time	Activity	Organization Participants
	<p>Individual Patient Tracer: Each reviewer will conduct tracers separately. Evaluation of patient care, treatment, and services, including:</p> <ol style="list-style-type: none"> 1. Advanced Imaging 2. Acute Comprehensive Stroke Care <ul style="list-style-type: none"> -Emergency care -Informed consent -Evaluation of the patient before surgery - IR suite -CT/MRI suite -Procedures and interventions -ICU care -Nursing care -Medical care -Additional care 3. Post Acute Care Comprehensive CSC Care <ul style="list-style-type: none"> -Assessment -Goals -Patient/Family education -Referrals -Transfers -Medical care -Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) 4. Transfer/Discharge 5. Follow-up Call 6. Closed Record Review: Reviewers may review closed medical records. 	<p>Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patient. May include:</p> <ul style="list-style-type: none"> -Emergency licensed independent practitioners and staff -Imaging licensed independent practitioners and staff -Surgical/procedural licensed independent practitioners and staff -ICU licensed independent practitioners and staff -Other licensed independent practitioners and staff providing stroke care -Speech therapist(s), physical therapist(s), and occupational therapist(s) -Discharge planner(s) and case manager(s) -Others at the discretion of the organization - Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff

Disease Specific Care Certification Comprehensive Stroke Center Certification (CSC) Agenda Template

DAY 1 Continued

Time	Activity	Organization Participants
12:30-1:00 p.m.	Reviewer Lunch	
1:00-3:30 p.m.	<p>Individual Patient Tracer: Each reviewer will conduct tracers separately. Evaluation of patient care, treatment, and services, including:</p> <ol style="list-style-type: none"> 1. Advanced Imaging 2. Acute Comprehensive Stroke Care <ul style="list-style-type: none"> -Emergency care -Informed consent -Evaluation of the patient before surgery - IR suite -CT/MRI suite -Procedures and interventions -ICU care -Nursing care -Medical care -Additional care 3. Post Acute Care Comprehensive CSC Care <ul style="list-style-type: none"> -Assessment -Goals -Patient/Family education -Referrals -Transfers -Medical care -Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) 4. Transfer/Discharge 5. Follow-up Call 6. Closed Record Review: Reviewers may review closed medical records. 	<p>Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patient. May include:</p> <ul style="list-style-type: none"> -Emergency licensed independent practitioners and staff -Imaging licensed independent practitioners and staff -Surgical/procedural licensed independent practitioners and staff -ICU licensed independent practitioners and staff -Other licensed independent practitioners and staff providing stroke care -Speech therapist(s), physical therapist(s), and occupational therapist(s) -Discharge planner(s) and case manager(s) -Others at the discretion of the organization - Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff
3:30-4:30 p.m.	<p>Reviewer Summary Session/Special Issue Resolution (optional) Reviewers to:</p> <ul style="list-style-type: none"> - Address any special issues for resolution - Communicate summary of the first day's observations - Select individual patient tracers for Day 2 	<p>Program representatives who can facilitate patient selection and tracer activity.</p>

Disease Specific Care Certification Comprehensive Stroke Center Certification (CSC) Agenda Template

DAY 2

Time	Activity	Organization Participants
8:00-8:30 a.m.	Daily briefing with the organization	As determined by organization
8:30-10:30 a.m.	<p>Individual Patient Tracer: Each reviewer will conduct tracers separately. Evaluation of patient care, treatment, and services, including:</p> <ol style="list-style-type: none"> 1. Advanced Imaging 2. Acute Comprehensive Stroke Care <ul style="list-style-type: none"> -Emergency care -Informed consent -Evaluation of the patient before surgery -IR suite -CT/MRI suite -Procedures and interventions -ICU care -Nursing care -Medical care -Additional care 3. Post Acute Care Comprehensive CSC Care <ul style="list-style-type: none"> -Assessment -Goals -Patient/Family education -Referrals -Transfers -Medical care -Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) 4. Transfer/Discharge 5. Follow-up Call 6. Closed Record Review: Reviewers may review closed medical records. 	<p>Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patient. May include:</p> <ul style="list-style-type: none"> -Emergency licensed independent practitioners and staff -Imaging licensed independent practitioners and staff -Surgical/procedural licensed independent practitioners and staff -ICU licensed independent practitioners and staff -Other licensed independent practitioners and staff providing stroke care -Speech therapist(s), physical therapist(s), and occupational therapist(s) -Discharge planner(s) and case manager(s) -Others at the discretion of the organization - Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff

Disease Specific Care Certification Comprehensive Stroke Center Certification (CSC) Agenda Template

Time	Activity	Organization Participants
10:30 -12:30 p.m.	<p>System Tracer: Data use, research, and performance improvement (PI): Conducted by both reviewers</p> <ul style="list-style-type: none"> - Use of a defined performance improvement methodology - -Volumes of procedures and interventions (including SAH, coilings for aneurysm, and clipping for aneurysm.) - Annual aneurysm clipping and coiling mortality rates - Complication rate data - Public reporting of outcomes - Current stroke performance measure data - Percentage of complex stroke patients that receive a follow-up phone call by a member of the organization's stroke team within seven days of discharge (Note: Applicable only to CSC patients who are discharged home) • Interdisciplinary program review and peer review process • Use of the stroke registry • Patient satisfaction data specific to complex stroke patient population • CSC research which must be patient-centered and approved by the Institutional Review Board (IRB). • Review of the program's stroke team log 	<p>Program clinical and administrative leadership. (Example: Stroke Coordinator, Stroke Program Medical Director)</p> <p>Individual(s) responsible for performance improvement and processes within the program</p>

Disease Specific Care Certification Comprehensive Stroke Center Certification (CSC) Agenda Template

DAY 2 Continued

Time	Activity	Organization Participants
12:30-1:00 p.m.	Reviewer Lunch	
1:00-3:00 p.m.	<p>Education, Competence Assessment, and the Credentialing Process: Conducted by both reviewers.</p> <p>Reviewers will review personnel records. Additionally reviewers will discuss education, competence, community education, and credentialing issues identified from the patient tracers and review of personnel records.</p> <ul style="list-style-type: none"> -Nursing Staff -Medical Staff -Other Staff -Community Education <p>The reviewers will also ask to view the personnel records of the:</p> <ul style="list-style-type: none"> - Medical Director of Stroke Program - Stroke Coordinator - Director of Rehabilitation Services - Advanced Practice Nurse 	<p>Individual(s) with authorized access to personnel and credential records</p> <p>Individual(s) familiar with program-specific requirements for team members such as supervisors, managers and leaders</p> <p>Clinical or medical director(s)</p> <p>Others at the discretion of the organization</p>
3:00-4:00 p.m.	Issue Resolution & Reviewer Report Preparation	<p>Certification review facilitator</p> <p>Program leaders and staff as requested by the reviewers.</p>
4:00-4:30 p.m.	Program Exit Conference	<p>Program and clinical leadership</p> <p>Others at the discretion of the organization</p>

Note: This agenda is a guide and may be modified based on organizational need and reviewer discretion.

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

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 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

- Organizations perform at least 15 mechanical thrombectomies and provide post-procedure care per year; if they do not meet this criterion, they may be eligible if they meet all other requirements and criteria. If this is the case, then:
 - The organization must provide 12 mechanical thrombectomies and provide post-procedure care by the end of the first full year following designation; and
 - If the organization does not reach an annual volume of 15 mechanical thrombectomies per year by the end of the second year, they will surrender their designation as a CSC
 - NYSDOH may conduct a review of cases and outcomes performed by a CSC with an annual volume of less than 15 mechanical thrombectomies to evaluate the appropriateness and quality of care provided until the annual volume reaches 15.
- All primary neurointerventionists who routinely take call to perform emergency mechanical thrombectomy must meet the following criteria:
 - Have performed 15 mechanical thrombectomies 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
 - Performed an average of 15 mechanical thrombectomies (as the primary operator) over the past 12 months or 30 over the past 24 months (procedures performed at hospitals other than the one applying for CSC certification can be included in the total).
- Provide care to 20 or more patients per year with a diagnosis of subarachnoid hemorrhage;
- Accomplish greater than or equal to 10 endovascular coiling or surgical clipping procedures per year for the treatment of aneurysm.

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

- Administer IV thrombolytic therapy to 25 eligible patients per year (or 50 patients over two years); IV thrombolytic therapy given at another hospital based on tele-stroke recommendation of the CSC and transferred to the CSC or there is evidence of follow-up monitoring by the CSC can be counted in this number.

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. This includes ensuring timely and accurate data submission to EMS as requested and complying with and monitoring programs established by regional EMS providers. The stroke coordinator should also take responsibility for collecting, storing and reporting data collection and for quality improvement of the stroke program.

Medical Director

The organization identifies a physician leader with sufficient extensive experience and expertise in neurology and cerebrovascular disease. This person shall be a physician on the hospital staff, licensed in New York State, and Board Certified in Internal Medicine, Emergency Medicine, Neurology, Neuroradiology, or Neurosurgery. The Medical Director may not be concurrently a Stroke Medical Director at another hospital.

The medical director shall attest to 8 hours of stroke focused continuing education on an annual basis.

Pre-hospital Services/EMS feedback

The organization tracks that EMS notified the ED of all potential incoming stroke patients and then provides feedback to EMS. The organization can contact their REMAC to connect with the Medical Director of the services to provide that feedback.

Neurologist

A neurologist must be available in person or via telemedicine within 15 minutes of the request.

Vascular Neurologist

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

Cerebrovascular Neurosurgeon

Cerebrovascular neurosurgeon is on call 24/7 with experience in clipping aneurysms and performing AVM surgery; Cerebrovascular Neurosurgeon or Interventional Neurologist or Interventional Neuroradiologist is on call 24/7 with experience in coiling aneurysms; Interventional Neurologist/Interventional Neuroradiologists that are also responsible for performing mechanical thrombectomy shall also fulfill requirements in the Neurointerventionists section.

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

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. Neurointerventionists shall be available by phone with access to imaging within 10 minutes of attempted contact and 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.

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 must complete eight (8) hours of stroke focused continuing education on an annual basis.

Rehabilitation Staff

The requirements for physical, occupational, and speech therapy are the same as what is required in the DSC manual under DSPR.5, EP 7; however, the following documentation is required:

- PT/OT schedule and on-call schedule
- List of personnel approved to complete a swallow screen
- Name/credentials of the rehabilitation physician leader

Telemedicine

Available 24/7 within 20 minutes to assess patients at PSCs and TSCs within catchment area (at a minimum this should include the ability to review imaging to assist in transfer determinations).

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:

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

- 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 imaging modalities, and time frame for diagnostic service completion and image sharing processes

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.

Vascular Imaging

The Comprehensive Stroke Center must have the ability to perform head and neck CTA arch to vertex 24/7. CTA imaging must be able to be read within 45 minutes either on-site or through teleradiology by a radiologist.

Patient Education

Resources for patient education should include a graphic on benefits and risks of IV thrombolytic therapy (e.g., NNT, likelihood of benefits to risk)

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.

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)

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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: NIHSS on Admission

NYS PSC 12: mRS on Discharge

NYS PSC 13: Pre-Notification

NYS PSC 14: Pre-Notification Content:

-Last Known Well communicated

-Stroke scale findings communicated

NYS PSC 15: Stroke Team Activated Prior to Arrival

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: Timeliness of reperfusion: arrival time to TICI 2B or higher (120 minutes)

NYS TSC 7: Timeliness of reperfusion: skin puncture to TICI 2B or higher (120 minutes)

NYS TSC 8: NIHSS Post Procedure

NYS CSC 1: Severity measurement for SAH and ICH

NYS CSC 2: Nimodipine Treatment Administered

Time Targets and Benchmark Goals

NYS PSC 16: Door to MD Assessment (10 minutes) – 85%

NYS PSC 17: Door to Stroke Team (15 minutes) – 85%

NYS PSC 18: Door to Brain Image Complete (25 minutes) – 85%

NYS PSC 19: Door to Brain Image Read (45 minutes) – 85%

NYS PSC 20: Door to IV tPA (60 minutes) – 85%

NYS PSC 21: Door to IV tPA (45 minutes) – 50%

NYS PSC 22: Door-in-door-out time at first hospital prior to transfer for acute therapy

NYS TSC 9: Door to Arterial Puncture Time (IA and Mechanical)

NYS TSC 10: Imaging to Puncture Time

Addendum for Thrombectomy-Capable Stroke Center (TSC) Certification

Introduction

Included in this TSC addendum is supplemental information to the *Certification Review Process Guide (RPG)*. Organizations preparing for the TSC certification will need to review the *Certification Review Process Guide* as well as the information in this addendum. The TSC addendum includes important information that is specific to TSC certification.

The TSC certification review is completed by a single reviewer over two days. Therefore, time frames for agenda items in the *Certification Review Process Guide* are not applicable to the TSC certification review. The TSC agenda reflects the correct time frames for the TSC review as does this addendum. Keep in mind that the time frames mentioned are flexible, and may be revised by the reviewers as necessary based on organizational need.

Background

Since 2015, The Joint Commission has provided three levels of stroke center certification—Acute Stroke Ready, Primary Stroke, and Comprehensive Stroke. However, Joint Commission-certified primary stroke centers are not all alike; one third of these centers perform endovascular thrombectomy (EVT). Recent studies have shown the efficacy of EVT for the treatment of large vessel occlusive (LVO) ischemic strokes. EVT is time-sensitive and current recommendations are that this procedure should ideally be done within six hours of the time the patient was last known well. Therefore, a dispersed network of hospitals capable of providing mechanical thrombectomies is needed so all patients with LVO can rapidly receive the care they need.

Eligibility

In addition to the general eligibility requirements outlined in the *Comprehensive Certification Manual for Disease-Specific Care*, at the time of application hospitals seeking TSC certification need to meet volume requirements for the number of mechanical thrombectomies performed.

- To be eligible for TSC certification, an organization must have performed mechanical thrombectomy and post-procedure care for at least 15 patients with ischemic stroke in the past 12 months or at least 30 patients over the past 24 months.
- Additionally, all neurointerventionists who perform mechanical thrombectomy at the organization that is applying for TSC certification, must have performed 15 mechanical thrombectomies over the past 12 months or 30 over the past 24 months. In evaluating the number of mechanical thrombectomies performed by an individual physician, procedures performed at hospitals other than the one applying for certification can be included in the physician's total.

DAY ONE

(All activities noted below have detailed descriptions earlier in this guide. Please consult the table of contents.)

Opening Conference and Orientation to Program (90 Minutes)

Organization Participants

- Disciplines representing the care needs of the complex stroke patient based on the TSC requirements.
 - Program clinical and administrative leadership
 - Stroke team members
 - Representatives from various departments – stroke unit, ICU, ED, radiology, case management/social work, etc. (at the discretion of the organization)

Opening Conference (15 Minutes)

- Introductions
- Overview of TSC certification by reviewers
- Agenda review
- Overview of SAFER™ matrix

Orientation to the Program (60-75 Minutes)

- The organization should be prepared to discuss or provide a 20-30 minute presentation, that includes:
 - A broad overview of the process of care for TSC patients implemented at the organization which may include: Scope of stroke services emergency care; advanced imaging; availability to perform interventions twenty-four hours a day, seven days a week; ICU/critical care (dedicated neuro ICU beds); post ICU care; rehabilitation care; transfer protocols; and transitions of care to home or extended care.
 - The following topics specific to the TSC program are helpful for the reviewer to fully understand your program:
 - Program mission, goals, and objectives
 - Program structure
 - Program leadership and management
 - Program design
 - Stroke team composition
 - Developing, implementing, and evaluating the program
 - Target population for the program
 - Identified needs of the program population
 - The selection, implementation, and evaluation of clinical practice guidelines
 - Model of neuro-ICU care
 - Evaluation of clinical practice guidelines use and appropriateness to the target population

- Performance improvement process, including evaluation of the disease management program's efficacy
- Telemedicine (if in use)

Reviewer Planning Session and Protocol Review Session (30 Minutes)

This session combines two activities: the reviewer planning session and review of TSC protocols.

