The Joint Commission: Comprehensive Overview of Advanced Stroke & Advance Heart Failure Programs

WA State Cardiac & Stroke Conference
Brian R. Johnson, Ph.D.
Associate Director
Hospital Business Development
September 13, 2016
Today’s Agenda

- The Core Elements of Certification
- Three Levels of Stroke Certification
- Advanced Heart Failure Certification

Additional Sources
- Preparation and Timeline
- The On-Site Review Process
Core Program Components

3,443 certified programs

- Standards
- Clinical Practice Guidelines
- Performance Measures
### Standard Chapters:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>Certification Participation Requirements</td>
</tr>
<tr>
<td>DSPR</td>
<td>Program Management</td>
</tr>
<tr>
<td>DSDF</td>
<td>Delivering or Facilitating Care</td>
</tr>
<tr>
<td>DSSE</td>
<td>Supporting Self Management</td>
</tr>
<tr>
<td>DSCT</td>
<td>Clinical Information Management</td>
</tr>
<tr>
<td>DSPM</td>
<td>Performance Management</td>
</tr>
</tbody>
</table>
Clinical Practice Guidelines

- Patient care must be based on guidelines / evidence-based practice
- Program identifies the guidelines it will use
- To reduce inappropriate variation in practice
- On-site review validates:
  - Rationale for selection / modification
  - Implementation of CPGs
  - Monitoring & improving adherence
Clinical Practice Guidelines

Where to locate Clinical Practice Guidelines:

National Guideline Clearinghouse
Performance Measures

The program collects measurement data to evaluate processes and outcomes
- Process measures
- Public reporting of interventional outcomes
- Identification of opportunities incorporated into PI program

The program has an organized, comprehensive approach to performance improvement
- Identify goals and set priorities
- Peer review process
- Monitoring complications
Today’s Agenda

- The Core Elements of Certification
- Three Levels of Stroke Certification
- The Advanced Heart Failure Certification
- Preparation and Timeline
- The On-Site Review
The Stroke Care Pyramid

Basic Care Hospital:
Assessment, identification, stabilization & transfer

Acute Stroke Ready Hospitals:
IV tPA, CT scanner, acute stroke expertise (via TeleStroke if needed)

Primary Stroke Center:
Stroke Unit, coordinator, Stroke Service, continuum of inpatient care

Comprehensive Stroke Center:
All PSC functions plus Neurosurgeon
Neuroendovascular, and full spectrum of hemorrhagic stroke care

~150-200
~1200-1500
~1200-1500
Acute Stroke Ready Hospital (ASRH)

- Launched in July 2015

- The Joint Commission’s ASHR program was developed with input from a group of experts from across the nation who participated in our Technical Advisory Panel (TAP) and field review all provided input into the requirements

  - **Formation and Function of Acute Stroke-Ready Hospitals Within a Stroke system of Care Recommendations from the Brain Attack Coalition (Stroke, 2013)**
Why Acute Stroke Ready …?

- Geography matters: 50% of the US population lives 60 minutes or more away from a PSC/CSC
- Serving the need of small and/or rural communities
- Suitable for small facilities (rural Acute Care Hospital or Critical Access Hospital (~100 beds or less)

- Getting patients to the nearest “stroke-ready” facility
- Limited staffing and resources
- Capitalizing on EMS expertise and collaborative PSCs and CSCs
Significant role for ASRHs

- Changing stroke demographics
  - Evolving tPA treatment rates
  - Developing national stroke system of care
  - Decreased all-cause mortality
    - Stroke decreased to 5th leading cause of death
    - Decrease ischemic stroke mortality
    - Relatively stable mortality for ICH and SAH
  - Increased number of stroke survivors and stroke prevalence expected over next 30 years
ASRH Eligibility– Requirements

- General Criteria
  - Stroke journal article; “Formation and Function of Acute Stroke Ready Hospital within a Stroke System of Care Recommendations from the Brain Attack Coalition – November 2013

- Clinical Practice Guidelines: Organizations can select from a variety of sources

