The Joint Commission

Disease-Specific Care Certification Review Process Guide

January 2024

Disease Specific Care Certification

Organization Review Process Guide

2024

Issue Date: December 19, 2023

Disease Specific Care Certification Review Process
What's New in 2024

New or revised content for 2024 is identified by underlined text in the activities noted below.

Changes effective January 1, 2024

NEW! Addendum for Acute Stroke Ready Hospital Certification – Added a new addendum to describe the review process for this advanced disease certification.

Addendum for Primary Stroke Center Certification
Addendum for New York State Stroke Services Certification – Primary Stroke Center
Addendum for Thrombectomy-Capable Stroke Center Certification
Addendum for New York State Stroke Services Certification – Thrombectomy-Capable Stroke Center
Addendum for Comprehensive Stroke Center Certification
Addendum for New York State Stroke Services Certification – Comprehensive Stroke Center – Updated all existing advanced disease certification stroke program addendums.

Other minor edits.

Table of Contents

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 Outreach

A Joint Commission account executive will contact your organization by phone or email shortly after receiving your application for certification. The purpose of this follow-up 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.).
- Confirm accuracy of any program-specific eligibility requirements, such as any pertinent volumes and procedures performed.
- Confirm clinical practice guidelines used by the program and any audited registry requirements.
- 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 #CPGsExplained 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:

- Registry data (such as INTERMACS)
- List of VAD patients who have received care and/or who have been implanted at the facility

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

Additional Items Required for Acute Heart Attack Ready (AHAR), Primary Heart Attack Center (PHAC), and Comprehensive Heart Attack Center (CHAC) (as applicable)

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

- ST-elevated myocardial infarction (STEMI)
- Non ST-elevated myocardial infarction (NSTEMI)
- Acute Cornonary Syndrome/chest pain (Unstable angina, angina (INOCA, SCAD)
- Cardiogenic shock with advanced therapies (as applicable)
- Cardiac arrest with ROSC, TTM, & other therapies
- Cardiac rehabilitation

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, 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.

Disease Specific Care Certification

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, once the reviewer arrives onsite, 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.

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, individual or individuals that will provide the Safety Briefing to the reviewer(s), 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)
- The organization is requested to provide the reviewer(s) with a Safety Briefing (informal, no more than five minutes) sometime during this activity. The purpose of this briefing is to inform the reviewer(s) of any current organization safety or security concerns and how Joint Commission staff should respond if your safety plans are implemented while they are on site. Situations to cover include:
  - Fire, smoke, or other emergencies
  - Workplace violence events (including active shooter scenarios)
  - Any contemporary issues the reviewer may experience during the time they are with you (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)
- 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, including the primary diagnosis, admission and discharge date, patient age, gender and ethnic origin, if available.
- 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, including the 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
- See the *Organization Review Preparation section of this guide for additional program-specific document lists for advanced certification stroke, VAD, total hip and knee, and heart attack programs.*

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

c. **For AHAR, PHAC, CHAC 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 acute STEMI, NSTEMI, ACS/chest pain, cardiac arrest w/ROSC, and cardiogenic shock (if possible). For those programs performing interventions such as interventional cardiology or cardiac surgery additional patients may be selected for tracer activity.

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
- Acute Heart Attack Ready organizations
- Primary Heart Attack Centers
- Comprehensive Heart Attack Centers

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

Disease Specific Care Certification

Reviewer Planning Session/Team Meeting

This activity only takes place on multi-day, certification on-site visits. Reviewers use this session to reflect on and debrief the day's observations and plan for upcoming review activities. This time may also be used for any follow-up activity that could not be completed earlier in the day.

In some cases, the reviewer may meet briefly with the program's review coordinator to discuss any open items from Day 1 and review the plan for Day 2.

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
Program's review coordinator or liaison, as requested by the reviewer

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 current or previous day and relay observations and note examples of strengths and possible vulnerabilities in performance. This session only takes place on multi-day certification on-site visits.

Duration
15-30 minutes. May take place at the end of Day 1 or be the first activity on Day 2. Reviewers will work with the organization to adjust the agenda as needed.

Participants

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

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 **not** make all program representatives stay for a discussion that is specific to a small group of individuals.

Disease Specific Care Certification

Summary Discussion

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

Organization Participants
Will vary depending upon the issue

Materials Needed for this Activity
Will vary depending upon the issue

Preparation for Summary Discussion
None required

Summary Discussion Description
Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at closing

The reviewer will work with the organization's certification contact to organize and conduct the summary discussion.

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.

Disease Specific Care Certification

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:

- DSPR.03, EP 4, c, d, e, f, g, h.: Disease-specific services provided
- Post hospital care coordination (such as: DSDF.04, EP 4; DSDF.06, EP 1, a; DSDF.6, EP 2; DSDF.06, EP 3; DSSE.01, EP 3, a; DSSE.03, EP 5, a, b).
- DSPR.05, EP 1, a, b: Research and written research protocol
- DSPM.01, EP 2, b: Interdisciplinary program level review and peer review
- DSPM.01, EP 5, a: Performance measures

Other eligibility:
To be eligible for CSC certification, an organization must meet the following requirements:

- 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.
- Demonstrated that all neurointerventionists who perform mechanical thrombectomy at the organization that is applying for CSC certification, 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.
- Demonstrated that IV thrombolytic therapy is administered 25 or more times per year for eligible patients.
  Note: Providing IV thrombolytic therapy to a total of 50 eligible patients over a two-year period is acceptable

Note 2: IV thrombolytic therapy administered in the following situations can be counted in the requirement of 25 administrations per year:

- IV thrombolytic ordered and monitored by the TSC via telemedicine with administration occurring at another hospital
- IV thrombolytic administered by another hospital, which then transferred the patient within 24 hours to the TSC

- Provided care to 20 or more patients per year with a diagnosis of subarachnoid hemorrhage caused by an aneurysm or at least 40 or more patients over a two year period.
- Treated 15 or more aneurysms per year using an FDA-approved device. Treating 30 or more anueyrsms over a two year period is acceptable.

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)

- Introductions
- Overview of CSC certification by reviewers
- Agenda review

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 24 hours a day, 7 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
    - Disease-specific care, treatment, and services provided
    - Identified needs of the program population, including health care equity efforts to reduce community disparities
    - The selection, implementation, and evaluation of clinical practice guidelines
    - Model of neuro-ICU care
    - Evaluation of clinical practice guidelines use and appropriateness to the disease-specific care, treatment, and services provided
    - 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:

- A list of complex stroke patient that is separated by diagnosis, date of admission, and pertinent patient demographics. The list includes patients who have experienced the following:
    - TIA
    - Ischemic stroke
    - IV thrombolytic
    - Mechanical thrombectomy
    - Surgical intervention for ischemic stroke (ex. hemicraniectomy)
    - Carotid artery procedure (ex. Symptomatic/asymptomatic stenting or endarterectomy)
    - Intracerebral hemorrhage stroke
    - Subarachnoid hemorrhage stroke
    - Aneurysm treatment
- Stroke log (including inpatient stroke codes)
- A list of current stroke patients in-house
- Other required documents include the following:
    - List of stroke team members and their credentials
    - CSC program protocols for care, treatment, and services provided including acute care processes and order sets for disease-specific care treatment, and services provided (see below)

- Interdisciplinary team meeting minutes

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 select patients to trace that are reflective of the disease-specific care, treatment, and services provided by the program. 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 the following:
    - Activation of stroke team
    - Process for obtaining EMS records
    - EMS protocols including rapid assessment and rapid communication with the emergency department
    - Meeting the concurrent emergent needs of two or more complex stroke patients
    - Medical stabilization of a 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 thrombolytic
    - Implementation of endovascular procedures
    - 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)
    - Any program-specific order sets utilized in the care of the stroke patient
- 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 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 do the following:

- 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 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 One (Morning Session, 2 Hours)

Organization Participants

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

- Emergency department physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- Radiology physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- Surgical/procedural physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- ICU physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- Speech therapist(s), physical therapist(s), and occupational therapist(s)
- Discharge planner(s) and case manager(s)
- Other staff who provide 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

- Staff who can review the entire clinical record of selected patients

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 do the following:

- 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 One: All tracers over the course of the review will be conducted separately by the reviewers. Plan for sufficient staff and licensed 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 of the following:

- 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 or during the planning session, the reviewers may request closed patient records for review. The purpose of the closed patient

records review is to evaluate the care provided to complex stroke patients throughout the continuum of care and the care provided during discharge/transitions.

Individual Patient Tracer Activity- Day One (Afternoon Session, 2 ½ Hours)
Plan to have sufficient staff 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 One afternoon tracer. See the CSC agenda for specific tracer activities.

Reviewer Planning/Team Meeting - 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 can also be included, as designated by the organization.

Reviewer Planning/Team Meeting
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 open issues with the organization
- Select patients for the Day Two individual tracers.
- Determine if additional information will be needed the following day.

Day Two

Daily briefing with the organization (30 minutes)
Reviewers will discuss the following with the organization:

- 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 Two (Morning Session 2 ½ Hours)
Plan to have sufficient staff 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 Two 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

- At the discretion of the organization, it is strongly suggested to develop a presentation (for example, PowerPoint) to guide the discussion and display program-relevant data.

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

- 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 the following:

- Use of a defined performance improvement methodology, including plans, action plans, and resulting improvements
- Review of the program's performance improvement plan including multidisciplinary involvement and current goals and priorities relevant to performance improvement planning and activities
- Processes to maintain data quality and integrity (for example, interrater reliability, minimizing data bias, data analysis tools)
- Reporting of required procedural volumes as applicable to program eligibility requirements
- Complication rates and reduction initiatives
- Current stroke performance measure data
- Process to follow-up with patients that discharge home (see DSSE.03, EP 5)
- Public reporting of outcomes per requirements
- Interdisciplinary program review and peer review process
- Use of an audited stroke registry
- Collection and use of patient experience and perception of care data related to the 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
- Documentation of quarterly meeting minutes and agenda related to performance improvement.

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 for initial certification. For organizations seeking recertification, data must be available from the previous 24 months.

* Patient experience and perception of care data must be addressed at the program level and related to the specific care, treatment, and services provided by the program. Organizationwide data (for example, HCAHPS) does not meet the requirement.

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 following:

- The written education plan for providing program-specific education to physicians, licensed practitioners, staff, and the surrounding community
- The processes to provide initial and ongoing education and training of physicians, licensed practitioners, and staff who provide disease-specific care, treatment, and services in the stroke program
- Review of competency assessments, credentialing, and education plans in accordance with program-specific and organizationwide policies, procedures, and applicable law and regulation

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

- Written education plan and how program-specific education is determined and approved (see DSPR.02, EP 2), including the following:
    - An overview of program-specific orientation to physicians, licensed practitioners, and staff who provide care to stroke patients within the program.

      Note: This includes hospitalist physician groups if they are admitting stroke patients to inpatient services or other specialties as applicable to care delivery models.
    - An overview of initial and ongoing competence assessments/training activities for staff caring for complex stroke patients that are pertinent to individual roles and responsibilities and are provided when staff responsibilities change; when new or revised policies, procedures, or guidelines are implemented; and/or other intervals defined by the program.
    - Plan for contract staff that includes orientation to the stroke program and required competencies assessment(s) and education (as applicable).
    - Education of all staff involved in care of stroke patients regarding stroke recognition signs and symptoms.
- Documentation of at least two educational programs focused on stroke prevention/care provided for the community.
- A minimum of one or more registered nurses providing stroke care is required to attend one regional or national meeting/seminar every other year, as identified by the organization.
- Evidence that the one or more registered nurses who attended the regional or national meeting/seminar provided education to the organization's CSC stroke nurses and other professional staff.
- Licensed practitioners and staff members prepare and present two or more education courses per year to staff within and outside of the CSC.

- Licensed practitioners and staff members who prepare and present education are identified by the organization.

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:

- For selected physician(s) files, the following will be reviewed using primary source verification (as applicable to the role):
  - Appointment letter
  - Privileges
  - Board certification (if applicable)
  - Licensure
  - DEA
  - Orientation to the stroke program
  - OPPE/FPPE
  - CME/Ongoing Education related to the program
- For selected staff member(s) files, the following will be reviewed using primary source verification (as applicable to the role):
  - Job description
  - Licensure
  - Certification (ex. disease-specific, ACLS, PALS, BLS)
  - Last signed performance evaluation
  - Stroke-specific orientation
  - Stroke-specific initial and ongoing education

In addition to selected personnel and credential files, the reviewers will also review the files of the members of the core stroke team, as identified by the organization.

For the review of all applicable licensure and certification, primary source verification is utilized.

It is at the discretion of the organization to determine the content and delivery method of education relevant to disease-specific care, treatment, and services provided by the program. The processes for how education is determine will be discussed during the review.

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at exit conference

The reviewer will work with the organization's certification contact to organize and conduct the summary discussion.

Reviewer Report Preparation (30 minutes)
The reviewers will use this time to compile, analyze, and organize the data they have 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 (CSC) Certification Agenda
Two Reviewers, Two-Day Review 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 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	Program representatives who can facilitate patient selection and tracer activities
10:00-10:30 a.m.	**Emergency Department Review** The organization is to provide a high level, brief overview of how care is provided to CSC patients in the emergency department. **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.** 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 practitioners, equipment and materials (including medications) that are required to care for acute complex stroke patients.	• Emergency Department Medical Director • Emergency Department Nurse Director/Manager • Emergency department licensed independent practitioners and staff as determined by the organization

	• Discuss your process for obtaining EMS records documenting care provided during the transfer to the facility. • Discuss transfer protocols	
10:30-12:30 p.m.	**Individual Patient Tracer:** Each reviewer will conduct tracers separately**.** Evaluation of patient care, treatment, and services, including: 1. **Advanced Imaging** 2. **Acute Comprehensive Stroke Care** -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** -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.	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 practitioners and staff • Imaging licensed practitioners and staff • Surgical/procedural licensed practitioners and staff • ICU licensed practitioners and staff • Other licensed 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
12:30-1:00 p.m.	**Reviewer Lunch**	
1:00-3:30 p.m.	**Individual Patient Tracer** *Each reviewer will conduct tracers separately.*	See above
3:30-4:30 p.m.	**Reviewer Planning/Team Meeting** Reviewers and program representatives will: • Address any open issues • Communicate summary of the first day's observations • Select individual patient tracers for Day 2	

Disease Specific Care Certification – Comprehensive Stroke Center Certification (CSC)
Two-Day Agenda

DAY 2

Time	Activity	Organization Participants
8:00-8:30 a.m.	**Daily Briefing**	As determined by organization
8:30-10:30 a.m.	**Individual Patient Tracer** *Each reviewer will conduct tracers separately.*	
10:30 -12:30 p.m.	**System Tracer - Data Use** Conducted by both reviewers • 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 • Patient follow-up processes • Interdisciplinary program review and peer review process • Use of the stroke registry • Patient experience and perception of care 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	• Program clinical and administrative leadership. (Example: Stroke Coordinator, Stroke Program Medical Director) • Individual(s) responsible for performance improvement and processes within the program
12:30-1:00 p.m.	**Reviewer Lunch**	
1:00-3:00 p.m.	**Competence Assessment and Credentialing Process** *Conducted by both reviewers.* Review of personnel records and credentials files for: • Medical Director of Stroke Program • Stroke Coordinator • Director of Rehabilitation Services • Advanced Practice Nurse • Nursing, medical and other staff identified during individual tracer activity Be prepared to discuss: • Education, competence, and credentialing issues identified from the patient tracers and review of personnel records • Community education activities	• 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
3:00-3:30 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs)	• Certification review facilitator • Program leaders and staff as requested by the reviewers.

