Update: Joint Commission Stroke Certification Standards and SAFER Scoring Matrix

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Associate Director, Certification
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Today’s Agenda

- Three Levels of Stroke Certification
- The Core Elements of Certification
- Preparation and Timeline
- The On-Site Review
- The SAFER Matrix
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

Certified Programs (as of 3/24/17)
- 3,573 certified programs in all categories
- 123 Comprehensive Stroke Centers
- 1,107 Primary Stroke Centers
- 26 Acute Stroke Ready certifications
### Comparison Grid: On Arrival

<table>
<thead>
<tr>
<th>Topic</th>
<th>ASRH</th>
<th>PSC</th>
<th>CSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessment personnel</td>
<td>ED physician, nurse practitioner, or physician assistant</td>
<td>ED physician</td>
<td>ED physician</td>
</tr>
<tr>
<td>Diagnostic testing capability</td>
<td>CT or MRI, labs available 24/7</td>
<td>CT, MRI, labs, CTA, MRA, cardiac imaging available 24/7</td>
<td>CT, MRI, labs, CTA, MRA, cardiac imaging, other cranial and carotid duplex ultrasound, TEE, TTE, catheter angiography 24/7</td>
</tr>
</tbody>
</table>

### Comparison Grid: Treatment

<table>
<thead>
<tr>
<th>Topic</th>
<th>ASRH</th>
<th>PSC</th>
<th>CSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment capabilities</td>
<td>IV thrombolytics. Anticipate transfer to PSC or CSC</td>
<td>IV thrombolytics. May also offer endovascular therapies</td>
<td>IV thrombolytics. Coiling and clipping of aneurysms; stenting of extracranial carotid arteries; carotid endarterectomy; endovascular therapies</td>
</tr>
<tr>
<td>Neurosurgical Services</td>
<td>Available within 3 hours thru transfer</td>
<td>Either thru transfer or onsite within 2 hours</td>
<td>Available 24/7: neuro-interventionalist, neuro-radiologist, neurologist, neurosurgeon</td>
</tr>
</tbody>
</table>
### Comparison Grid: Misc.

<table>
<thead>
<tr>
<th>Topic</th>
<th>ASRH</th>
<th>PSC</th>
<th>CSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke unit</td>
<td>No designated beds for acute stroke patients</td>
<td>Stroke unit or designated beds for acute stroke patients</td>
<td>Dedicated neuro intensive care beds available 24/7</td>
</tr>
<tr>
<td>Staff Education</td>
<td>• Core stroke team: 4 hours/year</td>
<td>• Core stroke team: 8 hours/year</td>
<td>• Core stroke team: 8 hours/year</td>
</tr>
<tr>
<td></td>
<td>• ED Staff: twice a year</td>
<td>• ED Staff: twice a year</td>
<td>• ED Staff: 2 hours/year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Stroke nurses: 8 hours per year</td>
</tr>
</tbody>
</table>

### Core Program Components

- Standards
- Clinical Practice Guidelines
- Performance Measures
Disease-Specific Care Standards

- Program Management
  7 standards
- Delivering or Facilitating Clinical Care
  6 standards
- Supporting Self-Management
  3 standards
- Clinical Information Management
  5 standards
- Performance Improvement and Measurement
  6 standards

Clinical Practice Guidelines

- Patient care must be based on guidelines / evidence-based practice
- Program identifies the guidelines it uses
- Most hospitals use the AHA’s Get With The Guidelines for stroke, but it is not specifically required.
Clinical Practice Guidelines

- Most frequently-cited requirement for improvement: approx. 35% of reviews cite stroke programs for not delivering care according to CPGs
  - Frequently this is due to missing documentation in the medical record.

ASRH – Non-Standardized Measures (for now)

- Choose four performance improvement measures
- At least two clinical measures
- Four months of data required at time of on-site review
- Standardized measures coming for 2018.
PSC and CSC - Standardized Measures

- Share four months of trended data at initial onsite visit
- Monitor data monthly
- Submit data quarterly to The Joint Commission

PSC Performance 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>X</td>
<td></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>X</td>
<td></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>X</td>
<td></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
CSC Performance Measures

Joint Commission Quality Measures for Disease-Specific Care Certification

<table>
<thead>
<tr>
<th>Measure Short Name</th>
<th>Ischemic Stroke</th>
<th>Hemorrhagic Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Institutes of Health Stroke Scale (NIHSS) Score Performed for Ischemic Stroke Patients</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Modified Rankin Score (mRS) at 90 Days</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Severity Measurement Performed for Subarachnoid Hemorrhage (SAH) and Intracerebral Hemorrhage (ICH) Patients (Overall Rate)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Procoagulant Reversal Agent Initiation for Intracerebral Hemorrhage (ICH)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hemorrhagic Transformation (Overall Rate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nimodipine Treatment Administered</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Median Time to Revascularization</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
Certification Timetable