- Performance Measures: Stage 1 requirements (4)
  - Performance improvement process
  - Measuring effectiveness
5 Key Elements of an ASRH: (Drip and Ship)

1. Relationship with EMS – support training in field assessment and communication ED
2. Stroke protocols & acute stroke team to expedite assessment & treatment of stroke
3. Ability to perform imaging & lab testing 24/7 and results within 45 minutes
4. Access to stroke expertise 24/7 (via in person or telemedicine) & transfer agreements with facilities that provide PSC/CSC services
5. Ability to administer IV-tPA
ASRH - Performance Measurement

- Four process or outcome measures to monitor on an ongoing basis
- At least two of the measures must be clinical
- Up to two measures can be non-clinical: administrative, utilization, financial, patient satisfaction, etc.
- Currently Stage 1 – However standardized measures coming in 2017
What Makes a Good Performance Measure?

- Results can be used for improvement
- Examples appropriate for ASRH
  - Door to administration of IV thrombolytic time
  - Turn around time for head CT/laboratory results
  - Practitioner response time to code stroke
  - Patient complication rate s/p IV thrombolytic
  - Time to telemedicine link initiation
Basic Care Hospital:
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The Stroke Care Pyramid
~150-200
~1200-1500
~1200-1500
Primary Stroke Centers (PSC)

- Launched in 2003

- The Joint Commission’s PSC program was developed with input from a group of experts from across the nation who participated in our Technical Advisory Panel (TAP) and field review all provided input into the requirements

- Revised in July 2014 to account for:
PSC – Standardized Performance Measures

Stroke National Hospital Inpatient Quality Measures

<table>
<thead>
<tr>
<th>Set Measure No.</th>
<th>Measure Short Name</th>
<th>Ischemic Stroke</th>
<th>Hemorrhagic Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>STK-1</td>
<td>Venous Thromboembolism (VTE) Prophylaxis</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>STK-2</td>
<td>Discharged on Antithrombotic Therapy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>STK-3</td>
<td>Anticoagulation Therapy for Atrial Fibrillation/Flutter</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>STK-4</td>
<td>Thrombolytic Therapy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>STK-5</td>
<td>Antithrombotic Therapy By End of Hospital Day 2</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>STK-6</td>
<td>Discharged on Statin Medication</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>STK-8</td>
<td>Stroke Education</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>STK-10</td>
<td>Assessed for Rehabilitation</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Details can be found in the Specifications Manual for National Hospital Inpatient Quality Measures at [www.jointcommission.org](http://www.jointcommission.org)
The Stroke Care Pyramid

- **Basic Care Hospital:**
  - Assessment, identification, stabilization & transfer

- **Acute Stroke Ready Hospitals:**
  - IV tPA, CT scanner, acute stroke expertise (via TeleStroke if needed)

- **Primary Stroke Center:**
  - Stroke Unit, coordinator, Stroke Service, continuum of inpatient care

- **Comprehensive Stroke Center:**
  - All PSC functions plus Neurosurgeon, Neuroendovascular, and full spectrum of hemorrhagic stroke care
Comprehensive Stroke Centers (CSC)

- Launched in September 2012, revised in 2013 with input from Technical Advisory Panel and Field

- Standards developed from evidence-based guidelines and a multidisciplinary advisory panel of technical experts

  - Recommendations for Comprehensive Stroke Centers: A Consensus Statement from the Brain Attack Coalition (Stroke, 2005)

  - Comprehensive Overview of Nursing and Interdisciplinary Rehabilitation Care of the Stroke Patient: A Scientific Statement from the American Heart Association (Stroke, 2010)
CSC Eligibility - Requirements

1. Volume of cases
   - Subarachnoid hemorrhage caused by an aneurysm: 20/year
     - Microsurgical clippings or Endovascular coiling procedures: 15/year
     - Intravenous (IV) tissue plasminogen activator: 25/year

2. Advanced imaging capabilities
   - Carotid duplex ultrasound
   - Catheter angiography available on site 24 hours a day, 7 days a week
   - CT angiography available on site 24 hours a day, 7 days a week
   - Extracranial ultrasonography
   - MR angiography (MRA) available on site 24 hours a day, 7 days a week
   - MRI, including diffusion-weighted MRI, available on site 24 hours a day,
     - 7 days a week
   - Transcranial Doppler
   - Transesophageal echocardiograph
   - Transthoracic echocardiography
CSC Eligibility – Requirements…Cont.