Disease Specific Care Certification – Comprehensive Stroke Center Certification (CSC) Two-Day Agenda

	• Were the goals of your team met during this review? • What made the review meaningful to the team	
3:30-4:00 p.m.	**Reviewer Report Preparation**	
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 program need and reviewer discretion.

Addendum for New York State Stroke Services Certification – CSC

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

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

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

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

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

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

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

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

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

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

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

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

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

Rehabilitation Services

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

Telemedicine

Transfer Agreement

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

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

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

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

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

Vascular Imaging

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

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

CT is initiated within 25 minutes of patient arrival and read within 45 minutes of patient arrival.

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.

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

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

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

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

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

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

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

Hospital-based quality improvement initiatives related to stroke

Patient Education

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

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

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

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

Performance Measures (for those performance measures that are not STK or CSTK measures, please have data available for the reviewers during the data session of the on-site visit)
NYS PSC 1: VTE Prophylaxis
NYS PSC 2: Discharge on Antithrombotic Therapy
NYS PSC 3: Anticoagulation Therapy for AFIB/Flutter
NYS PSC 4: Thrombolytic Therapy (arrive by 3.5 hours, treat by 4.5 hours)
NYS PSC 5: Antithrombotic Therapy by the end of Hospital Day Two
NYS PSC 6: Discharged on Statin Medication
NYS PSC 7: Stroke Education
NYS PSC 8: Smoking Cessation
NYS PSC 9: Assessed for Rehabilitation
NYS PSC 10: Dysphagia Screening
NYS PSC 11: Initial NIHSS Reported
NYS PSC 12: mRS on Discharge
NYS PSC 13: Pre-Notification: Percent of cases of advanced notification by EMS for patients transported by EMS from scene
NYS PSC 14: EMS Pre-Hospital Stroke Scale: Percent of patients arriving via EMS who had pre-hospital stroke scale performed
NYS PSC 15: Pre-Notification Content:
-Last Known Well communicated
-Stroke scale findings communicated
NYS PSC 16: Stroke Team Activated Prior to Arrival: Percent of patients arriving via EMS for whom the stroke team was activated prior to patient arrival based upon EMS pre-notification
NYS PSC 17: Door to MD Assessment (10 minutes)
NYS PSC 18: Door to Stroke Team (15 minutes)
NYS PSC 19: Door to Brain Image Complete (25 minutes)
NYS PSC 20: Door to Brain Image Read (45 minutes)
NYS PSC 21: Door to IV tPA (60 minutes) – 85%
NYS PSC 22: Door to IV tPA (45 minutes) – 50%
NYS PSC 23: Door-in-door-out time at first hospital prior to transfer for acute therapy (</= 90 minutes)
NYS TSC 1: mRS at 90 days: documented
NYS TSC 2: mRS at 90 days: following mechanical endovascular reperfusion therapy, favorable outcome
NYS TSC 3: Hemorrhagic transformation (overall rate)
NYS TSC 4: Mechanical Endovascular Reperfusion Therapy for Eligible Patients with Ischemic Stroke
NYS TSC 5: Thrombolysis in Cerebral Infarction (TICI post treatment reperfusion grade)
NYS TSC 6: NIHSS at Discharge
NYS TSC 7: Timeliness of reperfusion: arrival time to TICI 2B or higher (120 minutes)
NYS TSC 8: Timeliness of reperfusion: skin puncture to TICI 2B or higher (120 minutes)
NYS TSC 9: Door to Puncture Time
NYS TSC 10: Imaging to Puncture Time

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

Disease Specific Care Certification

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.

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

- DSPR.03 EP 4, b, c, g, h: Disease-specific services provided
- Post-hospital care coordination (such as DSDF. 04 EP 4, DSDF.06 EP 1, DSDF.06 EP 2, DSDF.06 EP 3, DSSE 01. EP 3 a, DSSE 03, EP 5)
- DSPM.01 EP 2, b: Interdisciplinary program-level review and peer review
- DSPM.01 EP 5: Performance measures

Other Eligibility

To be eligible for TSC certification, an organization must meet the following requirements:

- 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.
- Demonstrated that 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.
- Demonstrated that IV thrombolytic therapy is administered 25 or more times per year for eligible patients

Note: Providing IV thrombolytic therapy to a total of 50 eligible patients over a two-year period is acceptable

Note 2: IV thrombolytic therapy administered in the following situations can be counted in the requirement of 25 administrations per year:

- IV thrombolytic ordered and monitored by the TSC via telemedicine with administration occurring at another hospital

- IV thrombolytic administered by another hospital, which then transferred the patient within 24 hours to the TSC

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)

- At the discretion of the organization, it is strongly suggested to develop a presentation (e.g., PowerPoint) to guide the discussion and display program-relevant data.

- The organization should be prepared to provide a 20-30 minute presentation, that includes the following:

  - 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
- Disease-specific care, treatment, and services provided
- Identified needs of the program population, including health care equity efforts to reduce community disparities
- The selection, implementation, and evaluation of clinical practice guidelines
- Model of neuro-ICU care
- Evaluation of clinical practice guidelines use and appropriateness to the disease-specific care, treatment, and services provided
- 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:

- A list of complex stroke patients for the review that is separated by diagnosis, date of admission, and pertinent patient demographics. The list includes patients who have experienced the following (as applicable to services provided):
  - TIA
  - Ischemic stroke
  - IV thrombolytic
  - Mechanical thrombectomy
  - Surgical intervention for ischemic stroke (ex. hemicraniectomy)
  - Intracerebral hemorrhage stroke
  - Subarachnoid hemorrhage stroke
  - Aneurysm treatment
- Stroke log (including inpatient stroke codes)
- A list of current stroke patients in-house
- Other required documents include the following:
- List of stroke team members and their credentials
- TSC program protocols for care, treatment, and services provided including acute care processes and order sets for disease-specific care treatment, and services provided (see below)
- Interdisciplinary team meeting minutes

Selecting Patients for Individual Tracers and Protocol Review

- From the list of current stroke patients, the reviewers in conjunction with program representatives will select patients to trace that are reflective of the disease-specific care, treatment, and services provided by the program. 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 the following:
    - Activation of stroke team
    - Process for obtaining EMS records
    - EMS protocols including rapid communication with the emergency department
    - Acute workup of ischemic/hemorrhagic stroke patients
    - Informed consent for stroke interventions
    - Use of IV thrombolytic
    - Implementation of endovascular procedures
    - Reduction of complications
    - 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
    - Any program-specific order sets utilized in the care of the stroke patient
- 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 One (Morning Session, 2 ½ Hours)

Organization Participants
Program representatives, including staff who have been involved in the patient's care, who can facilitate tracer activities and escort the reviewer 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 the following:

- Emergency department physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- Radiology physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- Endovascular suite physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- ICU physicians, licensed practitioners, and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)

- Speech therapist(s), physical therapist(s), and occupational therapist(s)
- Discharge planner(s) and case manager(s)
- Other staff who provide 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
- Staff who can review the entire clinical record of selected patients

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 do the following:

- 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 TSC include, but are not limited to, stroke team members, physicians including neurosurgeons (if applicable), 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 One: Plan for sufficient staff and licensed 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 Record Review: During individual patient tracers, the reviewer may request closed patient records for review. The purpose of the closed patient records review is to evaluate the care provided to complex stroke patients throughout the continuum of care and the discharge/transitions of care. Closed chart review generally occurs during the second day of tracer activity.

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

Plan to have sufficient staff and licensed 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 One afternoon tracer. See the TSC agenda for specific tracer activities.

Reviewer Planning/Team Meeting - End of Day One (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 can also be included, as designated by the organization.

Reviewer Planning/Team Meeting

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 open issues with the organization
- Select patients for the Day Two individual tracers.

Determine if additional information will be needed the following day.

Day Two

Daily briefing with the organization (30 minutes)

Reviewer will review the following:

- 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 Two (Morning Session 3 Hours)

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

At the discretion of the organization, it is strongly suggested to develop a presentation (e.g., PowerPoint) to guide the discussion and display program-relevant data.

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

- 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 the following:

- Use of a defined performance improvement methodology including plans, action plans, and resulting improvements
- Review of the program's performance improvement plan including multidisciplinary involvement and current goals and priorities relevant to performance improvement planning and activities
- Processes to maintain data quality and integrity (for example, interrater reliability, minimizing data bials, data analysis tools)
- Reporting of required procedural volumes as applicable to program eligibility requirements
- Complication rates and reduction initiatives
- Current stroke performance measure data
- Public reporting of outcomes per requirements
- Process to follow-up with TSC patients who are discharged home
- Interdisciplinary program review and peer review process
- Use of an audited stroke registry
- Collection and use of patient experience and perception of care data related to stroke program patient population*
- Review of the program's stroke team log

- Documentation of quarterly meeting minutes and agenda related to performance improvement

For TSC requirements that call for organizational data (such as, complication rates), the organization must provide data from four months prior to the review data for initial certification. For organizations seeking recertification, data must be available from the previous 24 months.

* Patient experience and perception of care data must be addressed at the program level and related to the specific care, treatment, and services provided by the program. Organizationwide data (for example, HCAHPS) does not meet the requirement.

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 following:

- The written education plan for providing program-specific education to physicians, licensed practitioners, staff, and the surrounding community
- The processes to provide initial and ongoing education and training of physicians, licensed practitioners, and staff who provide disease-specific care, treatment, and services in the stroke program
- Review of competency assessments, credentialing, and education plans in accordance with program-specific and organizationwide policies, procedures, and applicable law and regulation

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

- Written education plan and how program-specific education is determined and approved (see DSPR.02, EP 2), including the following:
    - An overview of program-specific orientation to physicians, licensed practitioners, and staff who provide care to stroke patients within the program.

      Note: This includes hospitalist physician groups if they are admitting stroke patients to inpatient services or other specialties as applicable to care delivery models.
    - An overview of initial and ongoing competence assessments/training activities for staff caring for complex stroke patients that are pertinent to individual roles and responsibilities and are provided when staff responsibilities change; when new or revised policies, procedures, or guidelines are implemented; and/or other intervals defined by the program.

    - Plan for contract staff that includes orientation to the stroke program and required competencies assessment(s) and education (as applicable).

- Documentation of at least two educational programs focused on stroke prevention/care provided for the public
- Licensed practitioners and staff members prepare and present two or more education courses per year to staff within and outside of the CSC.
- Licensed practitioners and staff members who prepare and present education are identified by the organization.

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:

- For selected physician(s) files, the following will be reviewed using primary source verification (as applicable to the role):
    - Appointment letter
    - Privileges
    - Board certification (if applicable)
    - Licensure
    - DEA
    - Orientation to the stroke program
    - OPPE/FPPE
    - CME/Ongoing Education related to the program
- For selected staff member(s) files, the following will be reviewed using primary source verification (as applicable to the role):
    - Job description
    - Licensure
    - Certification (ex. disease-specific, ACLS, PALS, BLS)
    - Last signed performance evaluation
    - Stroke-specific orientation
    - Stroke-specific initial and ongoing education
- In addition to selected personnel and credential files, the reviewers will also review the files of the members of the core stroke team, as identified by the organization.
- For the review of all applicable licensure and certification, primary source verification is utilized.
- It is at the discretion of the organization to determine the content and delivery method of education relevant to disease-specific care, treatment, and services provided by the program. The processes for how education is determine will be discussed during the review.

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at Exit Conference

The reviewer will work with program representatives to organize and conduct the summary discussion.

Reviewer Report Preparation (30 minutes)

The reviewers will use this time to compile, analyze, and organize the data they have 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

Two-Day Review 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 representing the disciplines providing complex stroke care, at the discretion of the organization
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 -Transfers -Medical care	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 department physicians, licensed practitioners and staff -Radiology physicians, licensed practitioners and staff -Surgical/procedural physicians, licensed practitioners and staff -ICU physicians, licensed practitioners and staff -Other licensed 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,

Time	Activity	Organization Participants
	-Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) 6. **Transfer/Discharge** 7. **Follow-up Call** 8. **Closed Record Review:** Reviewers may review closed medical records.	clinical staff, and information technology (electronic medical record-EMR) staff
12:30-1:00 p.m.	**Reviewer Lunch**	
1:00-3:30 p.m.	**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: 1. **Acute Stroke Care** -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** -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.	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 department physicians, licensed practitioners, and staff -Radiology physicians, licensed practitioners, and staff -Surgical/procedural physicians, licensed practitioners and staff -ICU physicians, licensed practitioners, and staff -Other licensed 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.	**Reviewer Planning/Team Meeting** Reviewer will: – Address any open issues – Communicate summary of the first day's observations – Select individual patient tracers for Day 2	Program representatives who can facilitate patient selection and tracer activity.

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.	**Individual Patient Tracer**	
11:30 -1:00 p.m.	**System Tracer - Data Use** • Research • 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) • 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	Program clinical and administrative leadership. (Example: Stroke Coordinator, Stroke Program Medical Director) Individual(s) responsible for performance improvement and processes within the program
1:00-1:30 p.m.	**Reviewer Lunch**	
1:30-3:00 p.m.	**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. -Nursing Staff -Medical Staff -Other Staff -Community Education The reviewers will also ask to view the personnel records of the: – Medical Director of Stroke Program – Stroke Coordinator – Advanced Practice Nurse	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

Thrombectomy-Capable Stroke Center (TSC) Certification
Two-Day Agenda

Time	Activity	Organization Participants
3:00-3:30 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team	Certification review facilitator Program leaders and staff as requested by the reviewer
3:30 – 4:00 p.m.	**Reviewer Report Preparation**	
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 – TSC

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

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

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

Medical Director
The organization identifies a physician leader with extensive experience in cerebrovascular disease and experience caring for stroke patients. This person shall be a physician on the

hospital staff, licensed in New York State, and Board Certified in Neurology, Vascular Neurology, Critical Care, Neuro-Critical Care, Interventional Neuroradiology, or Neurosurgery.

