This blank page is here to maintain accurate page numbering once the photo-cover is inserted into the Adobe version of the organization review process guide.

After saving the Word document as an Adobe file, open it in Adobe Pro. Use the Organize Pages tool to replace this page with the photo-cover and save.

Disease Specific Care Core and Advanced Certification Programs

Review Process Guide

January 2026

Issue Date: January 1, 2026

What's New in 2026

New or revised content for 2026 is identified by underlined text in the activities noted below.

Changes effective January 1, 2026

The Review Process Guide (RPG) has been updated to reflect the following changes:

- New York State has updated and revised stroke-specific requirements for all three levels of stroke designation (Primary, Thrombectomy Capable, and Comprehensive Stroke Center). This review process guide now includes the following tables:
    - Table A: New York State's requirements for stroke center designation
    - Table B: New York State's performance measures and time targets
    - Table C: New York State's up-to-date stroke changes

- Details related to off-site (virtual) review processes have been added to the following sections: General Guidance and Opening Conference.

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Part I: Review Preparations

General Guidance and Overview

The purpose of the ***Review Process Guide (RPG)*** is to inform organizations and reviewers about the Disease Specific Care certification review process.

Organizations are encouraged to review the following documents prior to their review

- For all core and advanced certification programs, organizations are encouraged to download and review the agenda (as applicable to their program). The agendas can be obtained at the following website: Review Agenda | Joint Commission or copy and paste this web address: https://www.jointcommission.org/jc-connect/review-agenda
- The review process includes the program having knowledge of the DSC chapter requirements listed in the ***Comprehensive Certification Manual for Disease Specific Care*** **(DSC),** implementation of those requirements, and adherence to clinical practice guidelines.
- Organizations should also be familiar with ***Perspectives*** articles which are posted monthly to the organization's *Connect* (extranet) site that provides any updates of new and/or revised DSC program requirements.

Pre-Review Outreach

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

- Confirm information reported in the application for certification or recertification
- For the core DSC programs and some advanced DSC programs, including AHAR, ASRH, CHAC, CSC, HF, PHAC, PSC, and TSC, confirm the organization's preference for an on-site or off-site review.
- Verify travel planning information and directions to office(s) and facilities, as applicable to the on-site review.
- Confirm access to *Joint Commission Connect* extranet site and the certification-related information available there.
- Confirm accuracy of any program-specific eligibility requirements, such as any pertinent volumes and procedures performed. (see also, the *Comprehensive Certification Manual for Disease Specific Care-General Eligibility Requirements)*
- Confirm clinical practice guidelines used by the program and any audited registry requirements. (For DSC core programs, please see the *Comprehensive Certification Manual for Disease Specific Care-Table 2. Approved Clinical Practice Guidelines)*
- Answer any organization questions and address any concerns.

Logistics planning

For organizations that selected the on-site review, the account executive will confirm with the organization the following:

- 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 will also request to see some closed records as well in order to verify compliance with requirements such as those that address patient discharge and post discharge follow-up.

For organizations that selected the off-site (virtual) review, the account executive will confirm with the organization the following:

- Internet access/capabilities
- Capable of joining video conference applications (such as Zoom or Microsoft Teams) (breakout rooms may be used if there is more than on reviewer)
- Access to computer(s) with the ability to share screens and utilize camera functionalities
- Mobility of the camera-enabled computer to be used during tracer activity
- A dedicated space to privately discuss patient care, treatment, services

NOTE: *For all reviews (on-site or off-site) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy*.

Multiple Programs in Review

If one reviewer is evaluating multiple certification programs in the same day or across days, the account executive, with input of the reviewer, will develop an agenda that meets the needs of the program and organization leader's schedules.

Information Evaluated Prior to Certification Review

Joint Commission Certification Reviewer(s) assigned to perform the organization's review will receive the following items presented with the organization's Request for Certification:

1. Demographic information, including identification of the disease-specific care service(s) undergoing certification or recertification review

2. The DSC program is required to enter data in the Certification Measure Information Process (CMIP) form which is accessible from the organization's *Connect* (extranet) site. The following information must be maintained in CMIP as follows:

    i. Clinical Practice Guidelines: The title of the current clinical practice guidelines and/or evidence-based practices. (see the section CPG below)

    ii. Performance improvement (PI) plan: Describes in writing the following elements of the program's PI plan:
        - Scope and activities of PI program
        - Composition of the multidisciplinary team
        - Current years for the PI goals and objectives of the program
        - Activities to meet the current years PI goals and objectives
        - The process for program's PI including how fits into organization's PI activities

iii. **Performance Measures:** The program enters their performance measures that are relevant to their scope of care, treatment, and services as follows:

Non-standardized performance measures are entered and must include at least (2) clinically focused measures

Standardized performance measures (as defined by the advanced disease program) are entered into the corresponding measure section

iv. **Data Submission:** All certified programs, including both advanced certification programs with standardized measures and programs collecting non-standardized measure data, are required to report performance measure data **quarterly** to Joint Commission via CMIP.

3. The DSC program uploads program-specific documents based on the current document list available through the extranet site which must be completed by the due date listed on the "What's Due" section. The account executive will assist with the process in advance of certification review if needed.

Questions about Standards

To submit a question:

- Login to the organization's Joint Commission extranet site, *Connect*: https://customer.jointcommission.org/TJCPages/TJCHomeEmpty.aspx and click on Resources - Standards Interpretation, to submit the question.

  Or

- If personnel access is limited, please utilize *Connect*, and then go to the Standards Interpretation Page: https://www.jointcommission.org/standards_information/jcfaq.aspx to submit a question.