Materials Required for the Reviewer Planning Session:

- Current list of complex stroke patients (including those with TIA, ischemic, and hemorrhagic stroke [please differentiate patients diagnosed with ICH and SAH]) from at a minimum the last 4 months, who received emergent care, advanced imaging, endovascular mechanical thrombectomy, or medication therapy such as IV/IA tPA. Patients should be separated by diagnosis and date of admission. The list should include the patients' age, sex and admitting physician and the physician who performed the mechanical thrombectomy (if applicable).
- List of stroke team members and their credentials
- TSC protocols/order sets for care (having a printed copy of down-time order sets is helpful to reviewers)

Selecting Patients for Individual Tracers and Protocol Review

- From the list of current stroke patients, the reviewers in conjunction with program representatives will identify a minimum of 5 patients for tracing. Reviewers will also begin to identify personnel and credential files that they will need for review during the Competence Assessment/Credentialing Process/Education session.
- Based on the patients chosen for the initial individual patient tracer, the reviewers may choose to review the organization's TSC protocols related to the patient's specific care, treatment, and services, as required by The Joint Commission's TSC requirements. These protocols include:
 - Activation of stroke team
 - Process for obtaining EMS records
 - EMS protocols including communication with emergency department
 - Acute workup of ischemic/hemorrhagic stroke patients
 - Informed consent for stroke interventions
 - Use of IV tPA
 - Implementation of endovascular procedures
 - Nursing care through the continuum of care
 - Receiving stroke patient transfers
 - Transferring stroke patients to another hospital/facility
 - Transitions of care for patients within the organization (internal) and post hospitalization (external)
 - Referral process when the TSC does not provide post-acute, inpatient rehabilitation services
- The review of the protocols will continue throughout the review and they should remain available and easily retrievable. The reviewers will compare care provided during individual patient tracer activity to protocols utilized by the stroke program.

Individual Patient Tracer Activity- Day 1 (Morning Session, 2 ½ Hours)

Organization Participants

Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patients, including staff who are involved in the patient's care. This may include:

- Emergency licensed independent practitioners and staff
- Imaging licensed independent practitioners and staff
- Endovascular suite licensed independent practitioners and staff
- ICU licensed independent practitioners and staff
- Speech therapist(s), physical therapist(s), and occupational therapist(s)
- Discharge planner(s) and case manager(s)
- Other licensed independent practitioners and staff providing stroke care at the discretion of the organization
- Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology staff

Materials Needed for This Session

- Clinical record of selected patient

Overview of the Individual Patient Tracer Activity

The individual patient tracer activity is a method used to evaluate an organization's provision of care, treatment, and services, using the patient's experience as a guide. During an individual patient tracer, the reviewers will follow a patient's course of care, treatment or service through the program to assess the use and adherence to and diversion from clinical practice guidelines and organizational policies in the patient's care, treatment, or service.

Individual patient tracer activity usually begins in the emergency department and follows the patient through to the unit where the patient is currently being treated or the location from which they were discharged. The reviewer will speak with staff in all of the areas involved in the patient's encounter, including emergency services, advanced imaging, endovascular interventions, neuro-ICU care, post-ICU care, rehabilitation services, patient/family education, and transfer/discharge procedures.

On Day 1: Plan for sufficient staff and licensed independent practitioners to accommodate the reviewer conducting tracer activity in the organization. Also, plan for space to accommodate the reviewer conducting interviews during individual patient tracers so as not to interfere with patient care. If your organization utilizes electronic medical records/documentation, please plan to provide computer access for the reviewer during individual patient tracers. This can be done in a conference room or on the patient care unit.

The number of staff participating in the individual patient tracer activity should be limited. The rationale for limiting the number of staff participating in this activity is to reduce any distraction that the review process may have on patient care.

After each tracer, the reviewer will communicate to the program representatives and care providers any:

- Specific observations made
- Issues that will be continued to be explored in other tracer activity
- Need for additional record/policy review
- Issues that have the potential to result in requirements for improvement

Closed Chart Review: During individual patient tracers, the reviewer will request 1-2 closed patient records for review. The purpose of the closed patient records review is to evaluate the care provided throughout the continuum of care and the discharge/transitions care provided to complex stroke patients. The reviewer will also request information about the follow-up call if applicable. Closed chart review generally occurs during the second day of tracer activity.

Individual Patient Tracer Activity- Day 1 (Afternoon Session, 2 ½ Hours)

Plan to have sufficient staff and licensed independent practitioners to accommodate the reviewer conducting patient tracer activity throughout the organization. All aforementioned information pertaining to individual patient tracers is applicable to the Day 1 afternoon tracer. See the TSC agenda for specific tracer activities.

Reviewer Summary Session/Special Issue Resolution - End of Day 1 (1 Hour)

Organization Participants

Program representatives who can facilitate patient selection for Day Two tracer activity and an individual responsible for obtaining clinical records should be available. Other staff also, as designated by the organization.

Overview of Reviewer Summary Session/Special Issue Resolution

This session is for the reviewer to plan for Day Two of the review. During this time, the reviewer will:

- Address any special issues for resolution with the organization
- Select patients for the Day Two individual tracers.

The reviewer will also communicate a summary of the first day's observations to the program representatives and will determine if additional information will be needed the following day.

Day Two

Daily briefing with the organization (30 minutes)

Reviewer will:

- Provide a summary of Day One activities
- Follow-up on any unresolved issues from Day One
- Obtain any outstanding documents
- Identify any additional patients who were admitted overnight for potential tracer activity

Individual Patient Tracer Activity- Day 2 (Morning Session 3 Hours)

Plan to have sufficient staff and licensed independent practitioners to accommodate the reviewer conducting patient tracer activities throughout the organization. All aforementioned information pertaining to individual patient tracers is applicable to the Day 2 individual patient tracers.

System Tracer--Data Use (90 Minutes)

Organization Participants

- Program administrative and clinical leaders
- Individual(s) responsible for performance improvement processes within the program
- Others at the discretion of the organization

Materials Needed

- Performance measurement data addressed in requirements
- Action plans demonstrating the program's use of and response to data collection

During the session, the reviewer and program representatives will discuss:

- The basics of data gathering and preparation, including data collection, analysis, interpretation, and actions taken on opportunities for improvement
- Strengths and opportunities for improvement in the processes used to obtain data and meet internal and external information needs
- How clinical, management, and patient satisfaction data is used in decision-making and in improving patient safety and quality

Overview of the Data Use System Tracer

The system tracer session is focused on the program's use of data to improve care, treatment, and services, as well as the safety and quality of care for stroke patients. Specific areas of focus for TSC certification will include:

- Use of a defined performance improvement methodology including plans, action plans, and resulting improvements
- Volumes of procedures and interventions
- Complication rates
- Current stroke performance measure data
- Percentage of complex stroke patients that receive a follow-up phone call by a member of the organization's stroke team within seven days of discharge
(Note: Applicable only to TSC patients who are discharged home)
- Public reporting of outcomes per requirements
- Interdisciplinary program review and peer review process
- Use of the stroke registry
- Patient satisfaction data specific to complex stroke patient population
- Review of the program's stroke team log
 - Organizational Data:
 - For TSC requirements that call for organizational data (such as, tracking of adverse outcomes), the organization must provide data from the four months prior to the review date. This is applicable to organizations that currently have PSC certification and those that do not.

- For organizations that are transitioning from PSC to TSC, the organization must provide one year of data for the PSC data requirements (including the PSC Stroke Performance measures data).

Education, Competence Assessment, and the Credentialing Process Session (90 Minutes)

Organization Participants:

- Individual(s) familiar with program-specific requirements for team members such as supervisors, managers, and leaders
- Clinical or medical director(s)

Overview of the Competence Assessment/Credentialing Process/Education Session

This session is focused on:

- The process to provide ongoing education and training of practitioners
- The requirement addressing public education classes (2) offered by the TSC program/organization
- Others at the discretion of the organization

The reviewers will discuss the following education, competence assessment, and credentialing topics as they relate to TSC certification:

- Orientation
- Competence assessment for staff caring for complex stroke patients
- Contract personnel competence assessment and education (if contract staff is used)
- Core stroke team members required to have 8 hours of stroke education annually
- Reason and rationale related to which nurses were identified to receive the 8 hours of education
- Continuing education: staff involved in care of stroke patient to have stroke education annually without specific hour requirement
- On-going education, training, and in-service requirements for the program. Job descriptions for select:
 - Nursing Staff
 - Medical Staff
 - Other Staff who cared for patients identified during the patient tracers
- Additional job descriptions for the:
 - Medical Director of Stroke Program
 - Stroke Coordinator
 - Advanced Practice Nurse (if utilized)
- Documentation of at least two educational programs focused on stroke prevention/care provided for the public

The reviewers will participate in a facilitated review of selected personnel and Medical Staff credentialing files requested during the tracer activities for evidence reflecting completion of any required annual continuing education:

- 8 hours of continuing education for the core stroke team members (including the stroke medical director if he/she is not board certified in neurology)
- 8 hours of neurovascular disease and stroke continuing education for registered nurses caring for complex stroke patients, as identified by the organization

- 2 hours of continuing education per year on cerebrovascular disease, including acute stroke care for registered nurses in the emergency department, as identified by the organization
- Participation in educational activities related to stroke diagnosis and treatment at least twice a year for other emergency department staff members, as identified by the organization

Stroke Education for Nurses:

- Every individual nurse who provides care to complex stroke patients **does not** require 8 hours of education per year.
- The organization is to determine/identify the nurses providing complex stroke care who require the 8 hours of education. (TSC Requirement DSDF. 1, EP 7 e, provides examples of the type of nurses providing stroke care who may require this education.)
- Education can be counted on a “rolling” year basis as determined by the organization (e.g. March 2017 through March 2018).
- During the initial TSC review if all education is not yet completed, the organization can describe how the remaining education will be accomplished during the rest of the rolling year.
- After the initial review, the plan is to review TSC education ongoing through the organization’s intracycle phone call.

Issue Resolution and Reviewer Report Preparation (1 Hour)

This session combines two activities. The activities are broken down as the following:

Issue Resolution

- The reviewer will follow-up on potential findings that could not be resolved during earlier activities. The organization may also present any information they believe the reviewer may have missed or was not available during the allotted sessions.

Reviewer Report Preparation

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

Program Exit Conference (30 minutes)

- Reviewer will provide a summary of findings from the TSC review.

Disease Specific Care Certification Thrombectomy-Capable Stroke Center (TSC) Certification Agenda Template

DAY 1

Time	Activity	Organization Participants
8:00-9:30 a.m.	Opening Conference and Orientation to Program	Program clinical and administrative leadership Stroke team members Others at the discretion of the organization representing the disciplines providing complex stroke care
9:30-10:00 a.m.	Reviewer Planning Session & Protocol Review Session - A list of stroke patients for tracer selection separated by diagnosis, with date of admission -If inpatients are not available for a particular diagnosis, provide a list of all patients with that diagnosis for the previous 90 days - TSC protocols available for review for each stroke diagnosis - Job Description for the Stroke Program Coordinator and Medical Director - A copy of your stroke alert process - On-call schedules for IR physicians for the previous 90 days - Transfer policies/protocols	Program representatives who can facilitate patient selection and tracer activities
10:00-12:30 p.m.	Individual Patient Tracer: During this activity the reviewer will be moving throughout the organization and interacting with staff in areas that have been in contact with the patients selected for tracer activity. The reviewer may also want to speak with a patient or family of the patient with their permission. Evaluation of patient care, treatment, and services includes: 1. Emergency Department -How patients arrive and process for notification -Discuss process for obtaining EMS records -Discuss transfer in/transfer out protocols 2. Advanced Imaging 3. IR Suite - Informed consent 4. Acute Stroke Care -Stroke unit -ICU 5. Post-Acute Stroke Care -Assessment -Goals -Patient/Family education -Referrals	Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patient. May include: -Emergency licensed independent practitioners and staff -Imaging licensed independent practitioners and staff -Surgical/procedural licensed independent practitioners and staff -ICU licensed independent practitioners and staff -Other licensed independent practitioners and staff providing stroke care -Speech therapist(s), physical therapist(s), and occupational therapist(s) -Discharge planner(s) and case manager(s) -Others at the discretion of the organization

Disease Specific Care Certification Thrombectomy-Capable Stroke Center (TSC) Certification Agenda Template

Time	Activity	Organization Participants
	<ul style="list-style-type: none"> -Transfers -Medical care -Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) <p>6. Transfer/Discharge</p> <p>7. Follow-up Call</p> <p>8. Closed Record Review: Reviewers may review closed medical records.</p>	<ul style="list-style-type: none"> - Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff
12:30-1:00 p.m.	Reviewer Lunch	
1:00-3:30 p.m.	<p>Individual Patient Tracer: Reviewer will be moving throughout the organization and interacting with staff in areas that have been in contact with the patients selected for tracer activity. Evaluation of patient care, treatment, and services, including:</p> <p>1. Acute Stroke Care</p> <ul style="list-style-type: none"> -Emergency care -Informed consent - IR suite -CT/MRI suite -Procedures and interventions -ICU care -Nursing care -Medical care -Additional care <p>2. Post-Acute Stroke Care</p> <ul style="list-style-type: none"> -Assessment -Goals -Patient/Family education -Referrals -Transfers -Medical care -Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) <p>3. Transfer/Discharge</p> <p>4. Follow-up Call</p> <p>5. Closed Record Review: Reviewers may review closed medical records.</p>	<p>Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patient. May include:</p> <ul style="list-style-type: none"> -Emergency licensed independent practitioners and staff -Imaging licensed independent practitioners and staff -Surgical/procedural licensed independent practitioners and staff -ICU licensed independent practitioners and staff -Other licensed independent practitioners and staff providing stroke care -Speech therapist(s), physical therapist(s), and occupational therapist(s) -Discharge planner(s) and case manager(s) -Others at the discretion of the organization - Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff
3:30-4:30 p.m.	<p>Reviewer Summary Session/Special Issue Resolution (optional)</p> <p>Reviewer will:</p> <ul style="list-style-type: none"> – Address any special issues for resolution – Communicate summary of the first day's observations – Select individual patient tracers for Day 2 	<p>Program representatives who can facilitate patient selection and tracer activity.</p>

Disease Specific Care Certification Thrombectomy-Capable Stroke Center (TSC) Certification Agenda Template

DAY 2

Time	Activity	Organization Participants
8:00-8:30 a.m.	Daily briefing with the organization	As determined by organization
8:30-11:30 a.m.	<p>Individual Patient Tracer: Reviewer will be moving throughout the organization and interacting with staff in areas that have been in contact with the patients selected for tracer activity. Evaluation of patient care, treatment, and services, including:</p> <ol style="list-style-type: none"> 1. Acute Stroke Care <ul style="list-style-type: none"> -Emergency care -Informed consent -IR suite -CT/MRI suite -Procedures and interventions -ICU care -Nursing care -Medical care -Additional care 2. Post-Acute Stroke Care <ul style="list-style-type: none"> -Assessment -Goals -Patient/Family education -Referrals -Transfers -Medical care -Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) 3. Transfer/Discharge 4. Follow-up Call 5. Closed Record Review: Reviewers may review closed medical records. 	<p>Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patient. May include:</p> <ul style="list-style-type: none"> -Emergency licensed independent practitioners and staff -Imaging licensed independent practitioners and staff -Surgical/procedural licensed independent practitioners and staff -ICU licensed independent practitioners and staff -Other licensed independent practitioners and staff providing stroke care -Speech therapist(s), physical therapist(s), and occupational therapist(s) -Discharge planner(s) and case manager(s) -Others at the discretion of the organization - Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff

Disease Specific Care Certification Thrombectomy-Capable Stroke Center (TSC) Certification Agenda Template

Time	Activity	Organization Participants
11:30 -1:00 p.m.	<p>System Tracer: Data use, research, and performance improvement (PI):</p> <ul style="list-style-type: none"> – Use of a defined performance improvement methodology – Volumes of mechanical thrombectomies – Complication rate data – Public reporting of outcomes – Current stroke performance measure data – Percentage of complex stroke patients that receive a follow-up phone call by a member of the organization’s stroke team within seven days of discharge (Note: Applicable only to TSC patients who are discharged home) <ul style="list-style-type: none"> • Interdisciplinary program review and peer review process • Use of the stroke registry • Patient satisfaction data specific to complex stroke patient population • Review of the program’s stroke team log 	<p>Program clinical and administrative leadership. (Example: Stroke Coordinator, Stroke Program Medical Director)</p> <p>Individual(s) responsible for performance improvement and processes within the program</p>
1:00-1:30 p.m.	Reviewer Lunch	
1:30-3:00 p.m.	<p>Education, Competence Assessment, and the Credentialing Process: Reviewer will review personnel records and credentialing files. Additionally, reviewers will discuss education, competence, community education, and credentialing issues identified from the patient tracers and review of personnel records.</p> <ul style="list-style-type: none"> -Nursing Staff -Medical Staff -Other Staff -Community Education <p>The reviewers will also ask to view the personnel records of the:</p> <ul style="list-style-type: none"> – Medical Director of Stroke Program – Stroke Coordinator – Advanced Practice Nurse 	<p>Individual(s) with authorized access to personnel and credential records</p> <p>Individual(s) familiar with program-specific requirements for team members such as supervisors, managers and leaders</p> <p>Clinical or medical director(s)</p> <p>Others at the discretion of the organization</p>
3:00-4:00 p.m.	Issue Resolution & Reviewer Report Preparation	<p>Certification review facilitator</p> <p>Program leaders and staff as requested by the reviewer</p>

Disease Specific Care Certification Thrombectomy-Capable Stroke Center (TSC) Certification Agenda Template

Time	Activity	Organization Participants
4:00-4:30 p.m.	Program Exit Conference	Program and clinical leadership Others at the discretion of the organization

Note: This agenda is a guide and may be modified based on organizational need and reviewer discretion.