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

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

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

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

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

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

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

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

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

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

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

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

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

At a minimum, the transfer agreement should address:

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

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

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

Vascular Imaging

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

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

CT is initiated within 25 minutes of patient arrival and read within 45 minutes of patient arrival.

The Thrombectomy-Capable Stroke Center must have the ability to perform head and neck CTA 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 CTP 24/7.

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

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

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

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

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

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

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

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

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

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

Performance Measures (for those performance measures that are not STK or CSTK measures, please have data available for the reviewers during the data session of the on-site visit)
NYS PSC 1: VTE Prophylaxis
NYS PSC 2: Discharge on Antithrombotic Therapy

NYS PSC 3: Anticoagulation Therapy for AFIB/Flutter
NYS PSC 4: Thrombolytic Therapy (arrive by 3.5 hours, treat by 4.5 hours)
NYS PSC 5: Antithrombotic Therapy by the end of Hospital Day Two
NYS PSC 6: Discharged on Statin Medication
NYS PSC 7: Stroke Education
NYS PSC 8: Smoking Cessation
NYS PSC 9: Assessed for Rehabilitation
NYS PSC 10: Dysphagia Screening
NYS PSC 11: Initial NIHSS Reported
NYS PSC 12: mRS on Discharge
NYS PSC 13: Pre-Notification: Percent of cases of advanced notification by EMS for patients transported by EMS from scene
NYS PSC 14: EMS Pre-Hospital Stroke Scale: Percent of patients arriving via EMS who had pre-hospital stroke scale performed
NYS PSC 15: Pre-Notification Content:
-Last Known Well communicated
-Stroke scale findings communicated
NYS PSC 16: Stroke Team Activated Prior to Arrival: Percent of patients arriving via EMS for whom the stroke team was activated prior to patient arrival based upon EMS pre-notification
NYS PSC 17: Door to MD/DO (can include midlevel) Assessment (10 minutes)
NYS PSC 18: Door to Stroke Team (15 minutes)
NYS PSC 19: Door to Brain Image Initiated (25 minutes)
NYS PSC 20: Door to Brain Image Read (45 minutes)
NYS PSC 21: Door to IV thrombolytic (60 minutes) – 85%
NYS PSC 22: Door to IV thrombolytic (45 minutes) – 50%
NYS PSC 23: Door-in-door-out time at first hospital prior to transfer for acute therapy (</= 90 minutes)
NYS TSC 1: mRS at 90 days: documented
NYS TSC 2: mRS at 90 days: following mechanical endovascular reperfusion therapy, favorable outcome
NYS TSC 3: Hemorrhagic transformation (overall rate)
NYS TSC 4: Mechanical Endovascular Reperfusion Therapy for Eligible Patients with Ischemic Stroke
NYS TSC 5: Thrombolysis in Cerebral Infarction (TICI post treatment reperfusion grade)
NYS TSC 6: NIHSS at Discharge
NYS TSC 7: Timeliness of reperfusion: arrival time to TICI 2B or higher (120 minutes)
NYS TSC 8: Timeliness of reperfusion: skin puncture to TICI 2B or higher (60 minutes)
NYS TSC 9: Door to Puncture Time
NYS TSC 10: Imaging to Puncture Time

Disease Specific Care Certification

Addendum for Primary Stroke Center (PSC) Certification

Introduction

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

The PSC certification review is completed by a single reviewer over one day (please refer to the One Day Review Agenda in this guide). However, if a PSC performs mechanical thrombectomy to treat ischemic strokes, the review is completed by a single reviewer over two days. Keep in mind that the time frames indicated are flexible and may be revised by the reviewers as necessary based on organizational need.

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

Organization Participants

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

Opening Conference

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

Orientation to the Program

- At the discretion of the organization, it is strongly suggested to develop a presentation (ex. PowerPoint) to guide the discussion and display program-relevant data.
- The organization should be prepared to provide a 20 minute presentation that includes the following:
    - A broad overview of the process of care for PSC patients implemented at the organization which may include: Scope of stroke services emergency care; advanced imaging; designated beds for the care of stroke patients; transfer protocols; and transitions of care to home or extended care.
        - For PSCs that perform mechanical thrombectomy, also include interventional services and ICU care
    - The following topics specific to the PSC 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
- Disease-specific care, treatment, and services provided
- Identified needs of the program population, including health care equity efforts to reduce community disparities
- The selection, implementation, and evaluation of clinical practice guidelines
- Model of stroke care
- Evaluation of clinical practice guidelines use and appropriateness to the disease-specific care, treatment, and services provided
- 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

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

Materials Required for the Reviewer Planning Session:

- A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. The list includes patients who have experienced the following (as applicable to services provided by the program):
    - TIA
    - Ischemic stroke
    - IV thrombolytic
    - Mechanical thrombectomy (as applicable)
    - Surgical intervention for ischemic stroke (e.g., hemicraniectomy)
    - Intracerebral hemorrhage stroke (as applicable)
    - Subarachnoid hemorrhage stroke (as applicable)
    - Aneurysm treatment (as applicable)
- Stroke log (including inpatient stroke codes)
- A list of current stroke patients in-house
- Other required documents include the following:
    - List of stroke team members and their credentials
    - PSC program protocols for care, treatment, and services provided including acute care processes and order sets for disease-specific care treatment, and services provided (see below)

- Interdisciplinary team meeting minutes

Selecting Patients for Individual Tracers and Protocol Review

- From the list of current stroke patients, the reviewers in conjunction with program representatives will select patients to trace that are reflective of disease-specific care, treatment, and services provided by the program. 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 PSC protocols related to the patient's specific care, treatment, and services, as required by The Joint Commission's PSC requirements. These protocols include the following:
    - Activation of stroke team
    - Process for obtaining EMS records
    - EMS protocols including rapid assessment and communication with the emergency department
    - Acute workup of ischemic/hemorrhagic stroke patients
    - Use of IV thrombolytics
    - Reduction of complications
    - 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)
    - Any program-specific order sets utilized in the care of the stroke patient
- In addition to the above list, PSCs that perform mechanical thrombectomy should provide the following additional protocols:
    - Informed consent for stroke interventions
    - Implementation of endovascular procedures
- 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

Organization Participants

Program representatives, including staff who have been involved in the patients' care, who can facilitate tracer activities and escort 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 the following:

- Emergency department physicians, licensed practitioners and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- Radiology physicians, licensed practitioners and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- Speech therapist(s), physical therapist(s), and occupational therapist(s)
- Discharge planner(s) and case manager(s)
- Other staff who provide 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

For PSCs that perform mechanical thrombectomy, the following staff are also be included:

- Endovascular suite physician, licensed practitioners and staff (e.g., APPs, fellows, residents, nurses, ancillary staff)
- ICU physicians, licensed practitioners and staff (e.g., APPs, fellows, residents, nurses, ancillary 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 do the following:

- Follow a patient's course of care, treatment or service through the program:
    - Individual patient tracer activity usually begins in the emergency department and follows the patient through to 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, stroke care, rehabilitation care (as applicable), patient family education, referral, and transferring/discharge procedures

      Note: For PSCs that perform Mechanical thrombectomy, endovascular interventions and neuro-ICU care will also be included
- Assess the impact of interrelationships among the program disciplines on patient care:
    - The specific disciplines for PSC include, but are not limited to, stroke team members, physicians who provide care to stroke patients, radiologists, 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

Plan for sufficient staff and licensed 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 Record Review: During individual patient tracers or during the planning session, the reviewer may request closed patient records for review. The purpose of the closed patient records review is to evaluate the care provided to stroke patients throughout the continuum of care and the care provided during discharge/transitions. Closed chart review generally occurs after individual patient tracer activity.

System Tracer--Data Use

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

At the discretion of the organization, it is strongly suggested to develop a presentation (for example, PowerPoint) to guide the discussion and display program-relevant data.

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 PSC certification will include:

- Use of a defined performance improvement methodology including plans, action plans, and resulting improvements
- Review of the program's performance improvement plan including multidisciplinary involvement and current goals and priorities relevant to performance improvement planning and activities
- Processes to maintain data quality and integrity (for example, interrater reliability, minimizing data bias, data analysis tools)
- Volumes of procedures and interventions
- Complication rates and reduction initiatives
- Current stroke performance measure data
- Use of a stroke registry
- Collection and use of patient experience and perception of care data related to the stroke patient population*
- Review of the program's stroke team log
- Documentation of quarterly meeting minutes and agenda related to performance improvement

For PSCs that perform mechanical thrombectomy, additional areas of focus include:

- Multidisciplinary program-level review focusing on:
    - AI cause death within 72 hours of mechanical thrombectomy
    - Symptomatic intracerebral hemorrhage following mechanical thrombectomy
- Public reporting of outcomes as listed in the requirements
- Process to follow-up with patients that discharge home (see DSSE.03, EP 5)

* Patient experience and perception of care data must be addressed at the program level and related to the specific care, treatment, and services provided by the program. Organizationwide data (for example, HCAHPS) does not meet the requirement.

Education, Competence Assessment, and the Credentialing Process Session

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 following:

- The written education plan for providing program-specific education to physicians, licensed practitioners, staff, and the surrounding community

- The processes to provide initial and ongoing education and training of physicians, licensed practitioners, and staff who provide disease-specific care, treatment, and services in the stroke program
- Review of competency assessments, credentialing, and education plans in accordance with program-specific and organizationwide policies, procedures, and applicable law and regulation

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

- Written education plan and how program-specific education is determined and approved (see DSPR.02, EP 2), including the following:
    - An overview of program-specific orientation to physicians, licensed practitioners, and staff who provide care to stroke patients within the program.

      Note: This includes hospitalist physician groups if they are admitting stroke patients to inpatient services or other specialties as applicable to care delivery models.
    - An overview of initial and ongoing competence assessments/training activities for staff caring for complex stroke patients that are pertinent to individual roles and responsibilities and are provided when staff responsibilities change; when new or revised policies, procedures, or guidelines are implemented; and/or other intervals defined by the program.
    - Plan for contract staff that includes orientation to the stroke program and required competencies assessment(s) and education (as applicable).
    - Education of all staff involved in care of stroke patients regarding stroke recognition signs and symptoms.
- Documentation of at least two educational programs focused on stroke prevention/care provided for the community.

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:

- For selected physician(s) files, the following will be reviewed using primary source verification (as applicable to the role):
    - Appointment letter
    - Privileges
    - Board certification (if applicable)
    - Licensure
    - DEA
    - Orientation to the stroke program
    - OPPE/FPPE
    - CME/Ongoing Education related to the program
- For selected staff member(s) files, the following will be reviewed using primary source verification (as applicable to the role):
    - Job description
    - Licensure

- Certification (ex. disease-specific, ACLS, PALS, BLS)
- Last signed performance evaluation
- Stroke-specific orientation
- Stroke-specific initial and ongoing education

In addition to selected personnel and credential files, the reviewers will also review the files of the members of the core stroke team, as identified by the organization.

For the review of all applicable licensure and certification, primary source verification is utilized.

It is at the discretion of the organization to determine the content and delivery method of education relevant to disease-specific care, treatment, and services provided by the program. The processes for how education is determine will be discussed during the review.

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Review of any remaining information requested
- Review of identified findings
- Determination of what will be discussed at Exit Conference

The reviewer will work with the program's representatives to organize and conduct the summary discussion.

Reviewer Report Preparation (30 minutes)

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

Program Exit Conference

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

Disease Specific Care Certification
Primary Stroke Center (PSC) Certification Agenda
One-Day Review 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.	**Opening Conference** (10 minutes) • Introductions • Overview of PSC certification by reviewers • Agenda review **Orientation to Program** (30 minutes) Be prepared to discuss or provide a 20 minute presentation, that addresses the following aspects of the program: • A broad overview of the process of care for PSC patients which may include: ▪ Scope of stroke services emergency care; advanced imaging; ▪ Designated beds for the care of stroke patients; ▪ Transfer protocols; and transitions of care to home or extended care. • PSC program specifics such as: ▪ Program mission, goals, and objectives ▪ Program structure ▪ Program leadership and management ▪ Program design ▪ Stroke team composition ▪ Developing, implementing, and evaluating the program ▪ Disease-specific care, treatment, and services provided ▪ 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 ▪ Telemedicine (if in use) **Q & A Discussion** (20 minutes)	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.	**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.	**Individual Tracer Activity**	Program representative(s) who can facilitate tracer activity, and escort the

Disease Specific Care Certification – Primary Stroke Center (PSC) Certification
One-Day Agenda

Time	Activity	Organization Participants
11:00 – 11:30 a.m. 11:30 – 12:00 p.m. 12:00 – 12:30 p.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 their permission.	reviewer through the clinical setting following the course of care for the patient
12:30 – 1:00 p.m.	**Reviewer Lunch**	
1:00 – 1:30 p.m. 1:30 – 2:00 pm.	**System Tracer – Data Use** Specific areas of focus for PSC certification will include: • Use of a defined performance improvement methodology including plans, action plans, and resulting improvements • Volumes of procedures and interventions • Current stroke performance measure data • Use of the stroke registry • Patient satisfaction data specific to complex stroke patient population • Review of the program's stroke team log	• Program clinical and administrative leadership • Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization
2:00 – 2:30 p.m. 2:30 – 3:00 p.m.	**Competence Assessment/Credentialing Process** 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 PSC program/organization Be prepared to discuss PSC program specifics related to: • Orientation • Competence assessment for staff caring for complex stroke patients • Contract personnel competence assessment and education (if contract staff is used) • On-going education, training, and in-service requirements for the program • Job descriptions for select nursing staff, medical staff, and other staff who cared for patients identified during the patient tracers • Job descriptions for the Medical Director of Stroke Program, and Stroke Coordinator Requested personnel records and credentials files for various team members and staff encountered or referred to throughout the day will be reviewed at this time.	• 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

Disease Specific Care Certification – Primary Stroke Center (PSC) Certification
One-Day Agenda

Time	Activity	Organization Participants
3:00 – 3:30 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team	• Certification review facilitator • Program leaders and staff as requested by the reviewer
3:30 – 4:00 p.m.	**Reviewer Report Preparation**	
4:00 – 4:30 p.m.	**Program Exit Conference** Reviewer presentation of certification observations and requirements for improvement	• Program and clinical leadership • Others at the discretion of the organization

Disease Specific Care Certification
Primary Stroke Center -- Thrombectomy-Capable Agenda
Two-Day Review 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 -Transfers -Medical care	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 – Primary Stroke Center (PSC) Performing Mechanical Thrombectomy, Two-Day Review Agenda

Time	Activity	Organization Participants
	-Nursing care -Social work/Case management -Additional care (could include speech Therapy, physical therapy, occupational therapy, psychology, pharmacy) 6. **Transfer/Discharge** 7. **Follow-up Call** 8. **Closed Record Review:** Reviewers may review closed medical records.	- 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.	**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: 1. **Acute Stroke Care** -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** -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.	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 - 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.	**Reviewer Planning/Team Meeting** Reviewer will: – Address any open issues – Communicate summary of the first day's observations – Select individual patient tracers for Day 2	Program representatives who can facilitate patient selection and tracer activity.

