

The Joint Commission's Stroke Certification Enhancements for 2018



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David Eickemeyer, MBA; Associate Director,
Hospital Business Development



Disclosures



Current Stroke Certification Programs

Developed in Collaboration with AHA/ASA

- Primary Stroke Center – launched in 2003 (standardized performance measures in 2005); 1,116 certified programs
- Comprehensive Stroke Center – launched in 2012 (standardized performance measures in 2015); 144 certified programs
- Acute Stroke Ready – launched in 2015 (standardized performance measures coming in January 2018); 38 certified programs



Primary Stroke Center Certification

- Ability to care for patients with acute ischemic stroke
 - Rapid assessment, imaging, ability to administer intravenous thrombolytic therapy
 - Approximately 1/3 of Joint Commission Certified Primary Stroke Centers are able to provide mechanical thrombectomy
- Transfer protocols with a Comprehensive Stroke Center to care for neurosurgical emergencies/patients with hemorrhagic strokes
- 8 STK standardized performance measures





Comprehensive Stroke Center Certification

- Highest level of stroke care – in addition to providing all services available at a Primary Stroke Center:
 - Advanced imaging (CTA, MRA)
 - 24/7 availability of neurosurgical services, including ability to clip and coil aneurysms (volume requirements for clipping and coiling of aneurysms and treatment of SAH due to aneurysm)
 - Ability to meet concurrently emerging needs of multiple complex stroke patients
 - Participate in IRB research
 - Increased education requirements for staff
- 16 standardized performance measures
 - 8 STK measures
 - 8 CSTK measures (additional changes in January)





Acute Stroke Ready Hospital Certification

- Not likely candidates for primary stroke center certification due to a lack of resources to care for patients after IV thrombolytic therapy
- Ability to perform rapid assessment, head CT, labs, and administer IV thrombolytic therapy prior to transfer to a PSC or CSC.
- Five standardized performance measures beginning in January 2018





Revisions to Current Stroke Programs

- Maintenance occurs approximately every two years
- Current programs written at different times, by different project directors, based on different recommendations
- Contributions from Literature, feedback from stroke experts (TAP), feedback from the field





Revisions to Current Stroke Programs

- Maintenance for 2018 focuses on
 - Moving requirements that apply across all programs so they are located at the same standard and EP
 - Deleting redundant or low-value requirements
 - Revising requirements or adding notes for clarity
- Prepublication revisions are available on The Joint Commission's website. 2018 standards manual in November.





Examples of Revisions to Current Programs

- PSC/ASRH: note to clarify that telemedicine is not needed in the ED if ED practitioners are privileged in the diagnosis and treatment of acute stroke.
- PSC: language changed regarding the completion and interpretation of non-contrast head CT (45 minutes from time of patient presentation vs. 25 minutes for completion/20 minutes for interpretation)





Examples of Revisions to Current Programs

- CSC
 - Removal of depression screen prior to discharge
 - Staffing requirements revised for clarity
 - Who must be on-site vs. who can be available/on-call

Thrombectomy-Capable Stroke Certification - What do you know?

We're a CSC already

Heard about TSC -
We're going for it!

Heard about TSC -
Not for us.

Heard about TSC -
Don't know yet.

Haven't heard
about TSC

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New for 2018: Thrombectomy-Capable Stroke Center Certification



- Why Thrombectomy-Capable Stroke Center (TSC) Certification?
 - Not all PSCs are alike - 1/3 of Joint Commission certified PSCs perform mechanical thrombectomy
 - TSC certification recognizes primary stroke centers that have invested in extra capabilities, over and above the baseline PSC requirements
 - Importance of having a dispersed network of hospitals that are certified so patients can receive the care they need



Thrombectomy-Capable Stroke Center Certification Requirements

- In addition to meeting all requirements for a primary stroke center:
 - Minimum mechanical thrombectomy volume requirement
 - Ability to perform mechanical thrombectomy 24/7
 - Dedicated intensive care unit beds to care for acute ischemic stroke patients
 - Availability of staff and practitioners closely aligned with CSC expectations
 - A process to collect and review data regarding adverse patient outcomes following mechanical thrombectomy



Thrombectomy-Capable Stroke Center Certification Performance Measures



- TSCs will be required to submit data for standardized performance measures:
 - 8 stroke (STK) measures
 - 5 comprehensive stroke (CSTK) measures specific to ischemic stroke



Thrombectomy-Capable Stroke Center Certification Launch

- Prepublication Requirements/*Perspectives* Article: September 2017
- Pre-Application Process, for PSCs due for recertification before April 2018
- Application Open: January 2018
- Reviews Begin: potentially as early as January 2018





New for 2017: SAFER Matrix

Likelihood to Harm a Patient/Staff/Visitor

HIGH
(harm could happen at any time)

MODERATE
(harm could happen occasionally)

LOW
(harm could happen, but would be rare)

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)		
		DSDF.5, EP 1
DSPR.5, EP 3	DSPR.1, EP 6	
DSDF.4, EP 2		DSCT.5, EP 5

LIMITED
(unique occurrence that is not representative of routine/regular practice)

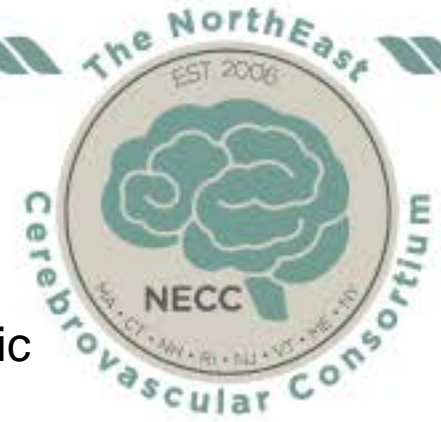
PATTERN (multiple occurrences with potential to impact few/some patients, visitors, staff and/or settings)

WIDESPREAD (multiple occurrences with potential to impact most/all patients, visitors, staff and/or settings)

Scope



Stroke Example



		<i>Immediate Threat to Life</i> <small>(follows current ITL processes)</small>		
Likelihood to Harm a Patient/Visitor/Staff	HIGH		X	
	MODERATE			
	LOW			
		LIMITED	PATTERN	WIDESPREAD

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.



Questions?

David Eickemeyer, Associate Director

630-792-5697

deickemeyer@jointcommission.org