Addendum for New York State Stroke Services Certification – Thrombectomy-Capable Stroke Center (TSC) Certification

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 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

- Organizations perform at least 15 mechanical thrombectomies and provide post-procedure care per year; if they do not meet this criterion, they may be eligible if they meet all other requirements and criteria. If this is the case, then:
 - The organization must provide 12 mechanical thrombectomies and provide post-procedure care by the end of the first full year following designation; and
 - If the organization does not reach an annual volume of 15 mechanical thrombectomies per year by the end of the second year, they will surrender their designation as a TSC or may have their designation revoked.
 - NYSDOH may conduct a review of cases and outcomes performed by a TSC with an annual volume of less than 15 mechanical thrombectomies to evaluate the appropriateness and quality of care provided until the annual volume reaches 15.
- All primary neurointerventionists who routinely take call to perform emergency mechanical thrombectomy must meet the following criteria:
 - Have performed 15 mechanical thrombectomies 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 and meet credentialing requirements. Volume criteria are applicable to each Neurointerventionist.
 - 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
 - Performed an average of 15 mechanical thrombectomies (as the primary operator) over the past 12 months or 30 over the past 24 months (procedures performed at hospitals other than the one applying for TSC certification can be included in the total).

Addendum for New York State Stroke Services Certification – Thrombectomy-Capable Stroke Center (TSC) 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. This includes ensuring timely and accurate data submission to EMS as requested and complying with and monitoring programs established by regional EMS providers. The stroke coordinator should also take responsibility for collecting, storing and reporting data collection and for 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 Internal Medicine, Emergency Medicine, Neurology, Neuroradiology, or Neurosurgery.

The medical director shall attest to 8 hours of stroke focused continuing education on an annual basis.

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 feedback to EMS. The organization can contact their REMAC to connect with the Medical Director of the services to provide that feedback.

Neurologist

A neurologist must be available in person or via telemedicine within 15 minutes of the request.

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. Neurointerventionists shall be available by phone with access to imaging within 10 minutes of attempted contact and 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.

Addendum for New York State Stroke Services Certification – Thrombectomy-Capable Stroke Center (TSC) Certification

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.

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 must complete eight (8) hours of stroke focused continuing education on an annual basis. Nurses working on the stroke unit or in the ICU that cares for complex stroke patients are knowledgeable about the stroke scale used in the organization (NIHSS).

Telemedicine

If used to assess patients (neurology to read imaging), telemedicine capability must be available 24/7 within 20 minutes of the patient's arrival (within 15 minutes for initial neurologist assessment per Neurology time parameters above).

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 imaging modalities, and time frame for diagnostic service completion and image sharing processes
- 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.

Addendum for New York State Stroke Services Certification – Thrombectomy-Capable Stroke Center (TSC) Certification

Vascular Imaging

The Thrombectomy-Capable Stroke Center must have the ability to perform head and neck CTA arch to vertex 24/7. CTA imaging must be able to be read within 45 minutes either on-site or through teleradiology by a radiologist.

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

Patient Education

Resources for patient education should include a graphic on benefits and risks of IV thrombolytic therapy (e.g., NNT, likelihood of benefits to risk)

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.

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: NIHSS on Admission

NYS PSC 12: mRS on Discharge

NYS PSC 13: Pre-Notification

NYS PSC 14: Pre-Notification Content:

-Last Known Well communicated

-Stroke scale findings communicated

NYS PSC 15: Stroke Team Activated Prior to Arrival

NYS TSC 1: mRS at 90 days: documented

Addendum for New York State Stroke Services Certification – Thrombectomy-Capable Stroke Center (TSC) Certification

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: Timeliness of reperfusion: arrival time to TICI 2B or higher (120 minutes)

NYS TSC 7: Timeliness of reperfusion: skin puncture to TICI 2B or higher (120 minutes)

NYS TSC 8: NIHSS Post Procedure

Time Targets and Benchmark Goals

NYS PSC 16: Door to MD Assessment (10 minutes) – 85%

NYS PSC 17: Door to Stroke Team (15 minutes) – 85%

NYS PSC 18: Door to Brain Image Complete (25 minutes) – 85%

NYS PSC 19: Door to Brain Image Read (45 minutes) – 85%

NYS PSC 20: Door to IV tPA (60 minutes) – 85%

NYS PSC 21: Door to IV tPA (45 minutes) – 50%

NYS PSC 22: Door-in-door-out time at first hospital prior to transfer for acute therapy

NYS TSC 9: Door to Arterial Puncture Time (IA and Mechanical)

NYS TSC 10: Imaging to Puncture Time

Addendum for New York State Stroke Services Certification – Primary Stroke Center (PSC) Certification

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 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. This includes ensuring timely and accurate data submission to EMS as requested and complying with and monitoring programs established by regional EMS providers. The stroke coordinator should also take responsibility for collecting, storing and reporting data collection and for 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 Internal Medicine, Emergency Medicine, Neurology, Neuroradiology, or Neurosurgery.

The medical director shall attest to 8 hours of stroke focused continuing education on an annual basis.

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 feedback to EMS. The organization can contact their REMAC to connect with the Medical Director of the services to provide that feedback.

Addendum for New York State Stroke Services Certification – Primary Stroke Center (PSC) Certification

Neurologist

A neurologist must be available in person or via telemedicine within 15 minutes of the request.

Diagnostic Radiologist

The Primary Stroke Center is required to have a diagnostic radiologist and/or physician privileged to interpret CT, CTA, and MRI of the brain. The facility should determine who is privileged to interpret these images.

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.

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 must complete eight (8) hours of stroke focused continuing education on an annual basis.

Telemedicine

If used to assess patients (neurology to read imaging), telemedicine capability must be available 24/7 within 20 minutes of the patient's arrival (within 15 minutes for initial neurologist assessment per Neurology time parameters above). Telemedicine is defined as a two-way audio and visual communication when being used to assess patients.

Transfer Agreement

Primary 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 imaging modalities, and time frame for diagnostic service completion and image sharing processes

Addendum for New York State Stroke Services Certification – Primary Stroke Center (PSC) Certification

- 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.

Vascular Imaging

NYSDOH Stroke Designation Program recommends 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 tPA. CTA imaging must be able to be read within 45 minutes of arrival either on-site or through teleradiology. Expectations for CTA prior to transfer for endovascular intervention should be clarified with the receiving facility.

While CTA is a strong recommendation of NYSDOH, it is not currently required for initial certification. However, **ALL** Primary Stroke Centers will be required to have 24/7 CTA capability by the time of the Center's recertification (schedule to be determined by the certifying agency).

Patient Education

Resources for patient education should include a graphic on benefits and risks of IV thrombolytic therapy (e.g., NNT, likelihood of benefits to risk).

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.

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

Addendum for New York State Stroke Services Certification – Primary Stroke Center (PSC) Certification

- 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: NIHSS on Admission
- NYS PSC 12: mRS on Discharge
- NYS PSC 13: Pre-Notification
- NYS PSC 14: Pre-Notification Content:
 - a. Last Known Well communicated
 - b. Stroke scale findings communicated
- NYS PSC 15: Stroke Team Activated Prior to Arrival

Time Targets and Benchmark Goals

- NYS PSC 16: Door to MD Assessment (10 minutes) – 85%
- NYS PSC 17: Door to Stroke Team (15 minutes) – 85%
- NYS PSC 18: Door to Brain Image Complete (25 minutes) – 85%
- NYS PSC 19: Door to Brain Image Read (45 minutes) – 85%
- NYS PSC 20: Door to IV tPA (60 minutes) – 85%
- NYS PSC 21: Door to IV tPA (45 minutes) – 50%
- NYS PSC 22: Door-in-door-out time at first hospital prior to transfer for acute therapy

Addendum for Advanced Certification for Total Hip and Total Knee Replacement (THKR)

Introduction

The Advanced Certification for Total Hip and Total Knee Replacement program focuses on the following:

- Provision of integrated, coordinated, patient-centered care that starts with the orthopedic consultation, through pre-, intra- and postoperative phases of care, to the orthopedic surgeon follow-up visit
- The care performed in inpatient, hospital-based outpatient (same day surgery), and ambulatory surgery care settings (free standing)
- Education of the patient who is receiving a total hip or total knee replacement about the preoperative, intraoperative, and postoperative phases of care
- Shared decision-making and the importance of addressing roles, procedures, goals, and medications with patients throughout the continuum of care
- Consistent communication and collaboration of all healthcare providers involved in the care of the patient receiving a total hip or total knee replacement throughout the continuum of care

About this Addendum

Included in this THKR addendum is supplemental information to the *Certification Review Process Guide (RPG)*. Organizations preparing for the THKR certification will need to review the general content in this *Certification Review Process Guide* as well as the information in this addendum. The THKR addendum includes important information that is specific to THKR certification.

The THKR certification review occurs over two days. Therefore, time frames for agenda items in the *Certification Review Process Guide* are not applicable to the THKR certification review. The THKR agenda reflects the recommended activity time frames for the THKR review, as does this addendum. Keep in mind that the time frames mentioned are **flexible**, and may be revised by the reviewers as necessary based on organizational need.

Note: Program Specific Qualifications: In addition to the eligibility criteria described in “The Joint Commission Certification Process” (CERT) chapter of the *Comprehensive Certification Manual for Disease-Specific Care*, programs seeking THKR certification must also:

- Apply for certification of the site that provides the procedure--each individual site must independently meet the eligibility criteria and standards
- Provide both total hip and total knee replacement procedures
- Be an active and continuous member of the American Joint Replacement Registry (AJRR) at the full subscription level and use the data collected from the registry to analyze and improve processes.
- At time of review, provide the Joint Commission reviewer the opportunity to observe either a total hip or total knee replacement procedure

Advanced THKR Certification On-site Review Description

Review Day 1

Opening Conference and Orientation to Program (90 Minutes)

Organization Participants

- Program clinical and administrative leadership (e.g. CEO, CNO, medical director, program interdisciplinary team members)
- Individual(s) responsible for performance improvement processes within the program and as applicable, the organization
- Others at the discretion of the organization

Opening Conference (15 minutes)

- Overview of THKR certification by reviewers

Orientation to the Program (60-75 minutes)

- The organization should be prepared to discuss or provide a 20-30 minute presentation, that includes:
 - A broad overview of the process of care for THKR patients implemented at the organization which may include: Scope of total hip and total knee replacement services from the orthopedic consultation through to the orthopedic surgeon follow-up visit; population/demographics; program mission, goals, and objectives; program structure and team composition; rehabilitation care; referral process; and, transitions of care to home or extended care.
 - The following subjects specific to the THKR program: (Note: This list contains subjects identified earlier in the *Orientation to the Program* activity, as well as some additional subjects specific to THKR. A combined list is provided here to minimize confusion.)
 - Program leadership
 - Program interdisciplinary team composition
 - Program design and integration into organization
 - Program scope
 - Program mission, goals, and objectives
 - Population characteristics and needs of clinical practice guidelines (CPGs)
 - Program evaluation of CPG use and deviation monitoring
 - Program improvements in CPG content and use overall program improvements implemented or planned
 - Service availability and accessibility dependent on program scope (inpatient, hospital based outpatient, ambulatory surgery center)
 - Program design influences (community needs assessment, patient selection, patient risks and outcomes, co-morbidities, evidence-based practice)
 - Patient self-management education resources
 - Access to patient centered care resources
 - Facilitating access to interdisciplinary care, treatment and service needs of patients
 - Communication and collaboration planning and processes throughout the continuum of care

- Transitions of care

Reviewer Planning and Protocol Review Session (30 Minutes)

Materials Required for the Reviewer Planning Session:

- Current list of total hip and total knee replacement patients for tracer selection
- List of patients having total hip and/or total knee replacement procedures on **Day 1 after opening conference or Day 2 of the review**
- If current patients are not available for the program, provide a list of all total hip and total knee replacement patients for the previous 90 days
- THKR protocols for care
- Job description for the medical director
- Transfer policies/ protocols
- Patient education materials
- Performance improvement action plans
- Program-specific orientation and competency documentation

Selecting Patients for Individual Tracers and Protocol Review

- From the list of current total hip and total knee replacement patients, the reviewers in conjunction with program representatives will identify a minimum of six patients for tracing; a minimum of three total hip replacements and three total knee replacements, this may include closed records. At least one of the patient tracers performed must allow for tracing the intraoperative process.
- The THKR certification has numerous requirements for protocols that focus on clinical care.
- Based on the patients chosen for the initial individual patient tracer, the reviewers may choose to review the organization's THKR protocols related to the patient's specific care, treatment, and services, as required by The Joint Commission's THKR requirements. These protocols include:
 - Process for obtaining orthopedic office records
 - Care of total hip and total knee replacement patients in an emergency situation
 - Care of total hip and total knee replacement patients in an elective situation
 - Informed consent for total hip and total knee replacement procedures
 - Reduction of complications
 - Consistency of care throughout the continuum
 - Continuity of care and communication throughout the preoperative, intraoperative, and postoperative periods
 - Transferring total hip and total knee replacement patients to another organization, especially communication and collaboration
 - Evaluating the receiving organization's ability to meet the individual patient's needs
 - Transitions of care for patients within the organization (internal) and post hospitalization (external)

- Referral process when the THKR does not provide post acute, inpatient rehabilitation services
- The review of the protocols will continue throughout the review and they should remain available and easily retrievable. The reviewers will compare care provided during individual patient tracer activity to protocols utilized by the total hip and total knee replacement program.
- The organization should plan for space to accommodate interviews conducted by the reviewer during individual patient tracers so as not to interfere with patient care.
- At the conclusion of each tracer, the reviewer will communicate to the program representatives and care providers any:
 - Specific observations made
 - Issues that will be continued to be explored in other tracer activity
 - Need for additional record review
 - Issues that have the potential to result in requirements for improvement
- Reviewers will also begin to identify personnel and credential files that they will need for review during the Competence Assessment, Credentialing Process, and Education session.

Individual Patient Tracer Activity (2 hours 30 minutes)

Organization Participants

Program representatives who can facilitate tracer activities including escorting the reviewers through the clinical setting following the course of care for the patients, including staff who have been involved in the patient's care. This may include:

- Surgical/procedural licensed independent practitioners and staff
- Physical therapist(s), and occupational therapist(s)
- Discharge planner(s) and case manager(s)
- Other licensed independent practitioners and staff providing total hip and total knee replacement care at the discretion of the organization
- Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology staff
- Others at the discretion of the organization

The number of staff participating in the individual patient tracer activity should be limited. The rationale for limiting the number of staff participating in this activity is to reduce any distraction that the review process may have on patient care.

Materials Needed for This Session

- Clinical record of selected patient
- If your organization utilizes electronic medical records/documentation, please plan to provide computer access for the reviewer during individual patient tracers. This can be done in a conference room or on the patient care unit.

Overview of the Individual Patient Tracer Activity

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

Clinical areas the reviewer will visit and communicate with are:

- Preoperative assessment/joint classes/discharge teaching

- Same day surgery
- Anesthesia/block room
- Preoperative holding
- Operating room
- PACU
- Physical therapy/gym
- Inpatient floor

Interdisciplinary Care Team members and other disciplines to consider interviewing during individual patient tracer activity include, but not limited to:

- Attending physician, hospitalist, or primary care physician
- Anesthesia
- Nursing staff
- Pharmacist
- Discharge planner or nurse case manager
- Physical therapy
- Other clinical and ancillary staff involved in the care of the total hip and total knee replacement patients

Dependent on timing and availability of staff; the reviewer may plan a conference call with the orthopedic surgeon's office (e.g. MD, scheduling, office staff, PA, NP, etc.) to discuss preoperative and follow-up visit process within the program

Closed Chart Review: During individual patient tracers, the reviewer will review at least one closed patient record. The purpose of the closed patient records review is to evaluate the care provided throughout the continuum of care and also the discharge/transitions care provided to total hip and total knee replacement patients. Reviewers will also request information about the program's process from the orthopedic consultation to patient arrival for surgery and then from discharge through to the orthopedic surgeon's follow-up visit.