3. Post-hospital care coordination for patients

4. The hospital will have dedicated neuro-intensive care unit (ICU) beds for complex stroke patients, including licensed independent practitioners and staff with the expertise and experience to provide on-site, neuro-critical care 24 hours a day, 7 days a week.

5. Peer review process
   - The hospital will have a peer review process to review and monitor the care provided to patients with ischemic stroke, subarachnoid hemorrhage and administration of tPA.
   - Part of the CSC’s quality improvement process
   - Includes a performance improvement plan when needed

6. Participation in stroke research
   - IRB approved, patient-centered research
Performance Measurement

CSCs must collect data on 16 Performance Measures
- 8 Primary Stroke Measures
- 8 Comprehensive Stroke Measures
## CSC – Standardized Performance Measures

<table>
<thead>
<tr>
<th>CSTK-01</th>
<th>NIHSS Performed for Ischemic Stroke Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSTK-02</td>
<td>Modified Rankin Score at 90 Days</td>
</tr>
<tr>
<td>CSTK-03</td>
<td>Severity Measurement Performed for SAH and ICH Patients (Overall Rate)</td>
</tr>
<tr>
<td>CSTK-04</td>
<td>Procoagulant Reversal Agent Initiation for ICH</td>
</tr>
<tr>
<td>CSTK-05</td>
<td>Hemorrhagic Transformation (Overall Rate)</td>
</tr>
<tr>
<td>CSTK-06</td>
<td>Nimodipine Treatment Administered</td>
</tr>
<tr>
<td>CSTK-07</td>
<td>Median Time to Revascularization</td>
</tr>
<tr>
<td>CSTK-08</td>
<td>Thrombolysis in Cerebral Infarction Post-Treatment Reperfusion Grade</td>
</tr>
</tbody>
</table>
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### Heart Failure Certification

#### Core DSC vs. Advanced Certification

<table>
<thead>
<tr>
<th>Core Disease-Specific in Heart Failure</th>
<th>Advanced Certification in Heart Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses core DSC standards</td>
<td>Core DSC standards plus additional expectations for transitions of care</td>
</tr>
<tr>
<td>Organization chooses clinical practice guidelines to implement</td>
<td>Certified Bronze-Level or higher on Get With The Guidelines</td>
</tr>
<tr>
<td>Organization chooses four performance measures</td>
<td>Standardized performance measures</td>
</tr>
<tr>
<td>Not setting-specific</td>
<td>Inpatient program, but requires either hospital HF clinic or formal arrangement with cardiology practice</td>
</tr>
</tbody>
</table>

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Performance Measurement Criteria for Advanced HF

- Six required inpatient measures
- Seven optional outpatient measures
- Full specifications at [www.jointcommission.org](http://www.jointcommission.org)
  - ACHF Performance Measurement Implementation Guide
Advanced HF Performance Measures -
6 Inpatient Required

- **ACHF-01**: Beta-blocker Therapy for LVSD
  Prescribed at Discharge

- **ACHF-02**: Post-discharge appointment for Heart
  Failure Patients

- **ACH-03**: Care Transition Record Transmitted

- **ACHF-04**: Discussion of Advanced
  Directives/Advance Care Planning

- **ACHF-05**: Advance Directive Executed

- **ACHF-06**: Post-Discharge Evaluation for Heart
  Failure Patients.
Advanced HF Performance Measures – 7 Outpatient Optional

- **ACHFOP-01**: Hospital Outpatient Beta-Blocker Therapy Prescribed for LVSD
- **ACHFOP-02**: Hospital Outpatient ACEI or ARB Prescribed for LVSD
- **ACHFOP-03**: Hospital Outpatient Aldosterone Receptor Antagonists prescribed for LVSD
- **ACHFOP-04**: Hospital Outpatient New York Heart Association (NYHA) Classification Assessment
- **ACHFOP-05**: Hospital Outpatient Activity Recommendations
- **ACHFOP-06**: Hospital Outpatient Discussion Of Advanced Directives/Advance Care Planning
- **ACHFOP-07**: Hospital Outpatient Advance Directive Executed
Benefits of Certification

- Builds the structure required for a systematic approach to clinical care
- Reduces variability and improves the quality of patient care
- Pushes you to look at yourself more closely
- Creates a loyal, cohesive clinical team
- Promotes a culture of excellence across the organization
- Provides an objective assessment of clinical excellence
- Promotes achievement to your community
Questions?