Disease Specific Care Certification – Primary Stroke Center (PSC) Performing Mechanical Thrombectomy, Two-Day Review Agenda

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.	**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: 1. **Acute Stroke Care** -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** -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.	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 - Staff who can facilitate medical record review such as medical record staff, clinical staff, and information technology (electronic medical record-EMR) staff
11:30 -1:00 p.m.	**System Tracer - Data Use** • Research • 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) • 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	Program clinical and administrative leadership. (Example: Stroke Coordinator, Stroke Program Medical Director) Individual(s) responsible for performance improvement and processes within the program

Disease Specific Care Certification – Primary Stroke Center (PSC) Performing Mechanical Thrombectomy, Two-Day Review Agenda

Time	Activity	Organization Participants
1:00-1:30 p.m.	**Reviewer Lunch**	
1:30-3:00 p.m.	**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. -Nursing Staff -Medical Staff -Other Staff -Community Education The reviewers will also ask to view the personnel records of the: – Medical Director of Stroke Program – Stroke Coordinator – Advanced Practice Nurse	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
3:00-3:30 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team	Certification review facilitator Program leaders and staff as requested by the reviewer
3:30 – 4:00 p.m.	**Reviewer Report Preparation**	
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 – PSC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

-Plans for the triage and transport of suspected stroke patients including, but not limited to, those patients who may have an emergent large vessel occlusion to an appropriate facility within a specified time.

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

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

Vascular Imaging

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

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

CT is initiated within 25 minutes of patient arrival and read within 45 minutes of patient arrival.

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.

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

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

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

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

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

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

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

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

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

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

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

b. Stroke scale findings communicated

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

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

Disease-Specific Care Certification

Addendum for Acute Stroke Ready Hospital (ASRH) Certification

Introduction

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

The ASRH certification review is completed by a single reviewer over one day (please refer to the One Day Review Agenda in this guide). Keep in mind that the time frames indicated are flexible and may be revised by the reviewer as necessary based on organizational need.

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

Opening Conference and Orientation to Program

Organization Participants

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

Opening Conference

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

Orientation to the Program

- At the discretion of the organization, it is strongly suggested to develop a presentation (ex. PowerPoint) to guide the discussion and display program-relevant data.
- The organization should be prepared to provide a 20-minute presentation that includes the following:
    - A broad overview of the process of care for ASRH patients implemented at the organization.
    - The following topics specific to the ASRH program are helpful for the reviewer to fully understand your program:
        - Program mission, goals, and objectives
        - Disease-specific care, treatment, and services provided
        - Program structure including how the organization determines which patients are admitted vs. transferred
        - Transfer relationships with higher levels of care
        - Program leadership and management

- Stroke team composition
- Developing, implementing, and evaluating the program
- Identified needs of the program population, including health care equity efforts to reduce community disparities
- Evaluation of clinical practice guidelines use and appropriateness to the disease-specific care, treatment, and services provided
- 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

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

Materials Required for the Reviewer Planning Session:

- A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. The list includes patients who have experienced the following (as applicable to services provided by the program):
  - TIA
  - Ischemic stroke
  - IV thrombolytic
  - Intracerebral hemorrhage stroke (as applicable)
  - Subarachnoid hemorrhage stroke (as applicable)
- Stroke log (including inpatient stroke codes)
- A list of current stroke patients in-house (as applicable)
- Other required documents include the following:
  - List of stroke team members and their credentials
  - ASRH program protocols for care, treatment, and services provided including acute care processes and order sets for disease-specific care treatment, and services provided (see below)
  - Interdisciplinary team meeting minutes

Selecting Patients for Individual Tracers and Protocol Review

- From the list of current stroke patients, the reviewers in conjunction with program representatives will select patients to trace that are reflective of disease-specific care, treatment, and services provided by the program. 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 ASRH protocols related to the patient's specific care, treatment, and services, as required by The Joint Commission's ASRH requirements. These protocols include the following:
  - Activation of stroke team
  - EMS protocols including rapid assessment and communication with the emergency department
  - Acute workup of ischemic/hemorrhagic stroke patients
  - Transferring stroke patients to another hospital/facility
  - Telemedicine (as applicable)

    - Use of IV thrombolytics
    - Reduction of complications
    - Nursing care through the continuum of care (as applicable)
    - Transitions of care for patients within the organization (internal) and post hospitalization (external)
    - Any program-specific order sets utilized in the care of the stroke patient
- 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

Organization Participants
Program representatives, including staff who have been involved in the patients' care, who can facilitate tracer activities and escort 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 the following:

- Emergency department physicians, licensed practitioners, and staff (for example, APPs, fellows, residents, nurses, ancillary staff)
- Radiology physicians, licensed practitioners, and staff (for example, APPs, fellows, residents, nurses, ancillary staff)
- If stroke patients are admitted to the organization:
    - Inpatient care areas
    - Speech therapist(s), physical therapist(s), and occupational therapist(s)
    - Palliative Care
    - Discharge planner(s) and case manager(s)
- Other staff who provide 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
- Staff who can review the entire clinical record of selected patients

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 reviewer will do the following:

- Follow a patient's course of care, treatment, or service through the program:
    - Individual patient tracer activity usually begins in the emergency department and follows the patient through to 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, stroke care, rehabilitation care (as applicable), patient family education, referral, and transferring/discharge procedures.

- Assess the impact of interrelationships among the program disciplines on patient care
- 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.

Plan for sufficient staff and licensed 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.

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

Closed Chart Review: During individual patient tracers, or during the planning session, the reviewer may request closed patient records for review. The purpose of the closed patient records review is to evaluate the care provided to stroke patients throughout the continuum of care and the care provided during discharge/transitions as applicable. Closed chart review generally occurs after individual patient tracer activity.

System Tracer--Data Use

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

At the discretion of the organization, it is strongly suggested to develop a presentation (for example, PowerPoint) to guide the discussion and display program-relevant data.

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 PSC certification will include:

- Use of a defined performance improvement methodology including plans, action plans, and resulting improvements
- Review of the program's performance improvement plan including multidisciplinary involvement and current goals and priorities relevant to performance improvement planning and activities
- Processes to maintain data quality and integrity (for example, interrater reliability, minimizing data bias, data analysis tools)
- IV Thrombolytic data
- Complication rates and reduction initiatives
- Current stroke performance measure data
- Collection and use of patient experience and perception of care data related to the stroke patient population*
- Review of the program's stroke team log
- Documentation of quarterly meeting minutes and agenda related to performance improvement

  * Patient experience and perception of care data must be addressed at the program level and related to the specific care, treatment, and services provided by the program. Organizationwide data (for example, HCAHPS) does not meet the requirement.

Education, Competence Assessment, and the Credentialing Process Session

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 following:

- The written education plan for providing program-specific education to physicians, licensed practitioners, staff, and the surrounding community
- The processes to provide initial and ongoing education and training of physicians, licensed practitioners, and staff who provide disease-specific care, treatment, and services in the stroke program
- Review of competency assessments, credentialing, and education plans in accordance with program-specific and organizationwide policies, procedures, and applicable law and regulation

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

- Written education plan and how program-specific education is determined and approved (see DSPR.02, EP 2), including the following:

- An overview of program-specific orientation to physicians, licensed practitioners, and staff who provide care to stroke patients within the program.
  Note: This includes hospitalist physician groups if they are admitting stroke patients to inpatient services or other specialties as applicable to care delivery models.
- An overview of initial and ongoing competence assessments/training activities for staff caring for complex stroke patients that are pertinent to individual roles and responsibilities and are provided when staff responsibilities change; when new or revised policies, procedures, or guidelines are implemented; and/or other intervals defined by the program.
- Plan for contract staff that includes orientation to the stroke program and required competencies assessment(s) and education (as applicable).
- Education of all staff involved in care of stroke patients regarding stroke recognition signs and symptoms.

.

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:

- For selected physician(s) files, the following will be reviewed using primary source verification (as applicable to the role):
  - Appointment letter
  - Privileges
  - Board certification (if applicable)
  - Licensure
  - DEA
  - Orientation to the stroke program
  - OPPE/FPPE
  - CME/Ongoing Education related to the program
- For selected staff member(s) files, the following will be reviewed using primary source verification (as applicable to the role):
  - Job description
  - Licensure
  - Certification (ex. disease-specific, ACLS, PALS, BLS)
  - Last signed performance evaluation
  - Stroke-specific orientation
  - Stroke-specific initial and ongoing education

In addition to selected personnel and credential files, the reviewers will also review the files of the members of the core stroke team, as identified by the organization.

For the review of all applicable licensure and certification, primary source verification is utilized.

It is at the discretion of the organization to determine the content and delivery method of education relevant to disease-specific care, treatment, and services provided by the program. The processes for how education is determine will be discussed during the review.

Summary Discussion

Topics that may be addressed include:

- Review of any remaining information requested
- Review of identified findings
- Determination of what will be discussed at Exit Conference

The reviewer will work with the program representatives to organize and conduct the summary discussion.

Reviewer Report Preparation

The reviewer will use this time to compile, analyze, and organize the data they have collected into a summary report of observations made throughout the review.

Program Exit Conference

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

DSC-Advanced Certification for Total Hip & Total Knee Replacement (THKR) Addendum

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 implementated or planned
        - Service availability and accessitbility 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 competencey 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 addtitional 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.

Reviewer Planning/Team Meeting (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

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

Overview

- 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 identifies 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 wer 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

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at closing

The reviewer will work with the organization's certification contact to organize and conduct the summary discussion.

Reviewer Report Preparation (30 minutes)

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-Total Hip & Total Knee Replacement Agenda
Two-Day Review 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	**Opening Conference (10 minutes)** • Greetings and introductions • Introductions of key program and organization staff **Orientation to Program (60 minutes)** • 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 **Q&A discussion (20 minutes)**	• Program clinical and administrative leadership (for example; 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

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** • 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: *Clinical Areas to consider visiting during tracer activity* • 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 *Interdisciplinary Care Team members to consider interviewing during tracer activity* • 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**	

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

Time	Activity	Organization Participants
2 hours	**Individual Patient Tracer** See description above	See suggested participants noted above
30 minutes	**Reviewer Planning/Team Meeting** Confer at the end of Day 1 and plan for Day 2 of the THKR review with the organization's staff • Address any open issues 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	**Daily Briefing** Communicate a summary of day 1 observations to the program representatives and determine if additional information will be needed the following day	• 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
Approximately 2 hours 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) 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.	**Individual Tracer Activity—Intraoperative Experience** **(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 organization instruction The activity will include: • Observation of preoperative process • Observe communication and collaboration between team members and patient, observe consistency of information being exchanged • Observe hand-offs (e.g. registration-to-preoperative RN, preoperative RN-to-anesthesia, preoperative RN-to-surgeon, surgeon-to-anesthesia, anesthesia-to-	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

Dependent on the volume of total hip and total knee cases, either the afternoon of Day 1 after opening conference or Day 2, the observations may occur within more than one patient and at more than one time frame.	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	
2 hours	**Individual Patient Tracer** See description above	See suggested participants noted above
60 minutes	**System Tracer – Data Use** • 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: • 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

30 minutes	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	• Certification review facilitator • Program leaders and staff as requested by the reviewers.
30 minutes	**Reviewer Report Preparation**	
30 minutes	**Program Exit Conference** • 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
The Advanced Certification for Acute Heart Attack Ready (AHAR) program focuses on the following:

- Assessment, diagnosis, and treatment of patients with acute coronary syndrome (ACS) who are managed by an interdisciplinary team that work across clinical specialties to provide optimal patient-centered care
- Development and use of guideline-based, institution-specific written protocols for triaging and managing patients who present with or develop signs and symptoms of ACS, including activation and response criteria
- Defined reperfusion strategy as either transfer for percutaneous coronary intervention (PCI) and/or administer fibrinolytic therapy, or perform PCI (if available)
- Education, training, and competence relevant to the practitioners' roles in providing care, treatment, or services
- Identification and use of current clinical practice guidelines selected to develop the program's protocols, policies and/or procedures that are used to deliver or facilitate the delivery of clinical care
- Individualized plan of care, shared decision-making, and education for each patient based on the patient's assessed needs through collaboration of all healthcare providers involved the care
- Organized, comprehensive approach for performance planning, review, and program improvement

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

The AHAR certification review occurs over one or two days as follows:

- A one-day review with one reviewer are for those programs that do not provide primary PCI and would transfer to a PCI-capable center (see One-Day Agenda).
- A two-day review with one reviewer is for those programs that provide primary PCI on a limited or part-time basis. (see Two-Day Agenda)

The one-day or two-day agendas reflect 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.

Note: Program-Specific Eligibility: In addition to the general eligibility requirements listed in "The Joint Commission Certification Process" (CERT) chapter of this *Comprehensive Certification Manual for Disease-Specific Care*, programs seeking AHAR must also meet the following:

- Provide care, treatment, and services for adults with ACS and complications related to ACS, such as cardiac arrest and cardiogenic shock, on-site 24 hours a day, 7 days a week
- Have served a minimum of 10 patients
- Currently participate in the American Heart Association's Get With The Guidelines® - Coronary Artery Disease.

Advanced AHAR Certification On-site Review Description

Day 1 - Morning

Note: Day 1 morning activities apply to both one-day and two-day reviews. The activities for the afternoon on day 1 are different for those participating in a two-day review.

Opening Conference and Orientation to Program (60 minutes)

- ACS patients implemented at the organization which may include: scope of cardiac services emergency care; diagnostic services (EKG, laboratory, X-ray, CT); transfer protocols to PCI-capable center; and transitions of care to community services/providers.
- The following subjects specific to the AHAR program are helpful for the reviewer to fully understand your program:
    - Program leadership
    - Program interdisciplinary team composition
    - Program design and integration into organization
    - Program scope of services
    - Program mission, goals, and objectives
    - Target population and service area
    - How the program addresses diversity, equity, and inclusion to reduce health care disparities
    - Program use, implementation, and evaluation of clinical practice guidelines (CPGs) and deviation monitoring
    - Program improvements based upon CPG content and overall program improvements that have been implemented or planned
    - Service availability and accessibility dependent on program scope (i.e., inpatient, hospital-based outpatient, cardiac rehabilitation)
    - Program design influences (i.e., community needs assessment, patient selection, patient risks and outcomes, co-morbidities, evidence-based practice)
    - Program provides at least two educational programs focused on cardiac care or heart attack prevention/care provided for the public
    - Patient self-management education resources
    - Access to patient-centered care resources
    - Facilitating patient access to interdisciplinary care, treatment and services

- Communication, collaborative planning, and processes that span the continuum of care
- Transitions of care (i.e., follow-up appointments with providers, cardiac rehabilitation)

Reviewer questions (10 minutes)

- Please allow time for the reviewer to ask some additional follow-up questions as they may seek further information regarding the program and presentation provided.