Individual Patient Tracer Activity- Day 1 (Afternoon Session, 2 Hours)

Plan to have sufficient staff and licensed independent practitioners to accommodate the reviewer that will be conducting patient tracer activity throughout the organization. All aforementioned information pertaining to individual patient tracers is applicable to the Day 1 afternoon tracer. See the THKR agenda for specific tracer activities.

Issue Resolution (30 minute)

This session is for the reviewer to

- Follow-up on any open issues requiring further exploration
- Review closed records or reexamine protocols, procedures, or other documentation
- Interview staff that may have been unavailable during tracer activity

Review Summary Session/Daily Briefing (30 minutes)

Organization Participants

- Program clinical and administrative leadership (e.g. CEO, CNO, medical director, program interdisciplinary team members)
- Others at the discretion of the organization
- The reviewer will communicate a summary of the first day's observations to the program representatives
- The reviewer and organization will discuss arrival time for Day 2; for example, if the intraoperative tracer will be occurring Day 2 for a 7:30 case start, the reviewer and organization should discuss an arrival time that will allow the reviewer to observe the preoperative process prior to the case. Additional patients will be selected for continuing tracer activity, as needed

Review Day Two

Intraoperative Tracer Activity (Approximately 2 hours)

Flexibility and clear communication between the reviewer and your organization for the intraoperative tracer activity is imperative

- **This tracer can occur at any time during the review after the Opening Conference, depending on patient availability. The organization and reviewer should confirm the timing for this activity as soon as possible, since this is a mandatory activity for advanced certification.**
- Reviewer will change into appropriate attire per your organization's instruction
- Dependent on the volume of total hip and total knee cases the observations may occur with more than one patient and at different times during the two day review

The Intraoperative Tracer Activity will include:

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

Organization Participants

- Program representative(s) who can facilitate tracer activity, that is, escort the reviewer through the clinical setting following the course of care for selected patients

Individual Patient Tracer Activity (2 hours)

Plan to have sufficient staff and licensed independent practitioners to accommodate the reviewer who will be conducting patient tracer activities throughout the organization. All

aforementioned information pertaining to individual patient tracers is applicable to the Day 2 individual patient tracers.

System Tracer--Data Use (1 hour)

Organization Participants

- Program administrative and clinical leaders (e.g. THKR medical director, joint coordinator, perioperative director, etc.)
- Individual(s) responsible for performance improvement processes within the program
- Others at the discretion of the organization

Materials Needed

- Performance measurement data addressed in requirements
- Action plans demonstrating the program's use of and response to data collection

During the session, the reviewers and program representatives will discuss:

- The basics of data gathering and preparation, including data collection, analysis, interpretation, and actions taken on opportunities for improvement
- Collection of data to monitor performance (e.g. patient satisfaction, coordination of care, outcomes, length of stay, etc.)
- Data sets, definitions, codes, classifications, and terminology that guide program data collection
- Performance improvement priorities identified through the total hip and total knee replacement program quality management process
- Activities to improve processes and outcomes

Overview of the Data Use System Tracer

The system tracer session is focused on the program's use of data to improve care, treatment, and services, as well as the safety and quality of care for total hip and total knee replacement patients. Specific areas of focus for THKR certification will include:

- The program monitors:
 - Infection (mechanical, wound)
 - Bleeding
 - Venous thrombosis
 - Readmission rate
- The program review performance measurement results to determine whether goals were achieved.
- The program reviews and prioritizes identified performance improvement opportunities
- The program evaluates care processes and transitions of care

Education, Competence Assessment, and Credentialing Process (1 hour)

Organization Participants:

- Individual(s) with authorized access to personnel and credential records

- Individual(s) familiar with program-specific requirements for team members such as supervisors, managers and leaders
- Clinical or medical director(s)
- Others at the discretion of the organization

Overview of the Competence Assessment, Credentialing Process, and Education Session

This session is focused on:

- The process to provide ongoing education and training of practitioners
- Others at the discretion of the organization

The reviewer will discuss the following education, competence assessment, and credentialing topics as they relate to THKR:

- Orientation
- Competence assessment for staff caring for THKR patients
- Contract personnel competence assessment and education (if contract staff is used)
- Specific education requirements and competencies for interdisciplinary team members
- Continuing education: staff involved in care of total hip and total knee replacement patients to have annual related education
- On-going education, training, and in-service requirements for the program

The reviewer will participate in a facilitated review of selected personnel and credential files requested during the tracer activities for evidence reflecting completion of any required continuing education and privilege lists:

- Orthopedic surgeons
- Nursing staff
- Other staff interviewed during individual patient tracers

Issue Resolution and Reviewer Report Preparation (1 hour)

This session combines two activities. The activities are broken down as the following:

Issue Resolution

- This follow-up session may include the following activities, but is not limited to:
 - Review of policies and procedures
 - Review of human resources files
 - Review of performance improvement data
 - Discussion with selected staff
- The reviewers will work with program representatives to organize and conduct all issue resolution activities.

Reviewer Report Preparation

The reviewers will use this time to compile, analyze, and organize the data he or she has collected into a summary report of observations made throughout the review.

Program Exit Conference (30 minutes)

Reviewers will provide a summary of findings from the THKR review

Disease Specific Care Certification

Advanced Certification for Total Hip and Total Knee Replacement

Agenda Template

Information needed during the Reviewer Planning Session includes:

- Current list of patients being treated in the total hip and total knee replacement program
- A list of patients having a total hip or total knee procedure **after opening conference Day 1 or Day 2** of the review
- A list of patients who accessed or progressed through the total hip and total knee replacement programs in the past four months
- An organization chart for the program, if one is available
- Performance measure data collected and reported for the required four measures
- Performance improvement action plans that demonstrate how data have been used to improve program care and services, when available

DAY 1

Time	Activity	Organization Participants
90 minutes	<p>Opening Conference (10 minutes)</p> <ul style="list-style-type: none"> • Greetings and introductions • Introductions of key program and organization staff <p>Orientation to Program (60 minutes)</p> <ul style="list-style-type: none"> • Program leadership • Program interdisciplinary team composition • Program design and integration into organization • Program scope • Program mission and goals for care • Population characteristics and needs of clinical practice guidelines (CPG) • Program evaluation of CPG use and deviation monitoring • Program improvements in CPG content and use overall program improvements implemented or planned • Service availability and accessibility dependent on program scope (inpatient, hospital based outpatient, ambulatory surgery center) • Program design influences (community needs assessments, patient selection, patient risks and outcomes, co-morbidities, evidence-based practice) • Patient self-management education resources' • Access to patient centered care resources • Facilitating access to interdisciplinary care, treatment and service needs of patients • Communication and collaboration planning and processes throughout the continuum of care • Transitions of care <p>Q&A discussion (20 minutes)</p>	<p>-Program clinical and administrative leadership (for example; CEO, CNO, medical director, program interdisciplinary team members)</p> <p>Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization</p> <p>Others at the discretion of the organization</p>

Disease Specific Care Certification Advanced Certification for Total Hip and Total Knee Replacement Agenda Template

Time	Activity	Organization Participants
30 minutes Note: Organization will need to ensure that total hip and/or total knee replacement procedures are being performed, either; Day 1 after opening conference or Day 2 of the review	Reviewer Planning Session & Protocol Review Session <ul style="list-style-type: none"> • List of total hip and total knee replacement patients for tracer selection • List of patients having total hip and/or total knee replacement procedures on Day 1 after opening conference or Day 2 of the review • If active patients are not available for the program, provide a list of all total hip and total knee replacement patients for the previous 90 days • THKR protocols available for review • Job description for the medical director • Transfer policies/protocols 	-Program representatives who can facilitate patient selection and tracer activities
2 hours 30 minutes Note: Patient education, interview or observation activity may be scheduled at a time that will facilitate the greatest participation	Individual Patient Tracer Evaluation of patient care, treatment, and services, including: <i>Clinical Areas to consider visiting during tracer activity</i> <ul style="list-style-type: none"> • Patient education, interview or observation; may include, preoperative assessment/classes (joint class), patient therapy observation, discharge teaching • Same day surgery • Anesthesia/block room • Preoperative holding • Operating room • PACU • Physical therapy/gym • Inpatient floor <i>Interdisciplinary Care Team members to consider interviewing during tracer activity</i> <ul style="list-style-type: none"> • Attending physician, hospitalist, or primary care physician • Anesthesia • Nursing staff • Pharmacist • Discharge planner or nurse case manager • Physical therapist Note: Dependent on timing and availability of staff; plan a conference call with the orthopedic surgeon's office (e.g. MD, scheduling, office staff, PA, NP) to discuss preoperative and follow up visit process within the program	-Program representative(s) who can facilitate tracer activity, that is, escort the reviewer through the clinical setting following the course of care for selected patients -Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff -Others at the discretion of the organization
30 minutes	Reviewer Lunch	
2 hours	Individual Patient Tracer	See suggested participants noted above

Disease Specific Care Certification Advanced Certification for Total Hip and Total Knee Replacement Agenda Template

Time	Activity	Organization Participants
	See description above	
30 minutes	<p>Issue Resolution Confer at the end of Day 1 and plan for Day 2 of the THKR review with the organization's staff</p> <ul style="list-style-type: none"> • Address any special issues for resolution with the organization • Discuss plan for arrival in am (if the intraoperative tracer will be occurring day 2 for a 7:30 case start, discuss when organization would recommend reviewer arrival dependent on observation of preoperative process prior to case) • Select any additional patients for day 2 	-Reviewer and program representative
30 minutes	<p>Daily Briefing Communicate a summary of day 1 observations to the program representatives and determine if additional information will be needed the following day</p>	-Program clinical and administrative leadership (for example; CEO, CNO, medical director, program interdisciplinary team members) - Others at the discretion of the organization

DAY 2

Time	Activity	Organization Participants
<p>Approximately 2 hours</p> <p>Note: Intraoperative tracer activity may be scheduled at a time that will facilitate the greatest participation (this may require a 6:30 a.m. arrival for 7:30 a.m. OR starts on Day 2)</p> <p>Note: Reviewer will not observe entire surgical procedure. Flexibility and clear communication with the organization for the THKR review is imperative, especially during the intraoperative tracer. Dependent on the volume of total hip and total knee cases, either the afternoon of Day 1 after opening conference or Day 2, the</p>	<p>Individual Tracer Activity—Intraoperative Experience</p> <p>(This tracer can occur at any time during the review after the Opening Conference, depending on patient availability. The organization and reviewer should confirm the timing for this activity as soon as possible, since this is a mandatory activity for advanced certification.)</p> <p>Reviewer will change into appropriate attire per organization instruction</p> <p>The activity will include:</p> <ul style="list-style-type: none"> • 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 	-Program representative(s) who can facilitate tracer activity, that is, escort the reviewer through the clinical setting following the course of care for selected patients

Disease Specific Care Certification Advanced Certification for Total Hip and Total Knee Replacement Agenda Template

observations may occur within more than one patient and at more than one time frame.		
2 hours	Individual Patient Tracer See description above	See suggested participants noted above
60 minutes	System Tracer – Data Use <ul style="list-style-type: none"> • Performance improvement approach and plan • Collection of data to monitor performance, some examples are patient satisfaction data, coordination of care, outcomes data, length of stay, etc. • Data sets, definitions, codes, classifications, and terminology that guide program data collection • Performance improvement priorities identified through the total hip and total knee replacement program quality management process • Activities to improve processes and outcomes 	-Program clinical and administrative leadership. (Example: THKR Medical Director, Joint coordinator, perioperative director) -Individual(s) responsible for performance improvement and processes within the program -Others at the discretion of the organization
30 minutes	Reviewer Lunch	
60 minutes	Competence Assessment and Credentialing Session Discuss the program’s education, competence, and credentialing and privileging processes for: <ul style="list-style-type: none"> • Nursing Staff • Medical Staff • Other Staff Based on patient tracers, select a sample of personnel records, credentials files and privilege lists to review.	-Individual(s) with authorized access to personnel and credential records -Individual(s) familiar with program-specific requirements for team members such as supervisors, managers and leaders -Clinical or medical director(s) -Others at the discretion of the organization
60 minutes	Issue Resolution & Reviewer Report Preparation	-Certification review facilitator -Program leaders and staff as requested by the reviewers.
30 minutes	Program Exit Conference <ul style="list-style-type: none"> • Review observations and any requirements for improvement by standard, EP, and advanced requirement identifiers • Allow time for questions regarding review findings and provide additional material regarding compliance with requirements • Review required follow-up actions as applicable 	-Program and clinical leadership -Others at the discretion of the organization

Note: This agenda is a guide and may be modified based on organizational need and reviewer discretion.

Advanced DSC–Acute Heart Attack Ready (AHAR) Certification Addendum

Introduction

Included in this Acute Heart Attack Ready (AHAR) addendum is supplemental information to the *Disease Specific Care (DSC) Certification Review Process Guide (RPG)*. Organizations preparing for the AHAR certification event will need to review the *Certification Review Process Guide* as well as the program specific information in this addendum.

The AHAR certification review is a one-day event. The agenda reflects the recommended activities and time frames for the onsite review. Keep in mind that the time frames mentioned are flexible and may be adjusted by the reviewers as necessary based on organizational need.

Background

The Joint Commission's Acute Heart Attack Ready (AHAR) Certification program recognizes hospitals that meet standards denoting the highest level of commitment to consistent and optimal ST-elevated myocardial infarction (STEMI) treatment for patients. This certification was developed in conjunction with the American Heart Association (AHA) and its Get With The Guidelines® – Coronary Artery Disease program to help establish and improve coordinated systems of care for STEMI treatment.

The AHAR certification program focuses on symptom onset, emergency medical services, the emergency department, inpatient settings, as well as catheterization laboratories, if applicable to the program. The program supports hospitals without 24 hour a day, 7 day a week primary percutaneous coronary intervention (PCI) coverage. Acute Heart Attack Ready hospitals may transfer STEMI patients to a primary PCI-capable hospital for care. PCI for STEMI refers to intervention(s) performed solely and emergently for treatment of a STEMI and does not include any elective or scheduled procedures.

Eligibility

In addition to the general Disease Specific Care eligibility requirements outlined in “The Joint Commission Certification Process” (CERT) chapter of the Comprehensive Certification Manual for Disease Specific Care, candidate Acute Heart Attack Ready (AHAR) programs must validate compliance with minimum case volumes during a time prior to the date of application and recertification. When applying for certification, candidate AHAR programs will need to demonstrate that:

- The program has served a minimum of 10 patients.
- The program is currently participating in the American Heart Association's Get With The Guidelines® – Coronary Artery Disease.
- The program is provided within a hospital that is designated as a smoke-free campus.

Opening Conference and Orientation to Program (1 Hour)

Organization Participants

Disciplines representing the care needs of the STEMI patient based on the AHAR requirements:

- Program administrative leaders
- Program clinical leaders, including medical director and STEMI coordinator
- Disciplines that are members of the STEMI team
- Disciplines representing the care needs of the STEMI patient including physicians, nurses, technologists, case managers and social workers, and others based on the AHAR requirements.
- Others at the discretion of the organization

Opening Conference (15 Minutes)

- Introductions
- Overview of AHAR certification by reviewers
- Agenda review
- Overview of SAFER™ matrix

Orientation to the Program (45 Minutes)

- The organization should be prepared to discuss or provide a 20-minute presentation, that includes:
 - STEMI program overview & review process

- Scope of STEMI services
- Symptom onset
- First medical contact
- Emergency medical services
- Emergency department; inpatient settings
- Catheterization laboratories (*if applicable to the program*)
- Transfer process
- Referral process/rehabilitation care
- Transitions of care to home or extended care
- Program mission, goals, and objectives
- Program structure
- Program leadership and management
- Program design (Including project plan or charter delineating the team's expectations, accountabilities, and goals).
- STEMI team composition
- Developing, implementing, and evaluating the program including:
 - Frequency and discussion topics of interdisciplinary team STEMI meetings. *Documentation includes roster with discipline (title) listed, attendance records, meeting minutes, exhibits, and handouts.*
 - Program's process and frequency for providing feedback to emergency medical service agencies and interfacility transport agencies.
 - Target population for
 - the program: STEMI patients who have the need for emergent care, advanced imaging, and Percutaneous Coronary Intervention (PCI). The target population also includes STEMI patients who receive fibrinolytic therapy.
- Identified needs of the program population
- The selection, implementation, and evaluation of clinical practice guidelines
- Evaluation of clinical practice guidelines use and appropriateness to the target population
- Performance improvement process, including evaluation of the disease management program's efficacy
- Community relationships: The program develops an outreach plan for educating the community on heart attack care.
 - Note: Documentation examples may include advertisement campaigns, public service announcements, specific trainings*
- Use of telemedicine (if applicable)

Reviewer Planning Session/Protocols Available for Review (30 minutes)

Materials Required for the Reviewer Planning Session:

The AHAR certification program requires the organization to have protocols for patient care. Protocols can be reviewed anytime during the on-site review.