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
• ASRH and PSC: One reviewer x one day
• CSC: Two reviewers x 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
  – Engaging practitioners and patients
– System tracer on data use
– Competency assessment and credentialing
– Summary of findings

Educational Opportunities
• One day per certification
SAFER™

Survey Analysis for Evaluating Risk (SAFER)

- A transformative approach for identifying and communicating risk levels associated with deficiencies cited during reviews
- Helps organizations prioritize and focus corrective actions
- Provides one, comprehensive visual representation of findings
- Replaces current scoring methodology
- **Implementation: January 2017**
The Joint Commission’s Survey Analysis for Evaluating Risk (SAFER) Matrix™

<table>
<thead>
<tr>
<th>Immediate Threat to Life (a threat that represents immediate risk or may potentially have serious adverse effects on the health of the patient, resident, or individual served)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood to Harm a Patient/Staff/Visitor</td>
</tr>
<tr>
<td>HIGH (harm could happen at any time)</td>
</tr>
<tr>
<td>MODERATE (harm could happen occasionally)</td>
</tr>
<tr>
<td>LOW (harm could happen, but would be rare)</td>
</tr>
</tbody>
</table>

**Scope**

<table>
<thead>
<tr>
<th>Label</th>
<th>Definition</th>
<th>Further Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIDESPREAD</td>
<td>Deficiency is pervasive in the facility, or represents systemic failure, or has the potential to impact most/all patients, visitors, staff</td>
<td>Process Failure. Scope is widespread when the deficiency affects most/all patients, is pervasive in the facility or represents systemic failure. Widespread scope refers to the entire organization, not just a subset of patients or one unit.</td>
</tr>
<tr>
<td>PATTERN</td>
<td>Multiple occurrences of the deficiency, or a single occurrence that has the potential to impact more than a limited number of patients, visitors, staff</td>
<td>Process Variation. Scope is pattern when more than a very limited number of patients are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same patient(s) have been affected by repeated occurrences of the same deficient practice.</td>
</tr>
<tr>
<td>LIMITED</td>
<td>Unique occurrence that is not representative of routine/regular practice, and has the potential to impact only one or a very limited number of patients, visitors, staff</td>
<td>An outlier. Scope is isolated when one or a very limited number of patients are affected and/or one or a very limited number of staff are involved, and/or the deficiency occurs in a very limited number of locations.</td>
</tr>
</tbody>
</table>
### Likelihood to Harm

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<th>Definition</th>
<th>Further Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>Harm could happen at any time</td>
<td>If the deficiency continues, it would be likely that harm could happen at any time to any patient (or did actually happen). Could directly lead to harm without the need for other significant circumstances or failures.</td>
</tr>
<tr>
<td>MODERATE</td>
<td>Harm could happen occasionally</td>
<td>If the deficiency continues, it would be possible that harm could occur but only in certain situations and/or patients. Could cause harm directly, but more likely to cause harm as a contributing factor in the presence of special circumstances or additional failures.</td>
</tr>
<tr>
<td>LOW</td>
<td>Harm could happen, but would be rare</td>
<td>It would be rare for any actual patient harm to occur as a result of the deficiency. Undermines safety/quality or contributes to an unsafe environment, but very unlikely to directly contribute to harm.</td>
</tr>
</tbody>
</table>

### A picture is worth 1000 words

<table>
<thead>
<tr>
<th>Scope</th>
<th>Immediate Threat to Life</th>
<th>Moderate Threat to a Patient/Staff/Visitor</th>
<th>Low Threat to a Patient/Staff/Visitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited</td>
<td></td>
<td>DSPR.5, EP 1</td>
<td>DSDF.5, EP 1</td>
</tr>
<tr>
<td>Pattern</td>
<td></td>
<td>DSPR.1, EP 6</td>
<td>DSDF.4, EP 2</td>
</tr>
<tr>
<td>Widespread</td>
<td></td>
<td>DSCT.5, EP 5</td>
<td>DSDF.4, EP 2</td>
</tr>
</tbody>
</table>

Immediate Threat to Life is a threat that represents immediate risk or may potentially have serious adverse effects on the health of the patient, resident, or individual served.

Limited is an occurrence that is not representative of routine/regular practice.

Pattern is multiple occurrences with potential to impact few/some patients, visitors, staff and/or settings.

Widespread is multiple occurrences with potential to impact most/all patients, visitors, staff and/or settings.
Example #1

In 1 of 5 records reviewed, the program did not meet the patient’s needs based on clinical practice guidelines as evidenced by aspirin not given on hospital day 2 but hospital day 3. Patient was evaluated on hospital day 2 by speech language pathologist and found to be safe for oral medications/food. Aspirin was delayed until the next day.