Reviewer Planning Session/Protocol Review (30 minutes)

This session combines two activities: the reviewer planning session (selecting patients for tracer activity) and review of the program's protocols.

Note: In advance of the scheduled review, please have prepared a current list of patients (see below) that is readily available/accessible immediately following the opening session so delays do not occur.

I. Materials Required for the Reviewer Planning Session:

- During the planning session, the reviewer will review the program's current inpatient/observation patient list of those with ACS-related diagnoses and select patients for individual tracer activities. Open and closed records will both be reviewed.
  Note: If there are no current inpatients (such as free-standing emergency rooms), the reviewer will select closed records to review.
- A current list includes patients from the past four months (for new certifications) or the past 12 months (for recertification) that includes:
  - Patients who were discharged or transferred from the emergency department (including those who arrived via EMS).
  - Patients who were admitted or place under observation status, that includes these diagnostic, treatment, or services categories:
    - ACS (STEMI, NSTEMI, Unstable Angina, Chest pain/ACS)
    - Cardiac arrest with ROSC
    - Cardiogenic shock
    - PCI performed at the facility (if applicable)
- The patient lists should be organized as follows:
  - Patient's room number (if current inpatient), age, gender, room number, admitting provider, diagnosis, treatment, MRN, dates of admission and discharge, and discharge disposition (transfer, SNF, expired, home).
  - If cardiac rehab services are provided, please provide a list of the post-PCI patients that are currently participating. The list should include MRN, name, age, gender, diagnosis, date of procedure, and dates of admission and discharge (as applicable).

Example: List # 1 **STEMI Patients** (e.g. ICD-10 codes I21.21)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

Example: List #2 **Cardiac Arrest** (e.g. ICD-10 I46.9, I97.120, Z86.74)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

Example: List #3 **Chest Pain** (e.g. ICD-10 R07.9, R07.89), **Unstable Angina** (e.g. ICD-10 I20.0, I20.9)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

II. Selecting Patients for Individual Tracers and Protocol Review

- From the patient lists provided (as described above), the reviewer will identify a minimum of 5 patients for tracing. Throughout individual tracer activities, the reviewer will identify personnel and medical staff credential files that will be needed during the Competence Assessment/Credentialing Process/Education session.
- Based on the patients selected for the individual tracer activities, the reviewer may evaluate the organization's AHAR protocols related to the care, treatment, and services that were provided to the patient, and as indicated by The Joint Commission's AHAR requirements. These protocols may include:
    - Activation of cardiac teams (such as interventional cardiology if applicable)
    - Process for obtaining EMS records
    - EMS protocols including communication with emergency department
    - Acute workup of ACS/chest pain patients
    - Informed consent for procedures performed
    - Use of IV fibrinolytics (if used as back-up)
    - Implementation of procedures
    - Nursing and therapeutic care through the continuum of care
    - Transferring patients to another hospital/facility (for services not provided)
    - Transitions of care for patients within the organization (internal) and post hospitalization (external)
    - Cardiac rehabilitation referral process
- The evaluation of program documents will continue throughout the review, comparing care provided during individual patient tracer activities to protocols, policies and algorithms utilized by the AHAR program. Please have program documents readily available in paper or electronic formats to improve efficiency of the review process.

Individual Tracer Activity - (3 Hours)

I. Organization Participants

- Program representatives who can facilitate tracer activities and escort the reviewer through the clinical settings following the course of care for the patients. Tracers will include staff who are involved in the patient's care. This may include:
    - Emergency department licensed practitioners and staff
    - Imaging licensed practitioners and staff

- Cardiology licensed practitioners
- Cardiac interventional laboratory licensed practitioners and staff
- Cardiac rehabilitation
- Discharge planner(s) and case manager(s)
- Other licensed and unlicensed practitioners and staff providing ACS/chest pain 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

II. Materials Needed for This Session
- Clinical records of selected patients

III. 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.
- The reviewer will follow a patient's course to assess the adherence to and diversion from the CPGs and organizational protocols in the care, treatment or services provided to the patient.
- Patient tracer activity usually begins in the emergency department and follows their course to the current location or from their discharge location.
    - The reviewer may speak with staff in all the areas involved in the patient's encounter, which may include emergency services, imaging, procedural, therapeutic and rehabilitation services, patient/family education, and transfer/discharge services.
- Plan for sufficient staff and practitioners to accommodate the reviewer conducting tracer activity in the organization.
- 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. **Note:** 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 summarize:
    - Specific observations made
    - Issues that will be continued to be explored in other tracer activity
    - Need for additional record or document review
    - Issues that have the potential to result in requirements for improvement

Reviewer Lunch (30 minutes)
- Please guide the reviewer to location of on-site lunch menu options. If there are no on-site food options, please consider planning in advance.

Activity Scheduling Note
- The following activities take place in the afternoon of a one-day review.
- On two-day reviews these activities take place on Day 2

System Tracer--Data Use Session (60 minutes)

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

II. Materials Needed
- Performance measurement data addressed in requirements
- Action plans demonstrating the program's use of and response to data

III. 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

IV. Overview of the Data Use System Tracer
- This 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 ACS patients. Specific areas of focus for AHAR 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 ACS performance measure data
    - Public reporting of outcomes per requirements
    - Interdisciplinary program review and peer review process
    - Use of the AHA GWTG-CAD registry and other registries (as applicable)
    - Patient satisfaction data specific to ACS patient population, and program improvements made based on that data
    - Review of the program's cardiac/STEMI team log
    - Organizational Data: For AHAR 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.

Competence Assessment/Credentialing Process Activity (1 hour)

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

II. Be prepared to discuss

- The program's process for onboarding staff as well as continuing collaboration and continuing education for program's clinical and non-clinical staff

III. Facilitated review

- Medical and clinical staff personnel files that will be requested during tracer activities that includes the following:
    - Competence assessment and education for on-boarding new staff
    - Licensure and/or certification, as applicable by discipline
    - Privileges and accompanying documentation
    - On-going or continuing education to maintain competency, by discipline
    - Performance evaluations, by discipline
- Job descriptions may be requested for the following:
    - Medical Director of AHAR Program
    - AHAR program Coordinator
    - Medical Staff
    - Advanced practice providers (if utilized)
    - Other clinical staff as requested

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at closing

The reviewer will work with the organization's certification contact to organize and conduct the summary discussion.

Report Preparation (30 minutes)

The reviewer will use this time to compile, analyze, and organize the data they have collected into a summary report of observations made throughout the review.

Program Exit Conference (30 minutes)

The reviewer will provide a preliminary certification report.

Advanced Disease Specific Care
AHAR (no PCI services) Certification Agenda
One-Day Review Template

Time	Activity	Organization Participants
8:00-9:00 am	**Opening Conference (10 minutes)** • Reviewer greeting and introductions • Introduction of program staff • Brief review of agenda **Orientation to Program (30 minutes)** Topics to be covered include: • 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 • Overall program improvements implemented or planned **Q & A Discussion (20 minutes)**	• Program Clinical and Administrative Leadership • Individuals responsible for performance improvement processes within the program and, as applicable, the organization • Others at the discretion of the organization
9:00–9:30 am	**Reviewer Planning Session**	Program representative(s) who can facilitate patient selection and tracer activity
9:30 am–12:30 pm	**Individual Tracer Activity**	Program representative(s) that can facilitate patient selection and tracer activity
12:30-1:00 pm	**Reviewer Lunch**	

1:00–2:00 pm	**System Tracer–Data Use Session**
	• Discuss how data is used by program to track performance and improve practice and/or outcomes of care
	• Discuss selected performance measures, including:
	  o Selection process
	  o Aspects of care and services and outcomes that measures address
	  o Data collection processes (Four months of data for initial certification and 12 months of data for recertification)
		Interdisciplinary team and those involved in performance improvement

Time	Activity	Organization Participants
	○ How is data reliability and validity conducted? ○ Reporting and presentation of data ○ Improvement opportunities discovered through data analysis ○ Improvements that have already been implemented or are planned based on performance measurement • Discuss patient satisfaction data, including improvements based on feedback	
2:00-3:00 pm	**Competence Assessment/Credentialing Process** • Orientation and training process for program • Methods for assessing competence of practitioners and team members • Inservice and other education and training activities provided to program team members Review of at least one file per discipline of those staff involved in the program ***Provider Files*** • Licensure • DEA Licensure • Most recent reappointment letters • Board certification • Privileges and applicable supporting documents • OPPE or FPPE (two most recent, as applicable) • CME or attestation for CME ***Staff Files*** • Licensure (if applicable) • Certification (if applicable) • Job description • Most recent performance evaluation • Program Specific *Orientation* Education/Competencies • Program Specific *Ongoing* Education/Competencies •	• Individuals responsible for program education • Medical Staff Office representatives • Human Resources
3:00-3:30 pm	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	Certification review facilitator Program leaders and staff as requested by the reviewers.

Time	Activity	Organization Participants
3:30 – 4:00 pm	**Reviewer Report Preparation**	
4:00-4:30 pm	**Program Exit Conference**	• Program Leadership • Hospital Leadership • Interdisciplinary Team Members

Advanced Disease Specific Care
AHAR (with limited or part-time PCI) Certification Agenda
Two-Day Review Template

DAY 1

Time	Activity	Organization Participants
8:00-9:00 am	**Opening Conference** • Reviewer greeting and introductions • Introduction of program staff • Brief review of agenda **Orientation to Program** Topics to be covered include: • 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 • Overall program improvements implemented or planned **Q & A Discussion**	• Program Clinical and Administrative Leadership • Individuals responsible for performance improvement processes within the program and, as applicable, the organization • Others at the discretion of the organization
9:00–9:30 am	**Reviewer Planning Session**	Program representative(s) who can facilitate patient selection and tracer activity
9:30 am–12:30 pm	**Individual Tracer Activity**	Program representative(s) that can facilitate patient tracer activity
12:30-1:00 pm	**Reviewer Lunch**	
1:00-4:00 pm	**Individual Tracer Activity (cont.)**	Program representative(s) that can facilitate patient tracer activity
4:00-4:30 pm	**Reviewer Planning Session/Team Meeting** *Planning for review day 2*	

DAY 2

Time	Activity	Organization Participants
8:00-8:15 am	**Daily Briefing** A summary of the first day's observations will be provided	As determined by the Center or organization

8:15-9:30 am	**System Tracer–Data Use Session**
	• Discuss how data is used by program to track performance and improve practice and/or outcomes of care
	• Discuss selected performance measures, including:
	  ○ Selection process
	  ○ Aspects of care and services and outcomes that measures address
	  ○ Data collection processes (Four months of data for initial certification and 12 months of data for recertification)
	  ○ How is data reliability and validity conducted?
	  ○ Reporting and presentation of data
	  ○ Improvement opportunities discovered through data analysis
	  ○ Improvements that have already been implemented or are planned based on performance measurement
	• Discuss patient satisfaction data, including improvements based on feedback
		Interdisciplinary team and those involved in performance improvement

9:30-11:30 am	**Individual Tracer Activity (cont.)**	Program representative(s) that can facilitate patient tracer activity
11:30 am-12:00 pm	**Reviewer Lunch**	
12:00-1:00 pm	**Competence Assessment/Credentialing Process** • Orientation and training process for program • Methods for assessing competence of practitioners and team members • Inservice and other education and training activities provided to program team members Review of at least one file per discipline of those staff involved in the program ***Provider Files*** • Licensure • DEA Licensure • Most recent reappointment letters • Board certification • Privileges and applicable supporting documents • OPPE or FPPE (two most recent, as applicable)	• Individuals responsible for program education • Medical Staff Office representatives • Human Resources

	• CME or attestation for CME ***Staff Files*** • Licensure (if applicable) • Certification (if applicable) • Job description • Most recent performance evaluation • Program Specific *Orientation* Education/Competencies • Program Specific *Ongoing* Education/Competencies	
1:00-1:30 pm	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	Certification review facilitator Program leaders and staff as requested by the reviewers.
1:30-2:30 pm	**Reviewer Report Preparation**	
2:30-3:00 pm	**Program Exit Conference**	• Program Leadership • Hospital Leadership • Interdisciplinary Team Members

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

Introduction
The Advanced Certification for Primary Heart Attack Center (PHAC) program focuses on the following:

- Assessment, diagnosis, and treatment of patients with acute coronary syndrome (ACS) who are managed by an interdisciplinary team who work across clinical specialties to provide optimal patient-centered care
- Development and use of guideline-based, institution-specific written protocols for triaging and managing patients who present with or develop signs and symptoms of acute coronary syndrome (ACS), including activation and response criteria
- Defined reperfusion strategy as primary percutaneous coronary intervention (PPCI) with a defined backup strategy
- Education, training, and competence relevant to the practitioner's role in providing care, treatment, or services
- Identification and use of current clinical practice guidelines selected to develop the program's protocols, policies and/or procedures used to deliver or facilitate the delivery of clinical care
- Individualized plan of care, shared decision-making, and education for each patient based on the patient's assessed needs through collaboration of all healthcare providers involved the care
- Organized, comprehensive approach for performance planning, review, and program improvement

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

The PHAC certification review occurs over two days with one reviewer (see Two-day Agenda) The two-day 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.

Note: Program-Specific Eligibility: In addition to the general eligibility requirements listed in "The Joint Commission Certification Process" (CERT) chapter of this *Comprehensive Certification Manual for Disease-Specific Care*, programs seeking PHAC must also meet the following:

- The program provides care, treatment, and services for adults with acute coronary syndrome (ACS) and complications related to ACS, such as cardiac arrest and cardiogenic shock on-site 24 hours a day, 7 days a week.
- The program provides primary percutaneous coronary intervention (PPCI) coverage for ST-elevated myocardial infarction (STEMI)/STEMI equivalent patients on-site 24 hours a day, 7 days a week.
- The program achieves the following organizational case volumes:

- The organization performs at least 200 percutaneous coronary intervention (PCI) procedures a year.

Note: This total volume includes primary PCI (PPCI) and any elective or scheduled PCI procedures performed.

- The organization performs at least 36 primary percutaneous coronary intervention (PPCI) procedures a year for STEMI/STEMI equivalent.

Note: This total volume includes all patients who underwent PPCI, as well as those patients who underwent rescue PCI for successful or failed thrombolysis at first point of contact.