Protocols for review include those associated with the patient's care, such as:

- Informed consent
- Emergency/urgent care protocols including triage, diagnosis, and treatment of a STEMI patient.
- Rapid identification of STEMI patient by 12 lead ECG within 10 minutes of arrival, including walk-ins.
- Activation of STEMI/catheterization laboratory team via a STEMI/alert call system, including documentation of staff utilization of the call system, (*if applicable to the program*).
- Informed consent for STEMI interventions
- Transferring STEMI patients to another hospital/facility
- PCI treatment protocol(s)
- Fibrinolytic therapy protocol
- Current list of Acute Myocardial Infarction patients from at a minimum of the last 4 months:
 - Fibrinolytic therapy
 - Patient transfers to STEMI receiving facility for PCI
 - Primary PCI procedures

- Patients should be separated by intervention and date of admission. The list should include the patients' age, sex and admitting physician and the physician who performed the PCI (if applicable).
- List of STEMI team members and their credentials
- AHAR protocols/order sets for care (having a printed copy of down-time order sets is helpful to reviewers)

Selecting Patients for Individual Tracers and Protocol Review:

From the list of current STEMI patients, the reviewers in conjunction with program representatives will identify patients for tracing. Reviewers will also begin to identify personnel and credential files that they will need for review during the Competence Assessment/Credentialing Process/Education session.

Based on the patients chosen for the initial individual patient tracer, the reviewers may choose to review the organization's AHAR protocols related to the patient's specific care, treatment, and services.

General patient services:

- Emergency medical, nursing and other care
- Advanced imaging procedures
- Interventions (PCI, PPCI, fibrinolytic therapy)
- Rehabilitation services
- Patient readiness for transfer/discharge; patient interview
- Family readiness for transfer/discharge; family interview
- Transfer/Discharge process

Specific program services:

- Patient admitted within past 24 hours—activation of STEMI Team, STEMI alert processes and response times.
- Transfer process when the need for PCI falls outside of catheterization laboratory operating hours. Includes identification of the need for transfer, communication with STEMI receiving center, patient care throughout process.
- Fibrinolytic Therapy – process plan

Reviewers will want to see that the program has a written protocol(s) designating primary PCI as the standard reperfusion strategy. Reviewers will look at other protocols throughout the visit, so they should remain available or be easily retrievable. The reviewers will compare care provided during individual patient tracer activity to protocols utilized by the STEMI program.

Individual Tracer Activities (3 Hours)

Organization Participants

Program representatives who can facilitate tracer activities such as escorting the reviewers through the clinical setting following the course of care for the patients, and staff who are involved in the patient's care. This may also include:

- Emergency licensed independent practitioners and staff
- Imaging licensed independent practitioners and staff
- Catheterization laboratory licensed independent practitioners and staff (*if applicable to the program*)
- ICU licensed independent practitioners and staff, (*if applicable to the program*)
- Other licensed independent practitioners and staff providing care at the discretion of the organization
- Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology staff

Materials Needed for This Session

- Clinical record of selected patient

Overview of the Individual Patient Tracer Activity

The individual patient tracer activity is a method used to evaluate an organization's provision of care, treatment, and services, using the patient's experience as a guide. During an individual patient tracer, the reviewers will follow a patient's course of care, treatment or service through the program to assess the use and adherence to and diversion from clinical practice guidelines and organizational policies in the patient's care, treatment, or service.

Individual patient tracer activity usually begins in the emergency department and follows the patient through to the unit where the patient is currently being treated or the location from which they were discharged. The reviewer will speak with staff in all of the areas involved in the patient's encounter, including emergency services, advanced imaging, catheterization interventions (*if applicable to the program*), ICU care, post-ICU care, rehabilitation services, patient/family education, and transfer/discharge procedures.

The sequence in which the tracer is conducted may vary based on staff availability, patient care needs, and organizational logistics. Observational data may be obtained through interactions with clinicians, direct observation in the specific clinical area, patient/family interview, and/or documentation within the patient's medical record.

Plan for sufficient staff and licensed independent practitioners to accommodate the reviewer conducting tracer activity in the organization. Also, plan for space to accommodate the reviewer conducting interviews during individual patient tracers so as not to interfere with patient care. If your organization utilizes electronic medical records/documentation, please plan to provide computer access for the reviewer during individual patient tracers. This can be done in a conference room or on the patient care unit.

The number of staff members participating in the individual patient tracer activity should be limited. The rationale for limiting the number of staff members participating in this activity is to reduce any distraction that the review process may have on patient care.

After each tracer, the reviewer will communicate to the program representatives and care providers any:

- Specific observations made
- Issues that will continue to be explored in other tracer activity
- Need for additional record/policy review
- Issues that have the potential to result in requirements for improvement

Clinical Areas that will be visited and included in the program evaluation include:

- *Emergency Department* - Focus is on the care provided to the patient by EMS, triage, nurses, and physicians; the communication with advanced imaging and interventional practitioners; the protocol or process for obtaining the EMS record.
- *Nursing Units*: telemetry, specialty cardiac, ICU – Focus is on care provided for the program's population; communication with STEMI team; protocols and process to treat STEMI patients.
- *Catheterization Laboratory*: Focus is on care provided for STEMI patients; communication with STEMI team, STEMI alert call system; protocols and process to treat STEMI patients for PCI services (*if applicable to the program*).
- *Advanced Imaging*: Availability of services and process when services are not available 24/7 but are needed for patients.
 - PCI/PPCI
 - Magnetic Resonance Imaging (MRI)
 - Magnetic Resonance Angiography (MRA)
 - Echocardiography
 - PET MRI
 - Transesophageal Echocardiography (TEE)
 - Nuclear Medicine

General program items that will be visited, discussed, observed, evaluated:

- Informed Consent
- Catheterization Laboratory
- CT/MRI suite
- Procedures and interventions.
- ICU/nursing/medical care
- Pharmacy
- Post-Acute Care STEMI
- Assessment
- Goals
- Patient/Family education
- Social work/Case management
- Referral/Transfer/Discharge: For patients transferring or near discharge, query the staff about the transfer/discharge process.

- Follow-up Call: If patient is near discharge to home, query the organization about the process for a follow-up phone call to determine the patient's status and post hospitalization care needs. *If applicable to facility process*
- Closed Record Review: Reviewers will review closed medical records.

Care Team:

Care team composition: Review of the program process for disciplines and practitioners, including those who provided care to the patients included in tracer activities. Review practitioners and other staff providing medical care and required experience (please refer to the standards and AHAR-specific requirements for the issues/topics related to these care team members that will be addressed):

- STEMI first responders - EMS, ED staff, STEMI medical director (or designee), STEMI coordinator, (per organization policy), STEMI team
- Emergency physicians
- Cardiologists/cardiac surgeons (*if applicable to the program*)
- Intensivists, fellows, residents, PAs, APNs providing cardiac/ICU care (*if applicable to the program*)
- Cardiac Interventionalist with expertise in Percutaneous Coronary Intervention (*if applicable to the program*)
- Diagnostic radiologist with STEMI experience
- Physicians with critical care privileges
- Nurses/other clinical staff and required experience to care for STEMI patients, including ED, cardiac specialty, ICU and telemetry nurses
- If program uses APNs and PAs to provide direct care to STEMI patients as an alternative to a physician, they must have additional education and experience in STEMI care, as defined by the organization, to provide this care.
- Imaging technologists, certified radiology technologist(s), qualified magnetic resonance imaging (MRI) technologists
- interventional technician(s) and nurses (*if applicable to the program*)
- Therapists, social workers, nurse case managers/discharge planners with knowledge of STEMI care, care coordination, rehabilitation, and making referrals to appropriate sites of ongoing care, rehabilitation, and community resources as indicated
- Pharmacist(s) with expertise in cardiac/STEMI (including PCI, fibrinolytic therapy, and other medications associated with STEMI care)
- Dietitian/dietary staff
- Other clinical and ancillary staff

Care Team Discussion Topics

- Informed consent specific to STEMI patients
- Model of ICU care (does the program use APNs, PAs, residents, or fellows?)
- Use of CPGs
- Patient/family education
- Referral process, transitions of care
- Follow-up post discharge, *if part of the process*
- GWTG@-CAD registry
- Performance measures – knowledge of any role they play in data collection, analysis, reporting or review and use in program improvement activity
- Education for role on care team, competency assessment process

Patient/Family Interviews – Reviewers will ask the patient or authorized family member about topics such as:

- Discussions with the licensed independent practitioner about potential benefits, risks, and side effects of the patient's proposed STEMI interventions and care; the likelihood of the patient achieving his or her goals; and any potential problems that might occur because of the intervention.
- Discussions with the care team members about reasonable alternatives to the patient's proposed STEMI interventions and care.
- Receiving needed education on such as current treatment, lifestyle changes, and health promotion.
- Involvement in treatment planning.
- Their knowledge of the process to report concerns related to care or safety issues.
- Education provided to patients being discharged home on:
 - Post-hospital care, including home care and rehabilitation therapy, as indicated
 - Durable medical equipment (DME) when indicated
 - Respite care

Closed Chart Review

During individual patient tracer time, the reviewer will request closed patient records for review. Closed record review provides an opportunity to see the entire continuum of care experienced by a STEMI patient from emergent arrival, through transitions of care, to transfer/discharge.

System Tracer--Data Use Session (60 minutes)

Organization Participants

- Program administrative and clinical leaders
- Individual(s) responsible for performance improvement processes within the program
- Others at the discretion of the organization

Materials Needed

- Performance measurement data addressed in requirements, including
 - Arrival-to-PCI within 90 and/or 60 minutes
 - EMS/first medical contact-to-PCI within 90 minutes
 - EMS/first medical contact-to-PCI within 120 minutes when transport time is 45 minutes or longer and arrival to PCI is 30 minutes or less (if applicable)
 - Arrival at Acute Heart Attack Ready organization-to-PCI within 120 minutes for patients transferred to a Primary Heart Attack Center for PCI (no fibrinolytics)
 - Arrival-to-fibrinolytics within 30 minutes (if fibrinolytics are administered)
 - Patient arrival to 12-lead ECG within 10 minutes or less
 - Call for transport to time of transport team's arrival (expectation defined by coordination between an AHAR and interfacility transport agency(ies))
 - Transport team's arrival to the time of departure (expectation defined by coordination between AHAR and interfacility transport agency(ies))
 - Patient arrival to patient departure within 30 minutes or less (door in–door out)
- Action plans demonstrating the program's use of and response to data

Overview of the Data Use System Tracer

The system tracer session is focused on the program's use of data to improve care, treatment, and services, as well as the safety and quality of care for STEMI patients.

During the session, the reviewer and program representatives will review available data and discuss:

- Data collection processes, both concurrent and retrospective, and process strengths and weaknesses
- Data dissemination – internal and external recipients
- Program's defined performance improvement methodology, PI plan and action plans
- Standardized performance measures
- Selection of two patient care data elements monitored for benchmarking
- Complication rate data
- Public reporting of outcomes
- Current STEMI performance measure data, including:
 - Time of sign/symptom onset, if available, to first medical contact through PCI.
 - From PCI through discharge, including cardiac rehabilitation referral, if applicable.
- Data related to program's target population
- Use of the GWTG®-CAD registry
- Patient satisfaction data specific to STEMI patient population and how it is used in decision-making and in improving patient safety and quality of care
- Program's STEMI team log/report:
 - Displaying the total number of PCI procedures by the following types:
 - Fibrinolytic therapy
 - Patient transfers to STEMI receiving facility for PCI
 - Primary PCI procedures
- Program identification of outliers in the following metrics and the processes put in place to support achievement of these metrics:
 - Arrival-to-PCI within 90 and/or 60 minutes
 - EMS/first medical contact-to-PCI within 90 minutes

- EMS/first medical contact-to-PCI within 120 minutes when transport time is 45 minutes or longer and arrival to PCI is 30 minutes or less (if applicable)
- Arrival at Acute Heart Attack Ready organization-to-PCI within 120 minutes for patients transferred to a Primary Heart Attack Center for PCI (no fibrinolytics)
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- Patient arrival to 12-lead ECG within 10 minutes or less
- Call for transport to time of transport team's arrival (expectation defined by coordination between an AHAR and interfacility transport agency(ies))
- Transport team's arrival to the time of departure (expectation defined by coordination between AHAR and interfacility transport agency(ies))
- Patient arrival to patient departure within 30 minutes or less (door in–door out)
- Documented feedback the program has given to emergency medical services and/or interfacility transport agencies for the most recent 6 months.
- Examples of feedback relayed by receiving centers within the most recent 6 months.
- Analysis of clinical and management data for use in decision-making and identifying opportunities to improve patient safety and quality of care

Competence Assessment and Credentialing Process Activity (60 minutes)

The purpose of this session is to discuss how the program meets the need for qualified and competent practitioners.

Organization Participants

- Program leaders
- Clinical leaders
- Individual(s) familiar with AHAR requirements for team members such as supervisors, managers, and leaders
- Clinical or medical director(s)
- Organization representatives responsible for human resources processes
- Organization representatives responsible for credentialing processes, if different from above
- Individuals with authorized access to, and familiar with the format of files
- Others at the discretion of the organization

Materials Needed for this Session

Personnel or credentials files for individuals identified by the reviewer

- A minimum of five (5) files will be selected
- At least one file per discipline (physician, nurse, social work, dietitian, therapist, etc.) represented on the STEMI team will be reviewed

Note: The reviewer will select these files based on the individuals encountered during tracer activity, that is, those caring for or who cared for the patient being traced. Please let the reviewer know if there could be a delay in getting files for review.

Competence Assessment & Credentialing Session Tool: This tool is available to use during this session. The purpose of this tool is to provide a standardized, easy-to-use format for collecting observations during the Competence Assessment and Credentialing Process activity.

Overview of the Competence Assessment/Credentialing Process/Education Session

Practitioners and staff have education, experience, training, and/or certification consistent with the program's scope of services, goals and objectives, and the care provided.

The reviewer will need to examine personnel records of:

- Nursing staff
- Medical staff
- Other staff interviewed during patient tracers

Review of job descriptions will include:

- Medical Director of STEMI Program
- STEMI Coordinator
- Interventional Cardiologist
- Catheterization Laboratory Staff

Discussion topics will include:

- Orientation processes
- Processes to assess practitioner competence

- Primary source license verification process for licensed independent practitioners
- Competence assessment for staff caring for STEMI patients
- Contract personnel competence assessment and education (if contract staff is used)
- Core STEMI team members required to have STEMI education
- Ongoing education, training, and in-service requirements for the program including:
 - STEMI recognition, identification, and treatment
 - Interdisciplinary training and education events for emergency medical service professionals, including 911 and interfacility transport. Documentation of agendas, rosters, or related material is required.
- Documentation of an outreach plan for educating the community on STEMI care.
- Credentialing process for cardiologists who perform percutaneous coronary intervention (PCI) and review files. (if applicable to the program).

For AHAR recertification, the organization will need to demonstrate how all the educational requirements have been met between the initial and the recertification review.

Issue Resolution & Reviewer Report Preparation (60 minutes – combined with Report Preparation)

Issue resolution time is an opportunity for the reviewer to follow-up on potential findings that could not be resolved in other onsite activities. This is also time for the organization to present any information that they believe the reviewer may have missed during the day or that may not have been immediately available upon the reviewer's request.

Organization Participants

Will vary depending upon the issue

Materials Needed for this Session

Will vary depending upon the issue

Preparation for Issue Resolution

None required

Overview of the Issue Resolution Session

The reviewer may have identified issues during individual tracer activity or other sessions that require further exploration or follow-up with staff. This follow-up may include a variety of activities such as:

- Review of policies and procedures
- Review of human resources files
- Review of performance improvement data
- Discussions with selected staff

The reviewer will work with the program's certification review coordinator to organize and conduct all issue resolution activity.

If there are no issues to resolve and the reviewer does not need any additional information, this activity will not need to occur. The reviewer will proceed with Report Preparation activity.

Program Exit Conference (30 minutes) Overview of Program Exit Conference

The Program Exit Conference is the final onsite activity when the organization receives a preliminary report of findings from the reviewer.