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Additional Sources
- Preparation and Timeline
- The On-Site Review Process
Additional Resources
## Stroke Certification Programs

<table>
<thead>
<tr>
<th>Program Concept</th>
<th>ASRH</th>
<th>PSC</th>
<th>CSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Medical Director</td>
<td>Sufficient knowledge of cerebrovascular disease</td>
<td>Sufficient knowledge of cerebrovascular disease</td>
<td>Has extensive expertise; available 24/7; 8 hours of stroke education annually</td>
</tr>
<tr>
<td>Acute Stroke Team</td>
<td>Available 24/7, at bedside within 15 minutes</td>
<td>Available 24/7, at bedside within 15 minutes</td>
<td>Available 24/7, at bedside within 15 minutes</td>
</tr>
<tr>
<td>Emergency Medical Services Collaboration</td>
<td>Access to protocols used by EMS</td>
<td>Access to protocols used by EMS</td>
<td>Access to protocols used by EMS, routing plans; records from transfer</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>No designated beds for acute care of stroke patients</td>
<td>Stroke unit or designated beds for the acute care of stroke patients</td>
<td>Dedicated neuro intensive care beds for complex stroke patients available 24/7</td>
</tr>
<tr>
<td>Initial Assessment of Patient</td>
<td>Emergency Department physician, nurse practitioner, or physician assistant</td>
<td>Emergency Department physician</td>
<td>Emergency Department physician</td>
</tr>
<tr>
<td>Diagnostic Testing Capability</td>
<td>CT, labs 24/7 (MRI 24/7 if used)</td>
<td>CT, MRI, labs, CTA, MRA 24/7, and cardiac imaging when necessary</td>
<td>CT, MRI, labs, CTA, MRA, other cranial and carotid duplex ultrasound, TEE, TTE, catheter angiography 24/7 and cardiac imaging when necessary</td>
</tr>
<tr>
<td>Neurologist Accessibility</td>
<td>24/7 via in person or telemedicine</td>
<td>24/7 via in person or telemedicine</td>
<td>Meets concurrently emergent needs of multiple complex stroke patients; Written call schedule for attending physicians providing availability 24/7</td>
</tr>
<tr>
<td>Neurosurgical Services</td>
<td>Within 3 hours (provided through transferring the patient)</td>
<td>Within 2 hours; OR is available 24/7 in PSCs providing neurosurgical services</td>
<td>24/7 availability: Neurointerventionalist; Neuroradiologist; Neurologist; Neurosurgeon</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>Within 20 minutes of it being necessary</td>
<td>Available if necessary</td>
<td>Available if necessary</td>
</tr>
<tr>
<td>Treatment Capabilities</td>
<td>IV thrombolytics; Anticipate transfer of patients who have received IV thrombolytics</td>
<td>IV thrombolytics; May have the ability to perform the following: Neurovascular interventions for aneurysms, Stenting of carotid arteries, Carotid endarterectomy, and Endovascular therapy</td>
<td>IV thrombolytics; Microsurgical neurovascular clipping of aneurysms; Neuroendovascular coiling of aneurysms; Stenting of extracranial carotid arteries; Carotid endarterectomy; Endovascular therapy</td>
</tr>
<tr>
<td>Transfer protocols</td>
<td>With one PSC or CSC</td>
<td>For neurosurgical emergencies</td>
<td>Receiving transfers and circumstances for not accepting transferred patients</td>
</tr>
<tr>
<td>Staff Stroke Education Requirements</td>
<td>ED staff – a minimum of twice a year; core stroke team at least 4 hours annually</td>
<td>ED staff – a minimum of twice a year; core stroke team at least 8 hours annually</td>
<td>Nurses and other ED staff - 2 hours annually; Stroke nurses and core stroke team - 8 hours annually</td>
</tr>
<tr>
<td>Provision of Educational Opportunities</td>
<td>Provides educational opportunities to prehospital personnel</td>
<td>Provides educational opportunities to prehospital personnel; Provides at least 2 stroke education activities per year to public</td>
<td>Sponsors at least 2 public educational opportunities annually; LIPs and staff present 2 or more educational courses annually for internal staff or individuals external to the comprehensive stroke center (e.g., referring hospitals)</td>
</tr>
<tr>
<td>Clinical Performance Measures</td>
<td>Non-Standardized Measures: Organization chooses 4 measures, at least 2 are clinical measures related to clinical practice guidelines</td>
<td>Standardized Measures: 8 core stroke measures</td>
<td>Standardized Measures: 8 core stroke measures and 8 comprehensive stroke measures for a total of 16</td>
</tr>
<tr>
<td>Research</td>
<td>N/A</td>
<td>N/A</td>
<td>Participates in patient-centered research that is approved by the IRB</td>
</tr>
<tr>
<td>Guidelines</td>
<td>Recommendations from Brain Attack Coalition for Acute Stroke Ready Hospitals, 2013</td>
<td>Recommendations from Brain Attack Coalition for Primary Stroke Centers, 2011</td>
<td>Recommendations from Brain Attack Coalition for Comprehensive Stroke Centers, 2005</td>
</tr>
<tr>
<td>Review</td>
<td>One Reviewer, One Day</td>
<td>One Reviewer, One Day</td>
<td>Two Reviewers, Two Days</td>
</tr>
</tbody>
</table>
Preparation Tips