Example #2

In 1 of 4 records reviewed, the program did not meet the patient’s needs for reassessments per chosen clinical practice guidelines as evidenced by one set of vital signs missing after the administration of Alteplase at 1700. Vital signs were present at 1638 and 1730.
Example #3

Care was not implemented according to clinical practice guidelines for patients presenting with acute ischemic stroke:

1. There was a delay by the neurologist to evaluate the patient and make a decision regarding the use of Alteplase. Alteplase administration was delayed approximately 45 minutes.

2. The program did not implement care and treatment according to assessed needs. Patient presented to ED with acute stroke symptoms. Blood pressure elevated, but treatment was not initiated in a timely manner to treat blood pressure.

3. The program did not implement care and treatment according to assessed needs. Patient with acute stroke without nutrition for 10 days. This was noted on rounds daily but not acted on by admitting physician.

Example #4

- The program leader(s) do not provide for the uniform performance of care, treatment, and services. In review of CEA patients, it was noted that the post CEA patients cared for in the ICU did not have post CEA orders. The only vital sign and neurological assessment monitoring orders were from the SICU admission orders (every 1 hour). The CSC needs to have standing order-sets for the care of the post CEA patient to ensure uniform care, treatment, and services.
Follow-up Actions

Follow-up customized and prioritized according to placement within SAFER Matrix

Prioritized Follow-up Action

<table>
<thead>
<tr>
<th>SAFER Matrix™ Placement</th>
<th>Required Follow-Up Activity</th>
</tr>
</thead>
</table>
| HIGH LIMITED, HIGH PATTERN, HIGH WIDESPREAD | • 60 day Evidence of Standards Compliance (ESC)  
ESC will include Who, What, When, and How sections  
ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis  
Finding will be highlighted for potential review by reviewers on subsequent visits |
| MODERATE / PATTERN, MODERATE / WIDESPREAD | • 60 day Evidence of Standards Compliance (ESC)  
ESC will include Who, What, When, and How sections  
ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis  
Finding will be highlighted for potential review by reviewers on subsequent visits |
| MODERATE / LIMITED, LOW / PATTERN, LOW / WIDESPREAD | • 60 day Evidence of Standards Compliance (ESC)  
ESC will include Who, What, When, and How sections |
| LOW / LIMITED | • 60 day Evidence of Standards Compliance (ESC)  
ESC will include Who, What, When, and How sections |
ESC Changes

- All Requirements for Improvement (RFIs) due in a 60 day ESC
  - 45 day ESC no longer applicable
- All findings require an ESC
  - OFI section of the report no longer applicable
- Findings of higher risk require 2 additional ESC fields

Benefits of the SAFER matrix

- Focus on patient safety
- Risk analysis
  - Takes each finding to the next level – the “so-what?” as to why the finding is important
- Visual representation of review
- Aggregate data for standards refinement, improving consistency, etc.
Resources Available

Extranet Site:

The Joint Commission Connect™

- Pre-Review
  - Learn More
  - Program Requirements - DISC
  - Review Process Guide - DISC
  - Agenda

- Post-Review
  - Learn More
  - Evidence of Standards Compliance
  - Measure of Success
  - Plan of Correction
  - Certification Report and Letter
  - Certification SAFER™ Matrix

- Quality Check
  - Learn More

- Customer Feedback
  - Learn More
  - Evaluations

- Application for Certification
  - Learn More
Resources Available

**SAFER Tool Home Page:**

<table>
<thead>
<tr>
<th>Resource Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFER™ Extract Tool User Guide</td>
</tr>
<tr>
<td>SAFER™ Integrative and Operational Definitions</td>
</tr>
<tr>
<td>SAFER® PowerPoint Presentation with Workshop Notes</td>
</tr>
<tr>
<td>Black SAFER Matrix™</td>
</tr>
<tr>
<td>SAFER program-specific resources</td>
</tr>
<tr>
<td>SAFER® General Frequently Asked Questions (FAQ)</td>
</tr>
<tr>
<td>SAFER® Perspectives articles</td>
</tr>
<tr>
<td>SAFER® Update News, and Stories</td>
</tr>
<tr>
<td>SAFER® Podcast</td>
</tr>
</tbody>
</table>

**Benefits of Certification**

- Improves the quality of patient care
- Requires a systematic approach to clinical care
- Creates a loyal, cohesive clinical team
- Promotes a culture of excellence across the organization
- Provides an objective assessment of clinical excellence
- Creates distinction in the marketplace
- Promotes achievement to consumers
Advertise Your Achievement

Questions?

safer@jointcommission.org
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