Organization Participants

- Program leaders
- Clinical leaders
- Other staff at the discretion of the organization

Materials Needed for this Session

Copies of the Summary of Certification Review Findings report—if it is being distributed to staff

Preparation for the Program Exit Conference

None required

Overview of the Program Exit Conference

This is a 30-minute activity that takes place at the completion of a program review. Administrative and clinical program leaders, and other organization staff, as invited, will hear a verbal report of observations, **review findings**, requirements for improvement, and where these are appearing on the SAFER™ matrix. The Summary of Certification Review Findings Report is shared with participants in the Exit Conference ONLY with the permission of the CEO. All reports left onsite are preliminary and subject to change upon review by Joint Commission central office staff.

Advanced DSC–Primary Heart Attack Center (PHAC) Certification Addendum

Introduction

Included in this Primary Heart Attack Ready (PHAC) addendum is supplemental information to the *Disease Specific Care (DSC) Certification Review Process Guide (RPG)*. Organizations preparing for the PHAC certification event will need to review the *Certification Review Process Guide* as well as the program specific information in this addendum.

The PHAC certification review is a one-day event. The agenda reflects the recommended activities and time frames for the onsite review. Keep in mind that the time frames mentioned are flexible and may be adjusted by the reviewers as necessary based on organizational need.

Background

The Joint Commission's Primary Heart Attack Center (PHAC) Certification program recognizes hospitals that meet standards denoting the highest level of commitment to consistent and optimal ST-elevated myocardial infarction (STEMI) treatment for patients. This certification was developed in conjunction with the American Heart Association (AHA) and its Get With The Guidelines® – Coronary Artery Disease program to help establish and improve coordinated systems of care for STEMI treatment.

The PHAC program will focus on symptom onset, first medical contact, emergency medical services, the emergency department, inpatient settings, and catheterization laboratories. Any hospital participating in this program is required to provide on-site primary percutaneous coronary intervention (PCI) coverage for STEMI patients 24 hours a day, 7 days a week.

Eligibility

In addition to the general Disease Specific Care eligibility requirements outlined in “The Joint Commission Certification Process” (CERT) chapter of the *Comprehensive Certification Manual for Disease Specific Care*, candidate Primary Heart Attack Centers (PHAC) programs must validate compliance with minimum case volumes during a time prior to the date of application and recertification. When applying for certification, candidate PHAC programs will need to demonstrate that:

- The program provides onsite 24 hours a day, 7 days a week primary PCI coverage for STEMI patients
- The program has served a minimum of 10 patients
- Interventional cardiologists who perform primary PCI for STEMI perform a minimum of 50 PCI procedures over 12 months (or 100 over 24 months) and a minimum of 11 Primary PCI procedures a year to maintain competency
- The program is currently participating in the American Heart Association's Get With The Guidelines® – Coronary Artery Disease.
- The program is provided within a hospital that is designated as a smoke-free campus

In addition to the program specific eligibility requirements outlined in the *Comprehensive Certification Manual for Disease-Specific Care*, hospitals need to meet the hospital volume requirements for the number of PCI and Primary PCI procedures performed.

- The program achieves hospital volume requirements by meeting one of the following options:
- The program performs a minimum of 150 PCI procedures and 36 primary PCI procedures in any consecutive rolling 4 quarters
- Primary Heart Attack Centers that have not performed 150 total PCI procedures and 36 primary PCI procedures over the most recent 12 months must provide the following documentation:
 - Process for interventional cardiologists to closely monitor clinical outcomes
 - Examples of STEMI systems of care processes/protocols in place, may be regionally adopted processes as well as internal processes
 - Formal association with a larger facility or facilities
 - For sites without on-site surgery, formal agreement(s) with facility(ies) that do provide surgery on-site and the associated transfer plan/protocol
 - Rotation schedule of interventionalists, clinical catheter laboratory staff, and hospital support staff at a high-volume PCI center

Opening Conference and Orientation to Program (1 Hour)

Organization Participants

Disciplines representing the care needs of the STEMI patient based on the PHAC requirements:

- Program administrative leaders
- Program clinical leaders, including medical director and STEMI coordinator
- Disciplines that are members of the STEMI team
- Disciplines representing the care needs of the STEMI patient including physicians, nurses, technologists, case managers and social workers, and others based on the PHAC requirements
- Others at the discretion of the organization

Opening Conference (15 Minutes)

- Introductions
- Overview of PHAC certification by reviewers
- Agenda review
- Overview of SAFER™ matrix

Orientation to the Program (45 Minutes)

- The organization should be prepared to discuss or provide a 20-minute presentation, that includes:
 - STEMI program overview & review process
 - Scope of STEMI services
 - Symptom onset
 - First medical contact
 - Emergency medical services
 - Emergency department; inpatient settings
 - Catheterization laboratories (including primary percutaneous coronary intervention (PCI) coverage for STEMI patients 24 hours a day, 7 days a week)
 - Referral process/rehabilitation care
 - Transitions of care to home or extended care
- Program mission, goals, and objectives
- Program structure
- Program leadership and management
- Program design (Including project plan or charter delineating the team's expectations, accountabilities, and goals)
- STEMI team composition
- Developing, implementing, and evaluating the program including:
 - Frequency and discussion topics of interdisciplinary team STEMI meetings. *Documentation includes roster with discipline (title) listed, attendance records, meeting minutes, exhibits, and handouts.*
 - Program's process and frequency for providing feedback to emergency medical service agencies and interfacility transport agencies.
 - Target population for the program: STEMI patients who have the need for emergent care, advanced imaging, and Percutaneous Coronary Intervention (PCI). The target population also includes STEMI patients who receive fibrinolytic therapy.
- Identified needs of the program population
- The selection, implementation, and evaluation of clinical practice guidelines
- Evaluation of clinical practice guidelines use and appropriateness to the target population
- Performance improvement process, including evaluation of the disease management program's efficacy
- On-call schedule for catheterization laboratory and interventional cardiologist coverage
- The program has an emergency/adverse weather contingency plan and policy addressing emergency/weather staffing that addresses a back-up plan in the event the catheterization laboratory staff cannot arrive within the required time frame.
- Community relationships: The program develops an outreach plan for educating the community on heart attack care.
Note: Documentation examples may include advertisement campaigns, public service announcements, specific trainings
- Use of telemedicine (if applicable)

Reviewer Planning Session/Protocols Available for Review (30 minutes)

Materials Required for the Reviewer Planning Session:

The PHAC certification program requires the organization to have many protocols for patient care. Protocols can be reviewed anytime during the on-site review.

Protocols for review include those associated with the patient's care, such as:

- Informed consent
- Emergency/urgent care protocols including triage, diagnosis, and treatment of a STEMI patient
- Rapid identification of STEMI patient by 12 lead ECG within 10 minutes of arrival, including walk-ins
- Activation of STEMI/catheterization laboratory team via a STEMI/alert call system, including documentation of staff utilization of the call system
- Informed consent for STEMI interventions
- Receiving STEMI patient transfers
- Transferring STEMI patients to another hospital/facility
- The program has a process that requires the catheterization laboratory staff and the interventional cardiologist to arrive on site within 30 minutes of STEMI activation.
- PCI treatment protocol(s)
- Fibrinolytic therapy protocol
- Current list of Acute Myocardial Infarction patients from at a minimum of the last 4 months:
 - Primary PCI procedures
 - Facilitated/rescue PCI procedures
 - Elective PCI procedures
 - PCI for STEMI (unstable >12 hours from symptom onset)
 - PCI for STEMI (stable > 12 hours from symptom onset)
 - PCI for STEMI (stable after successful full dose lytic)
 - PCI for NSTEMI
- Patients should be separated by intervention and date of admission. The list should include the patients' age, sex and admitting physician and the physician who performed the PCI (if applicable).
- List of STEMI team members and their credentials
- PHAC protocols/order sets for care (having a printed copy of down-time order sets is helpful to reviewers)

Selecting Patients for Individual Tracers and Protocol Review:

From the list of current STEMI patients, the reviewers in conjunction with program representatives will identify patients for tracing. Reviewers will also begin to identify personnel and credential files that they will need for review during the Competence Assessment/Credentialing Process/Education session.

Based on the patients chosen for the initial individual patient tracer, the reviewers may choose to review the organization's PHAC protocols related to the patient's specific care, treatment, and services.

General patient services:

- Emergency medical, nursing and other care
- Advanced imaging procedures
- Interventions (PCI, PPCI, fibrinolytic therapy)
- Rehabilitation services
- Patient readiness for discharge; patient interview
- Family readiness for discharge; family interview
- Transfer/Discharge process

Specific program services:

- Patient admitted within past 24 hours—activation of STEMI Team, STEMI alert processes and response times.
- Universal acceptance of STEMI patients.
- A plan for accepting simultaneous presentations of STEMI patients include the following:
- An emergency department "no diversion plan" for STEMI patients
- The ability to provide primary PCI regardless of emergency department diversion status
- Prioritization of emergent primary PCI for a STEMI patient (that is, postponing a scheduled nonemergent or clinically stable procedure to prioritize the emergent STEMI case)

- Call system from a transferring organization with universal patient acceptance by Primary Heart Attack Centers and the result of the immediate activation of the catheterization laboratory team, without the need for additional review or determination of bed availability.
- The program has an emergency/adverse weather contingency plan and policy addressing emergency/weather staffing that addresses a back-up plan in the event the catheterization laboratory staff cannot arrive within the required time frame.

Reviewers will want to see that the program has a written protocol(s) designating primary PCI as the standard reperfusion strategy. Reviewers will look at other protocols throughout the visit, so they should remain available or be easily retrievable. The reviewers will compare care provided during individual patient tracer activity to protocols utilized by the STEMI program.

Individual Tracer Activities (3 Hours)

Organization Participants

Program representatives who can facilitate tracer activities such as escorting the reviewers through the clinical setting following the course of care for the patients, and staff who are involved in the patient's care. This may also include:

- Emergency licensed independent practitioners and staff
- Imaging licensed independent practitioners and staff
- Catheterization laboratory licensed independent practitioners and staff
- ICU licensed independent practitioners and staff
- Other licensed independent practitioners and staff providing STEMI care at the discretion of the organization
- Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology staff

Materials Needed for This Session

- Clinical record of selected patient

Overview of the Individual Patient Tracer Activity

The individual patient tracer activity is a method used to evaluate an organization's provision of care, treatment, and services, using the patient's experience as a guide. During an individual patient tracer, the reviewers will follow a patient's course of care, treatment or service through the program to assess the use and adherence to and diversion from clinical practice guidelines and organizational policies in the patient's care, treatment, or service.

Individual patient tracer activity usually begins in the emergency department and follows the patient through to the unit where the patient is currently being treated or the location from which they were discharged. The reviewer will speak with staff in all of the areas involved in the patient's encounter, including emergency services, advanced imaging, catheterization interventions, ICU care, post-ICU care, rehabilitation services, patient/family education, and transfer/discharge procedures.

The sequence in which the tracer is conducted may vary based on staff availability, patient care needs, and organizational logistics. Observational data may be obtained through interactions with clinicians, direct observation in the specific clinical area, patient/family interview, and/or documentation within the patient's medical record.

Plan for sufficient staff and licensed independent practitioners to accommodate the reviewer conducting tracer activity in the organization. Also, plan for space to accommodate the reviewer conducting interviews during individual patient tracers so as not to interfere with patient care. If your organization utilizes electronic medical records/documentation, please plan to provide computer access for the reviewer during individual patient tracers. This can be done in a conference room or on the patient care unit.

The number of staff members participating in the individual patient tracer activity should be limited. The rationale for limiting the number of staff members participating in this activity is to reduce any distraction that the review process may have on patient care.

After each tracer, the reviewer will communicate to the program representatives and care providers any:

- Specific observations made
- Issues that will continue to be explored in other tracer activity
- Need for additional record/policy review

- Issues that have the potential to result in requirements for improvement

Clinical Areas to will be visited and included in the program evaluation include:

- *Emergency Department* - Focus is on the care provided to the patient by EMS, triage, nurses, and physicians; the communication with advanced imaging and interventional practitioners; the protocol or process for obtaining the EMS record.
- *Nursing Units*: telemetry, specialty cardiac, ICU – Focus is on care provided for the program's population; communication with STEMI team; protocols and process to treat STEMI patients.
- *Catheterization Laboratory*: Focus is on care provided for STEMI patients; communication with STEMI team, STEMI alert call system; protocols and process to treat STEMI patients for PCI services.
- *Advanced Imaging*: Availability of services and how facility provides services to that are not available 24/7 but are needed for patients.
 - The PHAC performs advanced imaging with multimodal imaging capabilities 24 hours a day/7 days a week:
 - PCI/PPCI
 - Magnetic Resonance Imaging (MRI)
 - Magnetic Resonance Angiography (MRA)
 - Echocardiography
 - PET MRI
 - Transesophageal Echocardiography (TEE)
 - Nuclear Medicine

General program items that will be visited, discussed, observed, evaluated:

- Informed Consent
- Catheterization Laboratory
- CT/MRI suite
- Procedures and interventions. *Note: Percutaneous Coronary Intervention (PCI) therapy for the treatment of STEMI is required to be available 24/7. Include evaluation of the patient pre-procedure*
- ICU/nursing/medical care
- Pharmacy
- Post-Acute Care STEMI
- Assessment
- Goals
- Patient/Family education
- Social work/Case management
- Referral/Transfer/Discharge: For patients transferring or near discharge, query the staff about the transfer/discharge process.
- Follow-up Call: If patient is near discharge to home, query the organization about the process for a follow-up phone call to determine the patient's status and post hospitalization care needs. *If applicable to facility process*
- Closed Record Review: Reviewers will review closed medical records.

Care Team:

Care team composition: Review of the program process for disciplines and practitioners, including those who provided care to the patients included in tracer activities. Review of practitioners and other staff providing medical care and required experience (please refer to the standards and PHAC-specific requirements for the issues/topics related to these care team members that will be addressed):

- STEMI first responders - EMS, ED staff, STEMI medical director (or designee), STEMI coordinator, (per organization policy), STEMI team
- Emergency physicians
- Cardiologists/cardiac surgeons
- Intensivists, fellows, residents, PAs, APNs providing cardiac/ICU care *(if applicable to the program)*
- Cardiac Interventionalist with expertise in Percutaneous Coronary Intervention
- Diagnostic radiologist with STEMI experience
- Physicians with critical care privileges

- Nurses/other clinical staff and required experience to care for STEMI patients, including ED, cardiac specialty, ICU and telemetry nurses
- If program uses APNs and PAs to provide direct care to STEMI patients as an alternative to a physician, they must have additional education and experience in STEMI care, as defined by the organization, to provide this care.
- Imaging technologists, certified radiology technologist(s), qualified magnetic resonance imaging (MRI) technologists
- interventional technician(s) and nurses
- Therapists, social workers, nurse case managers/discharge planners with knowledge of STEMI care, care coordination, rehabilitation, and making referrals to appropriate sites of ongoing care, rehabilitation, and community resources as indicated
- Pharmacist(s) with expertise in cardiac/STEMI (including PCI, fibrinolytic therapy, and other medications associated with STEMI care)
- Dietitian/dietary staff
- Other clinical and ancillary staff

Care Team Discussion Topics

- Informed consent specific to STEMI patients
- Model of ICU care (does the program use APNs, PAs, residents, or fellows?)
- Use of CPGs
- Patient/family education
- Referral process, transitions of care
- Follow-up post discharge, *if part of the process*
- GWTG@-CAD registry
- Performance measures – knowledge of any role they play in data collection, analysis, reporting or review and use in program improvement activity
- Education for role on care team, competency assessment process
- Availability of interventional cardiologist and catheterization laboratory staff

Patient/Family Interviews - Reviewers will ask the patient or authorized family member about topics such as:

- Discussions with the licensed independent practitioner about potential benefits, risks, and side effects of the patient's proposed STEMI interventions and care; the likelihood of the patient achieving his or her goals; and any potential problems that might occur because of the intervention.
- Discussions with the care team members about reasonable alternatives to the patient's proposed STEMI interventions and care
- Receiving needed education on such as current treatment, lifestyle changes, and health promotion
- Involvement in treatment planning.
- Their knowledge of the process to report concerns related to care or safety issues
- Education provided to patients being discharged home on:
- Post-hospital care, including home care and rehabilitation therapy, as indicated
- Durable medical equipment (DME) when indicated
- Respite care

Closed Chart Review

During individual patient tracer time, the reviewer will request closed patient records for review. Closed record review provides an opportunity to see the entire continuum of care experienced by a STEMI patient from emergent arrival, through transitions of care, to transfer/discharge.