- Review the standards in the *Disease-Specific Care Certification Manual*.
- Contact the Standards Interpretation Group:
  630-792-5900
  [http://www.jointcommission.org/standards_information/standards_online_question_form.aspx](http://www.jointcommission.org/standards_information/standards_online_question_form.aspx)
- Submit Performance Measure questions to
  [http://manual.jointcommission.org](http://manual.jointcommission.org)
- Pricing Unit for Certification Fees
  630-792-5115
Preparation Tips

- Conduct a gap analysis of current state versus the expectations of the standards.
- Conduct a mock certification review. Document areas of potential compliance or noncompliance.
- Develop preparation action plans from the results of the gap analysis and mock review and determine your certification timeline.
Advertise Your Achievement

- Notify your Marketing Dept. in advance of certification completion

Certification Publicity Kit

The information provided on this page is intended to help Joint Commission certified organizations publicize their certification and commitment to quality.

FAQs

- May we use the Joint Commission corporate logo in our publicity efforts?
- May we use a quote from a Joint Commission reviewer?
- What is the Pantone Matching System (PMS) color of the Gold Seal?

Achieve the Gold Seal

Collaborative Certification Publicity Kits

- Heart Failure
- Comprehensive Stroke Center
- Primary Stroke Center
- Acute Stroke Ready Hospital

Certification Program Publicity Kits
Preparing for Your Site Visit

- Request assistance from your accreditation/quality department
- Utilize your resources
- Mirror tracer experience
  - Increases staff comfort level in presenting patient case
- Interprofessional team discussion
  - Individual role and communication as a team
Certification Timeline

**Pre**
- Gap analysis to standards and guidelines; resolution of any gaps
- Apply 4-6 months before desired review date
- Data Collection

**Visit**
- 30 days advance notification of date
- Two reviewers, two days

**Post**
- Data collection and submission
- Intracycle conference call 12 months after visit
- Apply for recertification

**Visit**
- Recertification visit occurs 2 years after initial visit
- To be scheduled within 90 day window around anniversary date
- 7 days advance notice of date
The On-Site Evaluation

Activities:
- Program overview
- Patient tracers
- System tracer on data use
- Competency assessment and credentialing

Engaging practitioners and patients

Educational Opportunities
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