- The program is currently participating in the American Heart Association's Get With The Guidelines® - Coronary Artery Disease.

Advanced PHAC Certification On-site Review Description

Day One

Opening Conference and Orientation to Program (60 minutes)

I. 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

II. Opening Conference (15 minutes)

- Introductions
- Overview of PHAC certification by reviewers
- Agenda and general guidelines
- Overview of SAFER™ matrix

III. Orientation to the Program (20-30 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 acute coronary syndrome (ACS) patients implemented at the organization which may include:
    - Scope of cardiac services emergency care; advanced imaging; availability to perform interventions twenty-four hours a day, seven days a week; ICU/critical care (dedicated cardiac ICU beds); post ICU care; rehabilitation care; transfer protocols (if indicated); and transitions of care to home or extended care.
  - The following subjects specific to the PHAC program are helpful for the reviewer to fully understand your program:
    - Program leadership
    - Program interdisciplinary team composition
    - Program design and integration into organization
    - Program scope of services
    - Program mission, goals, and objectives
    - Target population and service area

- How the program addresses diversity, equity, and inclusion to reduce health care disparities
- Program use, implementation, and evaluation of clinical practice guidelines (CPGs) and deviation monitoring
- Program improvements based upon CPG content and overall program improvements that have been implemented or planned
- Service availability and accessibility dependent on program scope (i.e., inpatient, hospital-based outpatient, cardiac rehabilitation)
- Program design influences (i.e., community needs assessment, patient selection, patient risks and outcomes, co-morbidities, evidence-based practice)
- Program provides at least two educational programs focused on cardiac care or heart attack prevention/care provided for the public
- Patient self-management education resources
- Access to patient-centered care resources
- Facilitating patient access to interdisciplinary care, treatment and services
- Communication, collaborative planning, and processes that span the continuum of care
- Transitions of care (i.e., follow-up appointments with providers, cardiac rehabilitation)

IV. Reviewer questions (10 minutes)

- Please allow time for the reviewer to ask some additional follow-up questions as they may seek further information regarding the program and presentation provided.

Reviewer Planning Session/Protocol Review (30 minutes)

This session combines two activities: the reviewer planning session (selecting patients for tracer activity) and review of the program's protocols.

Note: In advance of the scheduled review, please have prepared a current list of patients (see below) that is readily available/accessible immediately following the opening session to not delay other review activities.

I. Materials Required for the Reviewer Planning Session:

- During the planning session, the reviewer will review the program's current inpatient/observation patient list of those with ACS-related diagnoses and select patients for individual tracer activities. Open and closed records will both be reviewed.

Note: If there are no current inpatients, the reviewer will select closed records to review.

- A current list includes patients from the past four months (for new certifications) or the past 12 months (for recertification) that includes:
  - Patients who were discharged or transferred from the emergency department (including those who arrived via EMS).
  - Patients who were admitted or place under observation status, that includes these diagnostic, treatment, or services categories:
    - ACS (STEMI, NSTEMI, Unstable Angina, Chest pain/ACS)
    - Cardiac arrest with ROSC
    - Cardiogenic shock
    - PCI performed at the facility (if applicable)
    - Cardiac rehab referrals patients (post-PCI patients, as applicable)
- The patient lists should be organized as follows:

- Patient's room number (if current inpatient), age, gender, room number, admitting provider, diagnosis, treatment, MRN, dates of admission and discharge, and discharge disposition (transfer, SNF, expired, home).
- For cardiac rehab patients, please provide name, age, gender, diagnosis, date of procedure, MRN, and dates of admission and discharge (as applicable).

Example: List # 1 **STEMI Patients** (e.g. ICD-10 codes I21.21)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

Example: List #2 **Cardiac Arrest** (e.g., ICD-10 I46.9, I97.120, Z86.74)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

Example: List #3 **Chest Pain** (e.g., ICD-10 R07.9, R07.89), **Unstable Angina** (e.g., ICD-10 I20.0, I20.9)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

II. Selecting Patients for Individual Tracers and Protocol Review

- From the patient lists provided (as described above), the reviewer will identify a minimum of 5 patients for tracing. Throughout individual tracer activities, the reviewer will identify personnel and medical staff credential files that will be needed during the Competence Assessment/Credentialing Process/Education session.
- Based on the patients selected for the individual tracer activities, the reviewer may evaluate the organization's PHAC protocols related to the care, treatment, and services that were provided to the patient, and as indicated by The Joint Commission's PHAC requirements. These protocols may include:
  - Activation of cardiac teams (such as interventional cardiology if applicable)
  - Process for obtaining EMS records
  - EMS protocols including communication with emergency department
  - Acute workup of ACS/chest pain patients
  - Informed consent for procedures performed
  - Use of IV fibrinolytics (if used as back-up)
  - Implementation of procedures
  - Nursing and therapeutic care through the continuum of care
  - Transferring patients to another hospital/facility (for services not provided)
  - Transitions of care for patients within the organization (internal) and post hospitalization (external)
  - Cardiac rehabilitation referral process
- The evaluation of program documents will continue throughout the review, comparing care provided during individual patient tracer activities to protocols, policies and algorithms utilized by the PHAC program. Please have program documents readily available in paper or electronic formats to improve efficiency of the review process.

Individual Tracer Activity - (3 Hours)

I. Organization Participants

- Program representatives who can facilitate tracer activities and escort the reviewer through the clinical settings following the course of care for the patients. Tracers will include staff who are involved in the patient's care. This may include:
    - Emergency department licensed practitioners and staff
    - Imaging licensed practitioners and staff
    - Cardiology licensed practitioners
    - Cardiac interventional laboratory licensed practitioners and staff
    - Cardiac rehabilitation
    - Discharge planner(s) and case manager(s)
    - Other licensed and unlicensed practitioners and staff providing ACS/chest pain 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

II. Materials Needed for This Session

- Clinical records of selected patients

III. 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.

- The reviewer will follow a patient's course to assess the adherence to and diversion from the CPGs and organizational protocols in the care, treatment or services provided to the patient.
- Patient tracer activity usually begins in the emergency department and follows their course to the current location or from their discharge location.
    - The reviewer may speak with staff in all the areas involved in the patient's encounter, which may include emergency services, imaging, procedural, therapeutic and rehabilitation services, patient/family education, and transfer/discharge services.
- Plan for sufficient staff and practitioners to accommodate the reviewer conducting tracer activity in the organization.
- 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. **Note:** 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 summarize:
    - Specific observations made
    - Issues that will be continued to be explored in other tracer activity
    - Need for additional record or document review
    - Issues that have the potential to result in requirements for improvement

Reviewer Lunch - (30 minutes)

- Please guide the reviewer to location of on-site lunch menu options. If there are no on-site food options, please consider planning in advance.

Individual Tracer Activity (continued) – (3 hours)
- The reviewer will continue conducting individual patient tracers as per the information provided above

Reviewer Planning Session/Team Meeting – (30 minutes)
Planning and discussing with organization leaders the activities for day two.

Day Two

Daily Briefing with the organization (15 minutes)
The 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 Tracer Activity (cont.) (3 hours and 45 min)
- The reviewer will continue conducting individual patient tracers as per the aforementioned information provided above

Reviewer Lunch (30 minutes)
- Please guide the reviewer to location of on-site lunch menu options. If the organization does not have on-site food options, please consider planning in advance.

System Tracer--Data Use Session (60 minutes)

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

II. Materials Needed
- Performance measurement data addressed in requirements
- Action plans demonstrating the program's use of and response to data

III. 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

IV. Overview of the Data Use System Tracer
- This 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 ACS patients. Specific areas of focus for PHAC 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 ACS performance measure data
- Public reporting of outcomes per requirements
- Interdisciplinary program review and peer review process
- Use of the AHA GWTG-CAD registry and other registries (as applicable)
- Patient satisfaction data specific to ACS patient population, and program improvements made based on that data
- Review of the program's cardiac/STEMI team log
- Organizational Data: For PHAC 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.

Competence Assessment/Credentialing Process Activity (60 minutes)

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

II. Be prepared to discuss
- The program's process for onboarding staff as well as continuing collaboration and continuing education for program's clinical and non-clinical staff

III. Facilitated review
- Medical and clinical staff personnel files that will be requested during tracer activities that includes the following:
  - Competence assessment and education for on-boarding new staff
  - Licensure and/or certification, as applicable by discipline
  - Privileges and accompanying documentation
  - On-going or continuing education to maintain competency, by discipline
  - Performance evaluations, by discipline
- Job descriptions may be requested for the following:
  - Medical Director of PHAC Program
  - PHAC program Coordinator
  - Medical Staff
  - Advanced practice providers (if utilized)
  - Other clinical staff as requested

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at closing

The reviewer will work with the organization's certification contact to organize and conduct the summary discussion.

Report Preparation (30 minutes)

The reviewer will use this time to compile, analyze, and organize the data they have collected into a summary report of observations made throughout the review.

Program Exit Conference (30 minutes)

The reviewer will provide a preliminary certification report.

Advanced Disease Specific Care
Primary Heart Attack Center (PHAC) Certification Agenda
Two-Day Review Template

DAY 1

Time	Activity	Organization Participants
8:00-9:00 am	**Opening Conference** • Reviewer greeting and introductions • Introduction of program staff • Brief review of agenda **Orientation to Program** Topics to be covered include: • 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 • Overall program improvements implemented or planned **Q & A Discussion**	• Program Clinical and Administrative Leadership • Individuals responsible for performance improvement processes within the program and, as applicable, the organization • Others at the discretion of the organization
9:00–9:30 am	**Reviewer Planning Session**	Program representative(s) who can facilitate patient selection and tracer activity
9:30 am–12:30 pm	**Individual Tracer Activity**	Program representative(s) that can facilitate patient tracer activity
12:30-1:00 pm	**Reviewer Lunch**	
1:00-4:00 pm	**Individual Tracer Activity (cont.)**	Program representative(s) that can facilitate patient tracer activity
4:00-4:30 pm	**Reviewer Planning/Team Meeting** *Planning for review day 2*	

DAY 2

Time	Activity	Organization Participants
8:00-8:15 am	**Daily Briefing** A summary of the first day's observations will be provided	As determined by the organization
8:15 am-12:00 pm	**Individual Tracer Activity (cont.)**	Program representative(s) that can facilitate patient tracer activity
12:00-12:30 pm	**Reviewer Lunch**	

12:30-1:30 pm	**System Tracer–Data Use Session**
	• Discuss how data is used by program to track performance and improve practice and/or outcomes of care
	• Discuss selected performance measures, including:
	  ○ Selection process
	  ○ Aspects of care and services and outcomes that measures address
	  ○ Data collection processes (Four months of data for initial certification and 12 months of data for recertification)
	  ○ How is data reliability and validity conducted?
	  ○ Reporting and presentation of data
	  ○ Improvement opportunities discovered through data analysis
	  ○ Improvements that have already been implemented or are planned based on performance measurement
	• Discuss patient satisfaction data, including improvements based on feedback
		Interdisciplinary team and those involved in performance improvement

1:30-2:30 pm	**Competence Assessment/Credentialing Process** • Orientation and training process for program • Methods for assessing competence of practitioners and team members • Inservice and other education and training activities provided to program team members Review of at least one file per discipline of those staff involved in the program ***Provider Files*** • Licensure • DEA Licensure • Most recent reappointment letters • Board certification • Privileges and applicable supporting documents • OPPE or FPPE (two most recent, as applicable) • CME or attestation for CME ***Staff Files*** • Licensure (if applicable)	• Individuals responsible for program education • Medical Staff Office representatives • Human Resources

	• Certification (if applicable) • Job description • Most recent performance evaluation • Program Specific *Orientation* Education/Competencies • Program Specific *Ongoing* Education/Competencies	
3:00-3:30 pm	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	Certification review facilitator Program leaders and staff as requested by the reviewers.
3:30 – 4:00 pm	**Reviewer Report Preparation**	
4:00-4:30 pm	**Program Exit Conference**	• Program Leadership • Hospital Leadership • Interdisciplinary Team Members

Advanced DSC–Comprehensive Heart Attack Center (CHAC) Certification Addendum

Introduction
The Advanced Certification for Comprehensive Heart Attack Center (CHAC) program focuses on the following:

- Assessment, diagnosis, and treatment of patients with acute coronary syndrome (ACS) who are managed by an interdisciplinary team who work across clinical specialties to provide optimal patient-centered care.
- Development and use of guideline-based, institution-specific written protocols for triaging and managing patients who present with or develop signs and symptoms of acute coronary syndrome (ACS), including activation and response criteria.
- Defined reperfusion strategy as primary percutaneous coronary intervention (PPCI) with a defined backup strategy.
- Education, training, and competence relevant to the practitioner's role in providing care, treatment, or services.
- Identification and use of current clinical practice guidelines selected to develop the program's protocols, policies and/or procedures used to deliver or facilitate the delivery of clinical care.
- Individualized plan of care, shared decision-making, and education for each patient based on the patient's assessed needs through collaboration of all healthcare providers involved the care.
- Organized, comprehensive approach for performance planning, review, and program improvement.

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

The CHAC certification review occurs over two days with two reviewers (see Two-day Agenda) The two-day 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.
Note: Program-Specific Eligibility: In addition to the general eligibility requirements listed in "The Joint Commission Certification Process" (CERT) chapter of this *Comprehensive Certification Manual for Disease-Specific Care*, programs seeking CHAC must also meet the following:

- The program provides care, treatment, and services for adults with acute coronary syndrome (ACS) and complications related to ACS, such as cardiac arrest and cardiogenic shock on-site 24 hours a day, 7 days a week.
- The program provides primary percutaneous coronary intervention (PPCI) coverage for ST-elevated myocardial infarction (STEMI)/STEMI equivalent patients on-site 24 hours a day, 7 days a week.
- The program provides cardiac surgical services on-site 24 hours a day, 7 days a week.
- The program achieves the following organizational case volumes:

- The organization performs at least 400 percutaneous coronary intervention (PCI) procedures/year.

Note: This total volume includes primary PCI (PPCI) and any elective or scheduled PCI procedures performed.

- The organization performs at least 36 primary percutaneous coronary intervention (PPCI) for STEMI/STEMI equivalent procedures/year.

Note: This total volume includes all patients who underwent PPCI, as well as those patients who underwent rescue PCI for successful or failed thrombolysis at first point of contact.

- The program is currently participating in the American Heart Association's Get With The Guidelines® - Coronary Artery Disease.