System Tracer--Data Use Session (60 minutes)

Organization Participants

- Program administrative and clinical leaders
- Individual(s) responsible for performance improvement processes within the program
- Others at the discretion of the organization

Materials Needed

- Performance measurement data addressed in requirements, including:
 - EMS/first medical contact-to-PCI within 90 minutes

- EMS/first medical contact-to-PCI within 120 minutes when transport time is 45 minutes or longer and arrival to PCI is 30 minutes or less (if applicable)
- Patient arrival to 12-lead ECG within 10 minutes or less
- Arrival-to-PCI within 90 and/or 60 minutes
- Arrival at STEMI receiving center to PCI within 120 minutes for patients transferred to a STEMI receiving center for PCI (no fibrinolytics)
- Patient arrival to fibrinolytic administration in 30 minutes or less (if fibrinolytics are administered)
- Hospital volume requirements: The program achieves hospital volume requirements by meeting one of the following options:
 - The program performs a minimum of 150 PCI procedures and 36 primary PCI procedures in any consecutive rolling 4 quarters.
 - Primary Heart Attack Centers that have not performed 150 total PCI procedures and 36 primary PCI procedures over the most recent 12 months must provide the following documentation:
 - Process for interventional cardiologists to closely monitor clinical outcomes
 - Examples of STEMI systems of care processes/protocols in place, may be regionally adopted processes as well as internal processes
 - Formal association with a larger facility or facilities
 - For sites without on-site surgery, formal agreement(s) with facility(ies) that do provide surgery on-site and the associated transfer plan/protocol
 - Rotation schedule of interventionalists, clinical catheter laboratory staff, and hospital support staff at a high-volume PCI center
- Action plans demonstrating the program's use of and response to data collection

During the session, the reviewer and program representatives will review available data and discuss:

- Data collection processes, both concurrent and retrospective, and process strengths and weaknesses
- Data dissemination – internal and external recipients
- Program's defined performance improvement methodology, PI plan and action plans
- Standardized performance measures
- Selection of two patient care data elements monitored for benchmarking
- Complication rate data
- Public reporting of outcomes
- Current STEMI performance measure data, including:
 - Time of sign/symptom onset, if available, to first medical contact through PCI.
 - From PCI through discharge, including cardiac rehabilitation referral, if applicable.
- Data related to program's target population
- Use of the GWTG®-CAD registry
- Patient satisfaction data specific to STEMI patient population and how it is used in decision-making and in improving patient safety and quality of care
- Program's STEMI team log/report:
 - Displaying the total number of PCI procedures by the following types:
 - Primary PCI procedures
 - Facilitated/rescue PCI procedures
 - Elective procedures
 - PCI for STEMI (unstable >12 hours from symptom onset)
 - PCI for STEMI (stable >12 hours from symptom onset)
 - PCI for STEMI (stable after successful full-dose fibrinolytics)
 - PCI for NSTEMI
- Program identification of outliers in the following metrics and the processes put in place to support achievement of these metrics:
 - EMS/first medical contact-to-PCI within 90 minutes
 - EMS/first medical contact-to-PCI within 120 minutes when transport time is 45 minutes or longer and arrival to PCI is 30 minutes or less (if applicable)
 - Patient arrival to 12-lead ECG within 10 minutes or less
 - Arrival-to-PCI within 90 and/or 60 minutes
 - Arrival at STEMI receiving center to PCI within 120 minutes for patients transferred to a STEMI receiving center for PCI (no fibrinolytics)
 - Patient arrival to fibrinolytic administration in 30 minutes or less (if fibrinolytics are administered)
- Documented feedback the program has given to emergency medical services and/or interfacility transport agencies for the most recent 6 months
- Examples of feedback relayed by referring centers within the most recent 6 months

- Analysis of clinical and management data for use in decision-making and identifying opportunities to improve patient safety and quality of care
- The program documents, monitors, and addresses catheterization laboratory metrics:
 - Arrival of all members of the catheterization call teams, including the interventional cardiologist, within 30 minutes of activation
 - Catheterization laboratory staff and cardiologist arrival times for patients, including those with prolonged transport time (>30 minutes). Documentation includes data that all staff arrived prior to patient's arrival.
 - Catheterization laboratory staff and cardiologist arrival times outside of the required time frames

Competence Assessment and Credentialing Process Activity (60 minutes)

The purpose of this session is to discuss how the program meets the need for qualified and competent practitioners.

Organization Participants

- Program leaders
- Clinical leaders
- Individual(s) familiar with PHAC requirements for team members such as supervisors, managers, and leaders
- Clinical or medical director(s)
- Organization representatives responsible for human resources processes
- Organization representatives responsible for credentialing processes, if different from above
- Individuals with authorized access to, and familiar with the format of files
- Others at the discretion of the organization

Materials Needed for this Session

Personnel or credentials files for individuals identified by the reviewer

- A minimum of five (5) files will be selected
- At least one file per discipline (physician, nurse, social work, dietitian, therapist, etc.) represented on the STEMI team will be reviewed

Note: The reviewer will select these files based on the individuals encountered during tracer activity, that is, those caring for or who cared for the patient being traced. Please let the reviewer know if there could be a delay in getting files for review.

Competence Assessment & Credentialing Session Tool: This tool is available to use during this session. The purpose of this tool is to provide a standardized, easy-to-use format for collecting observations during the Competence Assessment and Credentialing Process activity.

Overview of the Competence Assessment/Credentialing Process/Education Session

Practitioners and staff have education, experience, training, and/or certification consistent with the program's scope of services, goals and objectives, and the care provided.

The reviewer will need to examine personnel records of:

- Nursing staff
- Medical staff
- Other staff interviewed during patient tracers

Review of job descriptions will include:

- Medical Director of STEMI Program
- STEMI Coordinator
- Interventional Cardiologist
- Catheterization Laboratory Staff

Discussion topics to include:

- Orientation processes
- Processes to assess practitioner competence
- Primary source license verification process for licensed independent practitioners
- Competence assessment for staff caring for STEMI patients
- Contract personnel competence assessment and education (if contract staff is used)
- Core STEMI team members required to have STEMI education
- Ongoing education, training, and in-service requirements for the program including:

- STEMI recognition, identification, and treatment
- Interdisciplinary training and education events for emergency medical service professionals, including 911 and interfacility transport. Documentation of agendas, rosters, or related material is required.
- Documentation of an outreach plan for educating the community on STEMI care.
- Credentialing process for cardiologists who perform percutaneous coronary intervention (PCI) and review files.
- Annual report that indicates percutaneous coronary intervention (PCI) volumes performed by individual interventional cardiologists each month. The annual total number of PCI procedures by cardiologist must be broken down by the following PCI types:
 - Primary PCI procedures
 - Facilitated/rescue PCI procedures
 - Elective PCI procedures
 - PCI for STEMI (unstable >12 hours from symptom onset)
 - PCI for STEMI (stable > 12 hours from symptom onset)
 - PCI for STEMI (stable after successful full dose lytic)
 - PCI for NSTEMI

For PHAC recertification, the organization will need to demonstrate how all the educational requirements have been met between the initial and the recertification review.

Issue Resolution & Reviewer Report Preparation (60 minutes – combined with Report Preparation)

Issue resolution time is an opportunity for the reviewer to follow-up on potential findings that could not be resolved in other onsite activities. This is also time for the organization to present any information that they believe the reviewer may have missed during the day or that may not have been immediately available upon the reviewer's request.

Organization Participants

Will vary depending upon the issue

Materials Needed for this Session

Will vary depending upon the issue

Preparation for Issue Resolution

None required

Overview of the Issue Resolution Session

The reviewer may have identified issues during individual tracer activity or other sessions that require further exploration or follow-up with staff. This follow-up may include a variety of activities such as:

- Review of policies and procedures
- Review of human resources files
- Review of performance improvement data
- Discussions with selected staff

The reviewer will work with the program's certification review coordinator to organize and conduct all issue resolution activity.

If there are no issues to resolve and the reviewer does not need any additional information, this activity will not need to occur. The reviewer will proceed with Report Preparation activity.

Program Exit Conference (30 minutes) Overview of Program Exit Conference

The Program Exit Conference is the final onsite activity when the organization receives a preliminary report of findings from the reviewer.

Organization Participants

- Program leaders
- Clinical leaders
- Other staff at the discretion of the organization

Materials Needed for this Session

Copies of the Summary of Certification Review Findings report—if it is being distributed to staff

Preparation for the Program Exit Conference

None required

Overview of the Program Exit Conference

This is a 30-minute activity that takes place at the completion of a program review. Administrative and clinical program leaders, and other organization staff, as invited, will hear a verbal report of observations, review findings, requirements for improvement, and where these are appearing on the SAFER™ matrix. The Summary of Certification Review Findings Report is shared with participants in the Exit Conference ONLY with the permission of the CEO. All reports left onsite are preliminary and subject to change upon review by Joint Commission central office staff.

**Disease Specific Care
CLINICAL RECORD REVIEW TOOL**

(Program use of this tool is optional)

Appendix A

Areas of Review		Standard	Record Number				
			1	2	3	4	5
ITEMS FOR REVIEW							
1	There is a record for every patient	DSCT.5					
2	The record contains sufficient information to identify the patient	DSCT.5					
3	The record contains sufficient information to support the diagnosis	DSCT.5					
4	The record contains sufficient information to justify treatment or services	DSCT.5					
5	The record contains sufficient information to document the course and results of treatment or services	DSCT.5					
6	The record contains sufficient information to track the patients movement through the care system and facilitate continuity of care both internally and externally to the program	DSCT.5					
7	Records appear to be complete and accurate, with all necessary information available.	DSCT.5					
8	Comments are added to records in accordance with organization policy or procedure	DSCT.1					
9	Consent for release of information is on the record records in accordance with organization policy or procedure	DSCT.1					
10	The use of CPGs is evident in the record	DSDF.2					
11	The tailoring of CPGs for the patient is evident in the record	DSDF.3					
12	The management or the communication to the appropriate practitioner for the management of concurrently occurring conditions for the patient is evident in the record	DSDF.4					
13	The involvement of patient in making decisions about managing their disease or condition are evident in the record	DSSE.1					
14	The involvement of support structures in the promotion of life style changes that support self-management regimens is evident in the record	DSSE.2					
16	The patients response to making recommended life-style changes is evaluated	DSSE.2					
17	An assessment of the patients educational needs related to life-style changes is evident in the record	DSSE.3					
18	An assessment of the patients educational needs related to health promotion and disease prevention is evident in the record	DSSE.3					
19	An assessment of the patient's educational needs related to information about the patient's illnesses and treatments is evident in the record	DSSE.3					
20	An assessment of the patient's comprehension of education is evaluated initially and on an on-going basis.	DSSE.3					
21	When appropriate, there is evidence of the patient being notified about screening recommendations or life style changes related to preventing the disease for their family members	DSSE.3					

**Disease Specific Care
HUMAN RESOURCE RECORD REVIEW TOOL**
(Program use of this tool is optional)

Appendix B

Areas of Review		Standard	Record Number				
			1	2	3	4	5
ITEMS FOR REVIEW							
1	Practitioners have educational backgrounds, experience, training and/or certification consistent with the program's mission, goals, and/or objectives	DSDF.1					
2	All practitioners hired have a current license and competency is established.	DSDF.1					
3	The competence of practitioners is assessed when new techniques or responsibilities are introduced, and periodically within the timeframes defined by the organization.	DSDF.1					
4	All practitioners have current licenses	DSDF.1					
5	Current licensure is verified from primary sources	DSDF.1					
6	Although not required in the HR record, ascertain that orientation was conducted and relevant	DSDF.1					
7	Although not required in the HR record, ascertain participation in continuing education	DSDF.1					

Please note: Some items can be located outside the human resources record.

Appendix C – Onsite Review Agenda Templates

Agenda Description	Page
One Day, One Reviewer, One Disease	124
Multi-Hospital, Two Days, One Reviewer, One Disease	127
One Day, One Reviewer, Two Joint Replacement or Two Spine Surgery Programs	133
1.5 Days, One Reviewer, Lung Volume Reduction Surgery Program	136
1.5 Days, One Reviewer, Ventricular Assist Device Program	139

Organizations should work with their reviewer to identify any adjustments that might be needed to the on-site visit agenda.

Disease Specific Care Certification

One Disease, One Day Review Agenda Template

Note: Please refer to the Organization Review Preparation section of this guide for materials that the reviewer needs for the Planning Session.

Time	Activity	Organization Participants
8:00 – 8:30 a.m. 8:30 – 9:00 a.m.	<p>Opening Conference (10 minutes)</p> <ul style="list-style-type: none"> ▪ Greetings and introductions ▪ Introductions of key program and organization staff ▪ Brief review of agenda <p>Orientation to Program (30 minutes) Topics to be covered include:</p> <ul style="list-style-type: none"> ▪ Program leadership ▪ Program interdisciplinary team composition ▪ Program design and integration into hospital ▪ Program mission and goals for care ▪ Population characteristics and needs ▪ Program selection and implementation of clinical practice guidelines (CPG) ▪ Program evaluation of CPG use and deviation monitoring ▪ Program improvements in CPG content and use ▪ Overall program improvements implemented or planned <p>Q & A Discussion (20 minutes)</p>	<p>Program clinical and administrative leadership</p> <p>Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization</p> <p>Others at the discretion of the organization</p>
9:00 – 9:30 a.m.	Reviewer Planning Session	Program representative(s) who can facilitate patient selection and tracer activity
9:30 – 10:00 a.m. 10:00 – 10:30 a.m. 10:30 – 11:00 a.m. 11:00 – 11:30 a.m. 11:30 – 12:00 p.m. 12:00 – 12:30 p.m.	<p>Individual Tracer Activity</p> <p>During this activity the reviewer will be moving throughout the organization and interacting with staff in areas that have been in contact with the patients selected for tracer activity. The reviewer will also want to speak with the patient or family of the patient with their permission.</p>	Program representative(s) who can facilitate tracer activity, that is, escort the reviewer through the clinical setting following the course of care for the patient
12:30 – 1:00 p.m.	Reviewer Lunch	

Time	Activity	Organization Participants
1:00 – 1:30 p.m. 1:30 – 2:00 pm.	<p>System Tracer – Data Use</p> <p>During this activity the discussion will focus on the program’s selected performance measures.</p>	<p>Program clinical and administrative leadership</p> <p>Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization</p>
2:00 – 2:30 p.m. 2:30 – 3:00 p.m.	<p>Competence Assessment/Credentialing Process</p> <p>Discussion during this session will focus on:</p> <ul style="list-style-type: none"> ▪ Selection of disease specific care interdisciplinary team members ▪ Processes for obtaining team member credentials information ▪ Orientation and training process for disease specific care program team ▪ Methods for assessing competence of practitioners and team members ▪ In-service and other education and training activities provided to program team members. <p>Reviewers will request personnel records for review based on various team members and staff encountered or referred to throughout the day.</p>	<p>Individual with authorized access to personnel and credentials files</p> <p>Individual familiar with program-specific requirements for team members—supervisors, managers, leaders</p> <p>Clinical or medical director</p>
3:00 – 3:30 p.m. 3:30 – 4:00 p.m.	<p>Issue Resolution & Reviewer Report Preparation</p> <p>This time is reserved for the reviewer to finish reviewing any outstanding items and complete a report reflecting each program’s performance against the standards.</p>	<p>As requested by the reviewer:</p> <p>Certification review facilitator</p> <p>Program leaders and staff</p>
4:00 – 4:30 p.m.	<p>Program Exit Conference</p> <p>Reviewer presentation of certification observations and requirements for improvement</p>	<p>Program and clinical leadership</p> <p>Others at the discretion of the organization</p>

Disease Specific Care Certification

Multi-Hospital, One Disease, Two Day Review Agenda Template

Note: Please refer to the Organization Review Preparation section of the Disease Specific Care Review Process Guide for materials that the reviewer needs for the Planning Session.

Day 1

Time	Activity	Organization Participants
<p>8:00 – 8:30 a.m.</p> <p>8:30 – 9:00 a.m.</p>	<p>Opening Conference (10-15 minutes)</p> <ul style="list-style-type: none"> ▪ Reviewer greeting and introduction ▪ Introductions of <u>key</u> system, hospital and DSC program staff ▪ Brief review of agenda <p>Orientation to Hospital System’s DSC Program (20 minutes)</p> <ul style="list-style-type: none"> ▪ System design and implementation of DSC Program ▪ System influence on individual hospital program operations and performance ▪ System expectations of individual hospital performance ▪ Monitoring of overall DSC program performance <p>Orientation to Individual Hospital's DSC Program (30 minutes) Topics to be covered include:</p> <ul style="list-style-type: none"> ▪ Program leadership ▪ Program interdisciplinary team composition ▪ Program design and integration into hospital ▪ Program mission and goals for care ▪ Population characteristics and needs ▪ Program selection and implementation of clinical practice guidelines (CPG) ▪ Program evaluation of CPG use and deviation monitoring ▪ Program improvements in CPG content and use ▪ Overall program improvements implemented or planned <p>Q & A</p>	<p>Hospital System's DSC Program leaders and coordinators</p> <p>Individual Hospital's DSC Program leader and coordinator</p> <p>Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization</p> <p>Others at the discretion of the organization</p>
<p>9:00 – 9:30 a.m.</p>	<p>Reviewer Planning Session The program is requested to have a list of patients who they are currently caring for in the hospital or being followed in the outpatient setting (if applicable to the program)</p> <p>See the Disease Specific Care Review Process Guide for the specific type of information needed in the list.</p>	<p>DSC Program Coordinator or Program Team Member</p>

Disease Specific Care Certification

Multi-Hospital, One Disease, Two Day Review Agenda Template

Time	Activity	Organization Participants
9:30 – 10:00 a.m.	Individual Tracer Activity <ul style="list-style-type: none"> ▪ Tracing begins where patient is currently located (if currently hospitalized) ▪ The nurse caring for the patient is asked to walk the reviewer through the medical record and the course of care for the patient up to this point in time ▪ The patient course of care through the organization is mapped out, both forward and backward ▪ The map will be followed to move through the areas/services that encountered the patient ▪ Staff in each area will be asked to discuss the interaction they would have had with such a patient (Note: Reviewers refer to patients by characteristics, not by name) ▪ Multiple patients will be traced at the same time; interaction with as many disciplines and staff that work with patients is very important to the program evaluation ▪ Speaking with one or two patients and/or their families is a key component of this activity—the organization is asked to help arrange this interview 	Program representative(s) who can facilitate tracer activity, that is, escort the reviewer through the clinical setting following the course of care for selected patients
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Reviewer Lunch	
12:30 – 1:00 p.m.	Individual Tracer Activity ...continued	
1:00 – 1:30 p.m.		
1:30 – 2:00 pm.	System Tracer – Data Use	

Disease Specific Care Certification

Multi-Hospital, One Disease, Two Day Review Agenda Template

Time	Activity	Organization Participants
2:00 – 2:30 p.m.	<ul style="list-style-type: none"> ▪ Review how data are used by the program to track performance and improve practice and outcomes of care ▪ Review the program’s selected performance measures, including: <ul style="list-style-type: none"> - Selection process (not applicable if program using core measures) - Aspects of care and services and outcomes addressed by measures - Data collection process (4-months of data for initial certification; 12-months of data for recertification or core measures, as applicable) - Data reliability and validity - Reporting and presentation of data - Improvement opportunities discovered through data analysis - Improvements that have already been implemented or are planned 	<p>Program clinical and administrative leadership</p> <p>Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization</p>
2:30 – 3:00 p.m. 3:00 – 3:30 p.m.	<p>Competence Assessment/Credentialing Process</p> <p>At least one file per discipline (e.g., physician, nurse, social work, therapist, dietitian) represented on the disease management team may be requested and reviewed for the following information:</p> <ul style="list-style-type: none"> ▪ Relevant education, experience and training or certification as required by the program ▪ Current licensure ▪ Competence assessment <p>Discussion during this session will include:</p> <ul style="list-style-type: none"> ▪ Selection of disease management interdisciplinary team members ▪ Processes for obtaining team member credentials information ▪ Orientation and training process for disease management program team ▪ Methods for assessing competence of practitioners and team members ▪ In-service and other education and training activities provided to program team members. 	<p>Individual with authorized access to personnel and credentials files</p> <p>Individual familiar with program-specific requirements for team members—supervisors, managers, leaders</p> <p>Clinical or medical director, as available</p>

Disease Specific Care Certification

Multi-Hospital, One Disease, Two Day Review Agenda Template

Time	Activity	Organization Participants
3:30 – 4:00 p.m.	Issue Resolution <ul style="list-style-type: none"> ▪ Review of additional documentation ▪ Review of additional medical records, possibly closed records, if necessary ▪ Clarification of information ▪ Preparation for interim exit verbal report 	As requested by reviewer
4:00 – 4:30 p.m.	Hospital DSC Program Interim Exit Conference <ul style="list-style-type: none"> ▪ Reviewer presentation of hospital-specific program observations and requirements for improvement 	Individual Hospital's DSC Program leaders and coordinators Others at the discretion of the organization

Disease Specific Care Certification

Multi-Hospital, One Disease, Two Day Review Agenda Template

Day 2

Time	Activity	Organization Participants
8:00 – 8:30 a.m.	Opening Conference and Orientation to Individual Hospital's DSC Program	Individual Hospital's DSC Program leaders and coordinators Others at the discretion of the organization
8:30 – 9:00 a.m.	Reviewer Planning Session	<i>See Day 1 template for suggested participants and activity details</i>
9:00 – 9:30 a.m.	Individual Tracer Activity	
9:30 – 10:00 a.m.		
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.		
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.	Reviewer Lunch	
12:30 – 1:00 p.m.	System Tracer – Data Use	<i>See Day 1 template for suggested participants and activity details</i>
1:00 – 1:30 p.m.		
1:30 – 2:00 p.m.	Competence Assessment/Credentialing Process	
2:00 – 2:30 p.m.		As requested by reviewer
2:30 – 3:00 p.m.	Issue Resolution & Reviewer Report Preparation	
3:00 – 3:30 p.m.	<ul style="list-style-type: none"> ▪ Review of additional documentation ▪ Review of additional medical records, possibly closed records, if necessary ▪ Clarification of information ▪ Preparation for interim exit verbal report ▪ Completion of Hospital System's DSC Program report 	
3:30 – 4:00 p.m.	Hospital DSC Program Interim Exit Conference <ul style="list-style-type: none"> ▪ Reviewer presentation of hospital-specific program observations and requirements for improvement 	Individual Hospital's DSC Program leader and coordinator Others at the discretion of the organization
4:00 – 4:30 p.m.	Hospital System's DSC Program Summation <ul style="list-style-type: none"> ▪ Reviewer presentation of hospital system's overall certification observations and requirements for improvement 	Hospital System's DSC Program leaders and coordinators Others at the discretion of the organization

Disease Specific Care One Day Review Agenda Template Two Joint Replacement or Two Spine Surgery Programs*

* Two joint replacement programs can be reviewed in a single day. The eligible programs include any combination of: hip, knee, and shoulder. Two spine surgery programs can be reviewed in a single day. The eligible programs include any combination of: Spinal fusion, laminectomy, and discectomy.

Information needed during the Reviewer Planning Session includes:

- Current list of patients being treated in the two Joint Replacement programs or two Spine Surgery programs
- A list of patients who accessed or progressed through the two Joint Replacement or two Spine Surgery programs in the past 4-months
- An organization chart for the program(s), if available
- Performance measure data collected and reported for the required four measures
- Performance improvement action plans that demonstrate how data have been used to improve program care and services, when available

Time	Activity	Organization Participants
8:00 – 8:30 a.m. 8:30 – 9:00 a.m.	<p>Opening Conference (10 minutes)</p> <ul style="list-style-type: none"> ▪ Greetings and introductions ▪ Introductions of key program and organization staff ▪ Brief review of agenda <p>Orientation to Both Programs (30 minutes) Topics to be covered include:</p> <ul style="list-style-type: none"> ▪ Program leadership ▪ Program interdisciplinary team composition ▪ Program design and integration into hospital ▪ Program mission and goals for care ▪ Population characteristics and needs ▪ Program selection and implementation of clinical practice guidelines (CPG) ▪ Program evaluation of CPG use and deviation monitoring ▪ Program improvements in CPG content and use ▪ Overall program improvements implemented or planned <p>Q & A Discussion (20 minutes)</p>	<p>Program clinical and administrative leadership</p> <p>Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization</p> <p>Others at the discretion of the organization</p>
9:00 – 9:30 a.m.	Reviewer Planning Session	Program representative(s) who can facilitate patient selection and tracer activity
9:30 – 10:00 a.m. 10:00 – 10:30 a.m.	Individual Tracer Activity – 1st Program	Program representative(s) who

Time	Activity	Organization Participants
10:30 – 11:00 a.m.	During this activity the reviewer will be moving throughout the organization and interacting with staff in areas that have been in contact with the patients selected for tracer activity. The reviewer will also want to speak with the patient or family of the patient with his or her permission.	can facilitate tracer activity, that is, escort the reviewer through the clinical setting following the course of care for the patient
11:00 – 11:30 a.m.	Individual Tracer Activity – 2nd Program	Program representative(s) who can facilitate tracer activity, that is, escort the reviewer through the clinical setting following the course of care for the patient
11:30 – 12:00 p.m.		
12:00 – 12:30 p.m.		
12:30 – 1:00 p.m.	Reviewer Lunch	
1:00 – 1:30 p.m.	System Tracer – Data Use for Both Programs	Program clinical and administrative leadership
1:30 – 2:00 p.m.		
During this activity the discussion will focus on each program's selected performance measures.	Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization	
2:00 – 2:30 p.m.	Competence Assessment/Credentialing Process	Individual with authorized access to personnel and credentials files
2:30 – 3:00 p.m.		
Discussion during this session will focus on: <ul style="list-style-type: none"> ▪ Selection of program interdisciplinary team members ▪ Processes for obtaining team member credentials information ▪ Orientation and training process for the program team ▪ Methods for assessing competence of practitioners and team members ▪ In-service and other education and training activities provided to program team members. Reviewers will request personnel records for review based on various team members and staff encountered or referred to throughout the day.	Individual familiar with program-specific requirements for team members—supervisors, managers, leaders Clinical or medical director	

Time	Activity	Organization Participants
3:00 – 3:30 p.m.	<p>Issue Resolution & Reviewer Report Preparation</p> <p>This time is reserved for the reviewer to finish reviewing any outstanding items and complete a report reflecting each program’s performance against the standards.</p>	As requested by the reviewer:
3:30 – 4:00 p.m.		Certification review facilitator
		Program leaders and staff
4:00 – 4:30 p.m.	<p>Program Exit Conference</p> <p>Reviewer presentation of certification observations and requirements for improvement</p>	Program and clinical leadership
		Others at the discretion of the organization

Disease Specific Care Certification

Lung Volume Reduction Surgery Program Certification

Information needed during the Reviewer Arrival and Preliminary Planning Session

- Current list of hospitalized patients that have undergone or are scheduled for LVRS
- A list of discharged patients who had LVRS
- An organization chart for the program, if one is available
- Performance measure data collected and reported for the required four measures
- Performance improvement action plans that demonstrate how data have been used to improve program care and services, when available

DAY 1

Time	Activity	Organization Participants
8:00 – 8:30 a.m. 8:30 – 9:00 a.m.	Opening Conference and Orientation to Program	Program clinical and administrative leadership Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization Others at the discretion of the organization
9:00 – 9:30 a.m. 9:30 – 10:00 a.m.	Reviewer Planning Session	Program representative(s) who can facilitate patient selection and tracer activity
10:00 – 10:30 a.m. 10:30 – 11:00 a.m. 11:00 – 11:30 a.m. 11:30 – 12:00 p.m. 12:00 – 12:30 p.m.	Individual Tracer Activity <i>(three patients minimum)</i> Includes visiting/contacting at least the following units/areas: <ul style="list-style-type: none"> ▪ Thoracic surgery unit ▪ Pulmonary Rehab ▪ Pulmonary Function Testing Laboratory ▪ Pre-op, OR, PACU ▪ Radiology ▪ ICU ▪ Intermediate Care Area <p>Additionally, reviewers will want to have some contact with a patient(s) and will seek assistance from the organization to establish this contact.</p>	Contact with representatives from at least the following services should be made during this activity: - Pulmonology, - Cardio-Thoracic Surgery, - Anesthesia, - Nursing, - Pulmonary Rehab - Respiratory Therapy, - Patient educators, - Discharge Planning, - Case Management, - Social Work, If applicable, - Intensivists, Hospitalists, Home Care, Outpatient Rehab. - Others at organization's discretion
12:30 – 1:00 p.m.	Reviewer Lunch	
1:00 – 1:30 p.m. 1:30 – 2:00 p.m. 2:00 – 2:30 p.m.	Individual Tracer Activity...continued	
2:30 – 3:00 p.m.	System Tracer – Data Use	

3:00 – 3:30 p.m.		Program clinical and administrative leadership Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization
3:30 – 4:00 p.m.	Issue Resolution	As requested by the reviewer: Certification review facilitator Program leaders and staff
4:00 – 4:30 p.m.	Day 2 -- Reviewer Planning Session	

Lung Volume Reduction Surgery Program Certification DAY 2

Time	Activity	Organization Participants
8:00 – 8:30 a.m.	Competence Assessment & Credentialing Process	Individual with authorized access to personnel and credentials files Individual familiar with program-specific requirements for team members—supervisors, managers, leaders Clinical or medical director
8:30 – 9:00 a.m.		
9:00 – 9:30 a.m.	Individual Tracer Activity...continued	
9:30 – 10:00 a.m.		
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.	Reviewer Report Preparation	
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.	Program Exit Conference	Program and clinical leadership Others at the discretion of the organization

Disease Specific Care Certification Ventricular Assist Device Program Certification

Information needed during the Reviewer Planning Session

- Current list of hospitalized patients that have received or are scheduled to receive a VAD
- A list of discharged patients who received a VAD
- An organization chart for the program, if one is available
- Performance measure data collected and reported for the required four measures
- Performance improvement action plans that demonstrate how data have been used to improve program care and services, when available

DAY 1

Time	Activity	Organization Participants
8:00 – 8:30 a.m. 8:30 – 9:00 a.m.	Opening Conference and Orientation to Program	Program clinical and administrative leadership Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization Others at the discretion of the organization
9:00 – 9:30 a.m. 9:30 – 10:00 a.m.	Reviewer Planning Session	Program representative(s) who can facilitate patient selection and tracer activity
10:00 – 10:30 a.m. 10:30 – 11:00 a.m. 11:00 – 11:30 a.m. 11:30 – 12:00 p.m. 12:00 – 12:30 p.m.	Individual Tracer Activity <i>(three patients minimum—active patients desirable; if no active patients, most recently discharged patients will be selected)</i> Includes visiting/contacting the following units: <ul style="list-style-type: none"> ▪ Surgical Heart Unit ▪ Cardiac Rehab ▪ Cardiopulmonary Function Testing ▪ Pre-op, OR, PACU ▪ Radiology ▪ Telemetry Unit ▪ Physical Therapy <p>Additionally, reviewers will want to have some contact with a patient(s) and will seek assistance from the organization to establish this contact.</p>	Contact with representatives from at least the following services should be made during this activity: <ul style="list-style-type: none"> • Cardio-Thoracic Surgery • Nursing • Patient Educators • Intensivists (if applicable) • Perfusionist • Discharge Planner • Social Work • Home Care • Cardiac Rehab • Physical and Occupational Therapists • Outpatient Rehab • Dietician • Pharmacist
12:30 – 1:00 p.m.	Reviewer Lunch	
1:00 – 1:30 p.m. 1:30 – 2:00 p.m. 2:00 – 2:30 p.m.	Individual Tracer Activity...continued	
2:30 – 3:00 p.m.	System Tracer – Data Use	

3:00 – 3:30 p.m.		Program clinical and administrative leadership Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization
3:30 – 4:00 p.m.	Issue Resolution	As requested by the reviewer: Certification review facilitator Program leaders and staff
4:00 – 4:30 p.m.	Day 2 -- Reviewer Planning Session	

Ventricular Assist Device Program Certification DAY 2

Time	Activity	Organization Participants
8:00 – 8:30 a.m.	Competence Assessment & Credentialing Process	Individual with authorized access to personnel and credentials files Individual familiar with program-specific requirements for team members—supervisors, managers, leaders Clinical or medical director
8:30 – 9:00 a.m.		
9:00 – 9:30 a.m.	Individual Tracer Activity...continued	
9:30 – 10:00 a.m.		
10:00 – 10:30 a.m.		
10:30 – 11:00 a.m.	Reviewer Report Preparation	
11:00 – 11:30 a.m.		
11:30 – 12:00 p.m.	Program Exit Conference	Program and clinical leadership Others at the discretion of the organization

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