Advanced CHAC Certification On-site Review Description

Day 1

Opening Conference and Orientation to Program (90 minutes)

I. 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

II. Opening Conference (15 minutes)

- Introductions
- Overview of CHAC certification by reviewers
- Agenda and general guidelines
- Overview of SAFER™ matrix

III. Orientation to the Program (30-45 minutes)

- The organization should be prepared to discuss or provide a 30-45 minute presentation, that includes:
  - A broad overview of the process of care for acute coronary syndrome (ACS) patients implemented at the organization which may include:
    - Scope of cardiac services emergency care; advanced imaging; availability to perform interventions twenty-four hours a day, seven days a week (PCI and cardiac surgery); ICU/critical care (dedicated cardiac ICU beds); post ICU care; rehabilitation care; transfer protocols (if indicated); and transitions of care to home or extended care.
  - The following subjects specific to the CHAC program are helpful for the reviewer to fully understand your program:
    - Program leadership
    - Program interdisciplinary team composition
    - Program design and integration into organization
    - Program scope of services
    - Program mission, goals, and objectives
    - Target population and service area
    - How the program addresses diversity, equity, and inclusion to reduce health care disparities

        - Program use, implementation, and evaluation of clinical practice guidelines (CPGs) and deviation monitoring
        - Program improvements based upon CPG content and overall program improvements that have been implemented or planned
        - Service availability and accessibility dependent on program scope (i.e., inpatient, hospital-based outpatient, cardiac rehabilitation)
        - Program design influences (i.e., community needs assessment, patient selection, patient risks and outcomes, co-morbidities, evidence-based practice)
        - Program provides at least two educational programs focused on cardiac care or heart attack prevention/care provided for the public
        - Patient self-management education resources
        - Access to patient-centered care resources
        - Facilitating patient access to interdisciplinary care, treatment and services
        - Communication, collaborative planning, and processes that span the continuum of care
        - Transitions of care (i.e., follow-up appointments with providers, cardiac rehabilitation)

IV. Reviewer questions (20 minutes)

- Please allow time for the reviewers to ask some additional follow-up questions as they may seek further information regarding the program and presentation provided.

Reviewer Planning Session/Protocol Review (30 minutes)

This session combines two activities: the reviewers planning session (selecting patients for tracer activity) and review of the program's protocols.

Note: In advance of the scheduled review, please have prepared a current list of patients (see below) that is readily available/accessible immediately following the opening session to not delay other review activities.

I. Materials Required for the Reviewer Planning Session:

- During the planning session, the reviewer will review the program's current inpatient/observation patient list of those with ACS-related diagnoses and select patients for individual tracer activities. Open and closed records will both be reviewed.

Note: If there are no current inpatients the reviewer will select closed records to review.

- A current list includes patients from the past four months (for new certifications) or the past 12 months (for recertification) that includes:
    - Patients who were discharged or transferred from the emergency department (including those who arrived via EMS).
    - Patients who were admitted or place under observation status, that includes these diagnostic, treatment, or services categories:
        - ACS (STEMI, NSTEMI, Unstable Angina, Chest pain/ACS)
        - Cardiac arrest with ROSC
        - Cardiogenic shock
        - PCI performed at the facility
        - CABG performed at the facility
    - Patients participating in cardiac rehab (post-PCI and post-CABG patients)
- The patient lists should be organized as follows:

- Patient's room number (if current inpatient), age, gender, room number, admitting provider, diagnosis, treatment, MRN, dates of admission and discharge, and discharge disposition (transfer, SNF, expired, home).
- For cardiac rehab patients, please provide name, age, gender, diagnosis, date of procedure, MRN, and dates of admission and discharge (as applicable).

Example: List # 1 **STEMI Patients** (e.g. ICD-10 codes I21.21)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

Example: List #2 **Cardiac Arrest** (e.g., ICD-10 I46.9, I97.120, Z86.74)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

Example: List #3 **Chest Pain** (e.g., ICD-10 R07.9, R07.89), **Unstable Angina** (e.g., ICD-10 I20.0, I20.9)

Patient name	Age	Gender	Rm #	Admitting Provider	Diagnosis	Treatment	MRN	Admit and Discharge Dates	Disposition

II. Selecting Patients for Individual Tracers and Protocol Review

- From the list of current ACS/chest pain patients, the reviewers in conjunction with program representatives, will identify a minimum of 10 patients for tracing. Throughout individual tracer activities, the reviewer will identify personnel and medical staff credential files that will be needed during the Competence Assessment/Credentialing Process/Education session.
- Based on the patients selected for the individual tracer activities, the reviewer may evaluate the organization's CHAC protocols related to the care, treatment, and services that were provided to the patient, and as indicated by The Joint Commission's CHAC requirements. These protocols may include:
  - Activation of cardiac teams (such as interventional cardiology if applicable)
  - Process for obtaining EMS records
  - EMS protocols including communication with emergency department
  - Acute workup of ACS/chest pain patients
  - Informed consent for procedures performed
  - Use of IV fibrinolytics (if used as back-up)
  - Implementation of procedures
  - Nursing and therapeutic care through the continuum of care
  - Transferring patients to another hospital/facility (for services not provided)
  - Transitions of care for patients within the organization (internal) and post hospitalization (external)
  - Cardiac rehabilitation referral process
- The evaluation of program documents will continue throughout the review, comparing care provided during individual patient tracer activities to protocols, policies and algorithms utilized by the CHAC program. Please have program documents readily available in paper or electronic formats to improve efficiency of the review process.

Individual Tracer Activity - (3 Hours)

I. Organization Participants

- Program representatives who can facilitate tracer activities and escort the reviewer through the clinical settings following the course of care for the patients. Tracers will include staff who are involved in the patient's care. This may include:
    - Emergency department licensed practitioners and staff
    - Imaging licensed practitioners and staff
    - Cardiology licensed practitioners
    - Cardiac interventional laboratory licensed practitioners and staff
    - Cardiac surgery operating room licensed practitioners and staff
    - Cardiac rehabilitation staff
    - Discharge planner(s) and case manager(s)
    - Other licensed and unlicensed practitioners and staff providing ACS/chest pain 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

II. Materials Needed for This Session

- Clinical records of selected patients

III. 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.

- The reviewer will follow a patient's course to assess the adherence to and diversion from the CPGs and organizational protocols in the care, treatment or services provided to the patient.
- Patient tracer activity usually begins in the emergency department and follows their course to the current location or from their discharge location.
    - The reviewer may speak with staff in all the areas involved in the patient's encounter, which may include emergency services, imaging, procedural, therapeutic and rehabilitation services, patient/family education, and transfer/discharge services.
- Plan for sufficient staff and practitioners to accommodate the reviewer conducting tracer activity in the organization.
- 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. **Note:** 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 summarize:
    - Specific observations made
    - Issues that will be continued to be explored in other tracer activity
    - Need for additional record or document review
    - Issues that have the potential to result in requirements for improvement

Reviewer Lunch - (30 minutes)

- Please guide the reviewers to location of on-site lunch menu options. If there are no on-site food options, please consider planning in advance.

Individual Tracer Activities (continued) – (3 hours)
- The reviewers will continue conducting individual patient tracers as per the information provided above

Reviewer Planning Session/Team Meeting – (30 minutes)
Planning and discussing with organization leaders activities for day two.

Day Two

Daily Briefing with the organization (15 minutes)
The reviewers 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 Tracer Activity (cont.) (3 hours and 45 min)
- The reviewers will continue conducting individual patient tracers as per the aforementioned information provided above.

Reviewer Lunch (30 minutes)
- Please guide the reviewers to location of on-site lunch menu options. If the organization does not have on-site food options, please consider planning in advance.

System Tracer--Data Use Session (60 minutes)

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

II. Materials Needed
- Performance measurement data addressed in requirements
- Action plans demonstrating the program's use of and response to data

III. 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

IV. Overview of the Data Use System Tracer
- This 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 ACS patients. Specific areas of focus for CHAC certification will include:

- Use of a defined performance improvement methodology including plans, action plans, and resulting improvements
- Volumes of procedures, interventions and surgeries
- Complication rates
- Current ACS performance measure data
- Public reporting of outcomes per requirements
- Interdisciplinary program review and peer review process
- Use of the AHA GWTG-CAD registry and other registries (such as STS, as applicable)
- Patient satisfaction data specific to ACS patient population, and program improvements made based on that data
- Review of the program's cardiac/STEMI team log
- Organizational Data: For CHAC 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.

Competence Assessment/Credentialing Process Activity (1 hour)

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

II. Be prepared to discuss
- The program's process for onboarding staff as well as continuing collaboration and continuing education for program's clinical and non-clinical staff

III. Facilitated review
- Medical and clinical staff personnel files that will be requested during tracer activities that includes the following:
  - Competence assessment and education for on-boarding new staff
  - Licensure and/or certification, as applicable by discipline
  - Privileges and accompanying documentation
  - On-going or continuing education to maintain competency, by discipline
  - Performance evaluations, by discipline
- Job descriptions may be requested for the following:
  - Medical Director(s) of CHAC Program
  - CHAC program Coordinator
  - Medical Staff
  - Advanced practice providers (if utilized)
  - Other clinical staff as requested

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at closing

The reviewer will work with the organization’s certification contact to organize and conduct the summary discussion.

Report Preparation (30 minutes)

The reviewer will use this time to compile, analyze, and organize the data they have collected into a summary report of observations made throughout the review.

Program Exit Conference (30 minutes)

The reviewers will provide a preliminary certification report.

Advanced Disease Specific Care
Comprehensive Heart Attack Center Certification Agenda
Two-Day Review Template

DAY 1

Time	Activity	Organization Participants
8:00-9:30 am	**Opening Conference** • Reviewer greeting and introductions • Introduction of program staff • Brief review of agenda **Orientation to Program** Topics to be covered include: • 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 • Overall program improvements implemented or planned **Q & A Discussion**	• Program Clinical and Administrative Leadership • Individuals responsible for performance improvement processes within the program and, as applicable, the organization • Others at the discretion of the organization
9:30–10:00 am	**Reviewers Planning Session**	Program representative(s) who can facilitate patient selection and tracer activity
10:00 am–12:30 pm	**Individual Tracer Activity**	Program representative(s) that can facilitate patient tracer activity
12:30-1:00 pm	**Reviewers Lunch**	
1:00-4:00 pm	**Individual Tracer Activity (cont.)**	Program representative(s) that can facilitate patient tracer activity
4:00-4:30 pm	**Reviewer Planning/Team Meeting** *Planning for review day 2*	

DAY 2

<table>
<tr><th>Time</th><th colspan="2">Activity</th><th>Organization Participants</th></tr>
<tr><td>8:15 am-12:00 pm</td><td colspan="2">Individual Tracer Activity (cont.)</td><td>Program representative(s) that can facilitate patient tracer activity</td></tr>
<tr><td>12:00-12:30 pm</td><td colspan="2">Reviewers Lunch</td><td></td></tr>
<tr><td>12:30-1:30 pm</td><td colspan="2">System Tracer–Data Use Session
Discuss how data is used by program to track performance and improve practice and/or outcomes of care
Discuss selected performance measures, including:
Selection process
Aspects of care and services and outcomes that measures address
Data collection processes (Four months of data for initial certification and 12 months of data for recertification)
How is data reliability and validity conducted?
Reporting and presentation of data
Improvement opportunities discovered through data analysis
Improvements that have already been implemented or are planned based on performance measurement
Discuss patient satisfaction data, including improvements based on feedback</td><td>Interdisciplinary team and those involved in performance improvement</td></tr>
<tr><td>1:30-2:30 pm</td><td colspan="2">Competency and Credentialing Sessions</td><td rowspan="2">Individuals responsible for Program Education
Medical Staff Office representatives
Human Resources</td></tr>
<tr><td></td><td>Education and Competence Process Assessment

Discussion will focus on:
Processes for obtaining team members
Orientation and training processes
Methods for assessing team member competence
Inservice and other ongoing education
Education and competence issues identify during tracer activities
Note: The reviewer will request personnel records and credentials files to review based on team</td><td>Medical Staff Credentialing and Privileging Process Assessment

Discussion will focus on:
Credentialing and privileging process specific to cardiac care, treatment and services
If privileges are appropriate to the qualifications and competencies
Monitoring the performance of practitioners on a continuous basis
Evaluating the performance of licensed independent providers
Identified strength and areas for improvement</td></tr>
</table>

	members and staff encountered throughout the review.	Note: The reviewer will request files of a cardiologist, cardiac interventionalist, cardiovascular surgeon, emergency physician, and/or hospitalist. Additional files may be requested based on tracer activities.	
2:30-3:00 pm	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?		Certification review facilitator Program leaders and staff as requested by the reviewers.
3:00-4:00 pm	**Reviewer Report Preparation**		
4:00-4:30 pm	**Program Exit Conference**		• Program Leadership • Hospital Leadership • Interdisciplinary Team Members

DSC-Advanced Certification for Spine Surgery (ACSS) Addendum

Introduction
The Advanced Certification for Spine Surgery (ACSS) program focuses on the following:

- Provision of integrated, coordinated, patient-centered care that starts with the spine surgery consultation, through pre-, intra- and postoperative phases of care, to the spine 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 spine surgery 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 spine surgery throughout the continuum of care

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

The ACSS certification review occurs over two days. Therefore, time frames for agenda items in the *Certification Review Process Guide* are not applicable to the ACSS certification review. The ACSS agenda reflects the recommended activity time frames for the ACSS 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 ACSS certification must also:

- Apply for certification of the site that provides the procedure--each individual site must independently meet the eligibility criteria and standards
- Have provided spine surgery procedures to a minimum of 200 patients
- Be an active member of the American Spine Registry (ASR) 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 a spine surgery procedure

Advanced Certification for Spine Surgery – 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, spine coordinator, 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 ACSS 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 ACSS patients implemented at the organization which may include: Scope of spine surgery services from the spine consultation through to the spine 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 ACSS program: (Note: This list contains subjects identified earlier in the *Orientation to the Program* activity, *as* well as some additional subjects specific to ACSS. 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 spine surgery patients for tracer selection
- List of patients having spine surgery 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 spine surgery patients for the previous 90 days
- ACSS protocols for care
- Job description for the medical director and spine coordinator
- 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 spine surgery patients, the reviewers in conjunction with program representatives will identify a minimum of six (6) patients for tracing; this may include two (2) closed records. At least one(1) of the patient tracers performed must allow for tracing the intraoperative process.
- The ACSS 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 ACSS protocols related to the patient's specific care, treatment, and services, as required by The Joint Commission's ACSS requirements.
- 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 ACSS 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 another 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 spine surgery 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/back/spine classes/discharge teaching
- Same day surgery
- Anesthesia/block room
- Preoperative holding
- Operating room
- PACU
- Physical therapy/gym
- Inpatient floor
- ICU

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 spine surgery patient

Dependent on timing and availability of staff; the reviewer may plan a conference call with the spine surgeon's office (e.g. MD, scheduling, office staff, APP, 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 two closed patient records. 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 spine surgery patients. Reviewers will also request information about the program's process from the spine surgery consultation to patient arrival for surgery and then from discharge through to the spine 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 ACSS agenda for specific tracer activities.

Reviewer Planning/Team Meeting (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

Daily Briefing (30 minutes)

Organization Participants

- Program clinical and administrative leadership (e.g. CEO, CNO, medical director, spine coordinator, 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 spine surgery 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. ACSS medical director, spine 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 and standardized measure sets
- 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 identifies through the spine surgery 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 spine surgery patients.

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 ACSS:

- Orientation
- Competence assessment for staff caring for ACSS 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 spine surgery 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:

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

Summary Discussion (30 minutes)

Topics that may be addressed include:

- Any issues not yet resolved
- The identified Requirements for Improvement (RFIs)
- Sharing best practices to inspire quality improvement and/or outcomes
- Determination if RFIs will be discussed in detail at closing

The reviewer will work with the organization's certification contact to organize and conduct the summary discussion.

Report Preparation (30 minutes)

The reviewer will use this time to compile, analyze, and organize the data they have 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 ACSS review

Disease Specific Care Certification
Advanced Certification for Spine Surgery Agenda
Two-Day Review Template

Information needed during the Reviewer Planning Session includes:

- Current list of patients being treated in the spine surgery program
- A list of patients having a spine surgery procedure **after opening conference Day 1 or Day 2** of the review
- A list of patients who accessed or progressed through the spine surgery 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 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	**Opening Conference (10 minutes)** • Greetings and introductions • Introductions of key program and organization staff **Orientation to Program (60 minutes)** • 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	Program clinical and administrative leadership (for example, CEO, CNO, medical director, spine coordinator, 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

Time	Activity	Organization Participants
	• Communication and collaboration planning and processes throughout the continuum of care • Transitions of care **Q&A discussion (20 minutes)**	
30 minutes Note: Organization will need to ensure that spine surgery procedures are being performed, either; Day 1 after opening conference **or** Day 2 of the review	**Reviewer Planning Session & Protocol Review Session** • List of spine surgery patients for tracer selection • List of patients having spine surgery 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 spine surgery patients for the previous 90 days • ACSS 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: *Clinical Areas to consider visiting during tracer activity* • 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 • ICU *Interdisciplinary Care Team members to consider interviewing during tracer activity* • 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, APP) to	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

Time	Activity	Organization Participants
	discuss preoperative and follow up visit process within the program	
30 minutes	**Reviewer Lunch**	
2 hours	**Individual Patient Tracer** See description above	See suggested participants noted above
30 minutes	**Reviewer Planning/Team Meeting** Confer at the end of Day 1 and plan for Day 2 of the ACSS review with the organization's staff • Address any issues needing 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	Program representative
30 minutes	**Daily Briefing** Communicate a summary of day one observations to the program representatives and determine if additional information will be needed the following day	Program clinical and administrative leadership (for example; CEO, CNO, medical director, spine coordinator, program interdisciplinary team members) Others at the discretion of the organization

DAY 2

Time	Activity	Organization Participants
Approximately 2 hours 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) Note: **Reviewer will not observe entire surgical procedure**. Flexibility and clear	**Individual Tracer Activity—Intraoperative Experience** **(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 organization instruction The activity will include: • Observation of preoperative process	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

communication with the organization for the ACSS review is imperative, especially during the intraoperative tracer. Dependent on the volume of spine surgery cases, either the afternoon of Day 1 after opening conference or Day 2, the observations may occur within more than one patient and in more than one-time frame.	• 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	
2 hours	**Individual Patient Tracer** See description above	See suggested participants noted above
60 minutes	**System Tracer – Data Use** • 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 spine surgery program quality management process • Activities to improve processes and outcomes	Program clinical and administrative leadership. (Example: ACSS Medical Director, Spine 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: • 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

30 minutes	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	Certification review facilitator Program leaders and staff as requested by the reviewers.
30 minutes	**Reviewer Report Preparation**	
30 minutes	**Program Exit Conference** • 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.

Disease Specific Care Certification

CLINICAL RECORD REVIEW TOOL

(Program use of this tool is optional)

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)

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.

Review Agenda Templates

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

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.	**Opening Conference** (10 minutes) ▪ Greetings and introductions ▪ Introductions of **key** program and organization staff ▪ Brief review of agenda **Orientation to Program** (30 minutes) Topics to be covered include: ▪ 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 **Q & A Discussion** (20 minutes)	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.	**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.	**Individual Tracer Activity** 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.	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**	
1:00 – 1:30 p.m.	**System Tracer – Data Use**	

Time	Activity	Organization Participants
1:30 – 2:00 pm.	During this activity the discussion will focus on the program's selected performance measures.	Program clinical and administrative leadership Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization
2:00 – 2:30 p.m. 2:30 – 3:00 p.m.	**Competence Assessment/Credentialing Process** Discussion during this session will focus on: ▪ 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. Reviewers will request personnel records for review based on various team members and staff encountered or referred to throughout the day.	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
3:00 – 3:30 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	As requested by the reviewer: Certification review facilitator Program leaders and staff
3:30 – 4:00 p.m.	**Reviewer Report Preparation**	
4:00 – 4:30 p.m.	**Program Exit Conference** Reviewer presentation of certification observations and requirements for improvement	Program and clinical leadership Others at the discretion of the organization

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
8:00 – 8:30 a.m. 8:30 – 9:00 a.m.	**Opening Conference (**10-15 minutes) ▪ Reviewer greeting and introduction ▪ Introductions of key system, hospital and DSC program staff ▪ Brief review of agenda **Orientation to Hospital System's DSC Program** (20 minutes) ▪ 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 **Orientation to Individual Hospital's DSC Program** (30 minutes) Topics to be covered include: ▪ 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 **Q & A**	Hospital System's DSC Program leaders and coordinators Individual Hospital's DSC Program leader and coordinator 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.	**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) See the **Disease Specific Care Review Process Guide** for the specific type of information needed in the list.	DSC Program Coordinator or Program Team Member

Time	Activity	Organization Participants
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.	**Individual Tracer Activity** ▪ 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
12:00 – 12:30 p.m.	**Reviewer Lunch**	
12:30 – 1:00 p.m. 1:00 – 1:30 p.m.	**Individual Tracer Activity …continued**	
1:30 – 2:00 pm. 2:00 – 2:30 p.m.	**System Tracer – Data Use** ▪ 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: - 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	Program clinical and administrative leadership Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization
2:30 – 3:00 p.m. 3:00 – 3:30 p.m.	**Competence Assessment/Credentialing Process** 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: ▪ Relevant education, experience and training or certification as required by the program ▪ Current licensure	Individual with authorized access to personnel and credentials files Individual familiar with program-specific requirements for team members—supervisors, managers, leaders

Time	Activity	Organization Participants
	▪ Competence assessment Discussion during this session will include: ▪ 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.	Clinical or medical director, as available
3:30 – 4:00 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	As requested by reviewer
4:00 – 4:30 p.m.	**Hospital DSC Program Interim Exit Conference** ▪ 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

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**	*See Day 1 template for suggested participants and activity details*
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**	
1:00 – 1:30 p.m.		

Disease Specific Care Certification – Multi-Hospital, One Disease, Two-Day Review Agenda

Time	Activity	Organization Participants
1:30 – 2:00 pm. 2:00 – 2:30 p.m.	**Competence Assessment/Credentialing Process**	*See Day 1 template for suggested participants and activity details*
2:30 – 3:00 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	As requested by reviewer
3:00 – 3:30 p.m.	**Reviewer Report Preparation**	
3:30 – 4:00 p.m.	**Hospital DSC Program Interim Exit Conference** ▪ 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** ▪ 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
Two Joint Replacement or Two Spine Surgery Programs*
One-Day Review Agenda Template

* 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.	**Opening Conference** (10 minutes) ▪ Greetings and introductions ▪ Introductions of **key** program and organization staff ▪ Brief review of agenda **Orientation to Both Programs** (30 minutes) Topics to be covered include: ▪ 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 **Q & A Discussion** (20 minutes)	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.	**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 can facilitate tracer

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.	activity, that is, escort the reviewer through the clinical setting following the course of care for the patient
11:00 – 11:30 a.m. 11:30 – 12:00 p.m. 12:00 – 12:30 p.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
12:30 – 1:00 p.m.	**Reviewer Lunch**	
1:00 – 1:30 p.m. 1:30 – 2:00 pm.	**System Tracer – Data Use for Both Programs** During this activity the discussion will focus on each program's selected performance measures.	Program clinical and administrative leadership Individual(s) responsible for performance improvement processes within the program and, as applicable, the organization
2:00 – 2:30 p.m. 2:30 – 3:00 p.m.	**Competence Assessment/Credentialing Process** Discussion during this session will focus on: ▪ 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 with authorized access to personnel and credentials files Individual familiar with program-specific requirements for team members—supervisors, managers, leaders Clinical or medical director
3:00 – 3:30 p.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	As requested by the reviewer: Certification review facilitator Program leaders and staff

Time	Activity	Organization Participants
3:30 – 4:00 p.m.	**Reviewer Report Preparation**	
4:00 – 4:30 p.m.	**Program Exit Conference** Reviewer presentation of certification observations and requirements for improvement	Program and clinical leadership Others at the discretion of the organization

Disease Specific Care Certification
Lung Volume Reduction Surgery Program Certification
Review Agenda Template

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 *(three patients minimum)* Includes visiting/contacting at least the following units/areas: ▪ Thoracic surgery unit ▪ Pulmonary Rehab ▪ Pulmonary Function Testing Laboratory ▪ Pre-op, OR, PACU ▪ Radiology ▪ ICU ▪ Intermediate Care Area Additionally, reviewers will want to have some contact with a patient(s) and will seek assistance from the organization to establish this contact.	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

Time	Activity	Organization Participants
12:30 – 1:00 p.m.	Reviewer Lunch	
1:00 – 1:30 p.m.	Individual Tracer Activity…continued	
1:30 – 2:00 p.m.		
2:00 – 2:30 p.m.		
2:30 – 3:00 p.m.		
3:00 – 3:30 p.m.	System Tracer – Data Use	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.		
4:00 – 4:30 p.m.	Reviewer Planning Session/Team Meeting	As requested by the reviewer: • Certification review facilitator • Program leaders and staff

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.		

Time	Activity	Organization Participants
10:30 – 11:00 a.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	As requested by the reviewer: Certification review facilitator Program leaders and staff
11:00 – 11:30 a.m.	Reviewer Report Preparation	
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
Review Agenda Template

Information needed during the Preliminary Planning activity

- Current list of hospitalized patients that have received or are scheduled to receive a VAD
- A list of all outpatients with a long-term VAD receiving care, treatment, or services from the program
- 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 – 9:00 a.m.	**Opening Conference and Orientation to Program**	• Program's clinical and administrative leadership • Hospital Leadership
9:00 – 9:30 a.m.	**Reviewer Planning Session**	Program representatives who can facilitate patient selection and tracer activity
9:30 – 12:30 p.m.	**Individual Tracer Activity** • Tour of patient care areas, patient interviews and staff interviews o May include ED, medical/surgical or critical care cardiac units, operating room, PACU or cardiac ICU, interventional/cardiac cath labs, or clinic. o Includes staff interviews o Includes patients and family interview, if willing to participate. • Interactive review of patient records with team member or organization staff actively working with the patient—the patient's course of care, treatment and services up to the present and anticipated for the future • At the conclusion of tracers, the reviewer will communicate to the organization leaders and care providers: o Specific observations made o Issues that will continue to be explored in another tracer activity o Need for additional records to verify standards compliance, confirm procedures, and validate practice	Program representatives who can facilitate tracer activity
12:30 – 1:00 p.m.	**Reviewer Lunch**	
1:00 – 4:00 p.m.	**Individual Tracer Activity…continued**	
4:00 – 4:30 p.m.	**Reviewer Planning Session**	• Program's Joint Commission contact • Others requested by reviewer

DAY 2

Time	Activity	Organization Participants
8:00 – 8:15 a.m.	**Daily Briefing** A brief summary of the first day's observations will be provided	As determined by the Center or organization
8:15 – 9:30 a.m.	**System Tracer–Data Use Session** Please have the following information available: • Performance improvement (PI) data • Audited registry data for required registry – (such as INTERMACS) Discuss how data is used by the program to track performance and improve practice and/or outcomes of care. Discuss selected performance measures, including: • How data reliability and validity is conducted • Improvement opportunities discovered through data analysis • Improvements based on performance measurement • Patient satisfaction data and improvements made to the program based on patient feedback	Inter-disciplinary Team and those involved in Performance Measurement review
9:30 – 10:30 a.m.	**Competence Assessment/Credentialing Process** Discussion will include a focus on: • Processes for obtaining team members • Orientation and training processes • Methods for assessing team member competence • Inservice and ongoing education and training for program team members (including providers) • Education and competence issues identify during tracer activities • Credentialing and privileging process specific to VAD care, treatment and services • Privileges as appropriate to qualifications and competencies for VAD • Monitoring the performance of practitioners on a continuous basis • Evaluating the performance of licensed independent providers • Identified strength and areas for improvement Provider Files • Current licensure and DEA • Most recent re-appointment letter • Privileges and accompanying documentation • Board certification(s) • OPPE or FPPE (two most recent) • Program specific competency/education at onboarding/orientation to VAD	• Individuals responsible for Program Education • Medical Staff Office Personnel • Human Resources

Time	Activity	Organization Participants
	• Surgical training for surgeons • Program specific continuing VAD education (attestation and/or evidence of CME) Staff Files • Licensure (if applicable) • Certification (if applicable) • Most recent performance evaluation • Job description • Program specific *orientation* education & competency • Program specific *ongoing* education & competencies	
10:30 – 11:00 a.m.	**Individual Tracer Activity (cont.) and Issue Resolution** Reviewer may ask to review additional patient records or program documents to verify standards compliance, if needed	• Program representatives who can facilitate tracer activity • Others requested by reviewer
11:00 – 11:30 a.m.	**Summary Discussion** This time will be utilized for a final discussion prior to the reviewer's report preparation and the exit conference. Topics that may be discussed include: • Any issues not yet resolved (IOUs) • The identified Requirements For Improvement (RFIs) • Sharing best practices to inspire quality improvement and/or outcomes • Educative activities of value to the program (i.e., knowledge sharing related to CPGs or the latest scientific breakthroughs) • Were the goals of your team met during this review? • What made the review meaningful to the team?	• Program's Joint Commission contact • Others requested by reviewer
11:30 – 12:30 p.m.	**Reviewer Report Preparation**	
12:30 – 1:00 p.m.	**Program Exit Conference**	• Program Leadership • Hospital Leadership • Interdisciplinary Team Members • Program's Joint Commission contact • Others at Program's discretion

Page intentionally left blank.