Questions about the on-site or off-site (virtual) review process, agenda, scheduling, etc., please contact your Joint Commission Account Executive.

Clinical Practice Guidelines

A disease specific care program seeking Joint Commission certification must demonstrate that it is providing care, treatment, and services according to current clinical practice guidelines and/or evidence-based practice.

Clinical Practice Guidelines (CPGs) are statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

CPGs have two parts:

- The foundation is a systematic review of the research evidence bearing on a clinical question, focused on strength of the evidence on which clinical decision-making for that condition is based.
- A set of recommendations, involving both the evidence and value judgments regarding benefits and harms of alternative care options, addressing how patients with that condition should be managed, everything else being equal.

The organization may choose to utilize more than one clinical practice guideline to meet the needs of their patients; however, all clinical practice guidelines utilized by the program must be entered into the Certification Measure Information Process (CMIP) tool on the organization's *Joint Commission Connect* extranet site.

- For core DSC programs, please see the list of current CPGs listed in Table 2. Approved Clinical Practice Guidelines of the *DSC Comprehensive Certification Manual*.

- For Advanced DSC programs, the organization identifies which current clinical practice guideline(s) it has selected to implement that is specific to the care, treatment, and services it provides.

When entering the CPGs utilized by the program into CMIP, please enter or copy the cited reference that includes the date, author or professional organization(s), and title of the clinical practice guideline(s).

PART II: Agenda Specific Activities

Opening Conference

Objective
To gain a better understanding of the organization's program structure, scope of care, treatment, and services provided by the program, as well as discuss the structure of the review process and answer any questions.

Note: If the organization has selected the off-site (virtual) option, the opening conference for programs with a two-day and two-reviewer agenda (such as CHAC and CSC) will be conducted the day before. A mutually agreed upon time will be coordinated with the reviewer once the organization receives their seven-day notice.

Organization Participants
- 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.
- Program(s) administrative and clinical leadership and others at the discretion of the organization
- If applicable, pre-hospital providers
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy*.

Materials Needed for this Session
- A prepared presentation (such as a PowerPoint)
- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity when presenting at opening conference

Opening Conference
- Reviewer(s) will begin this session with a few remarks and introduction of themselves, followed by an introduction of the program staff
- 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 the 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 the organization (for example, seasonal weather-related events, anticipated or current civil unrest, or labor action)
- Next, hospital and/or program leadership will present an overview (PowerPoint) of their disease-specific care program. Topics to be covered include:
  - Program leadership
  - Program interdisciplinary team composition
  - Program design and integration into hospital
  - Program mission, vision, and goals of care

    - Population characteristics/demographics and needs (such as a community needs assessment)
    - Diversity, equity, inclusion, and belonging program efforts
    - Program selection and implementation of Clinical Practice Guidelines (CPGs)
    - Overall program improvements implemented and planned
- The reviewer will clarify if questions can be asked during the presentation or following the presentation.
- Reviewer will end session with:
    - Overview of agenda and objectives
    - Dialogue about what the reviewer can do to help make this a meaningful review for the program

Reviewer Planning Session

Objective

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 and may ask to review additional documents (such as order sets, clinical pathways, protocols, etc., that are used to implement selected clinical practice guidelines).

Organization Participants

- Program representative(s) that will facilitate tracer activity
- Individual(s) responsible for obtaining clinical records
- Individuals who can readily patient information in the electronic medical record
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

The following is a list of items that reviewers WILL NEED to have available during the Reviewer Planning Session.

1. A current list of patients being treated in the disease specific care program that includes the following information:
    - Patient age, gender, and ethnicity, if available
    - Unit/service admitted to (if applicable)
    - Primary diagnosis related to the disease-specific care program
    - Admission and discharge date (if not currently an inpatient)
    - Disposition status (home, SNF, home with home care, acute rehab, etc.)
2. A list of patients who accessed or progressed through the disease specific care program as follows:
    - For initial reviews only, the past four (4) months
    - For recertification, the past twelve (12) months

NOTE: For some Advanced DSC programs (such as stroke, cardiac, heart failure, total hip, and total knee) see Patient List Requirements in the next section

Selecting Patients to Trace

- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity for sharing the list of active patients, closed records to review, list of staff who are working on the day of the review (for selecting files for the Competency and Credentialing session) and any other documents that may be requested by the reviewer.
- From the patient lists provided, the reviewers will begin selecting patients they want to trace and may request program representative's assistance in identifying patients who may fit the description.

- The reviewer will prioritize patients for tracer activity with the organization's assistance.
- If there are no current patients available to trace on the day of the review, the reviewer will select files from the discharge list provided.

Patient list Requirements for Advanced DSC Programs

STROKE PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Acute Stroke Ready Hospitals (ASRH)

A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients includes patients (as applicable to services provided by the program):
- TIA
- AIS no treatment
- AIS with IV thrombolytic therapy
- ICH (as applicable)
- SAH (as applicable)

For Primary Stroke Centers (PSC)

A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no treatment
- AIS with IV thrombolytic therapy
- ICH (as applicable)
- SAH (as applicable)

For Primary Stroke Centers (PSC) that perform mechanical thrombectomy

A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no intervention
- AIS with thrombolytic therapy
- AIS with endovascular therapy
- ICH (as applicable)
- SAH (as applicable)
- Stroke log (including inpatient stroke codes)
- Current stroke patients in-house

For Thrombectomy Capable Centers (TSC)

A list of stroke patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no intervention
- AIS with thrombolytic therapy
- AIS with endovascular therapy
- ICH (as applicable)
- SAH (as applicable)
- Surgical intervention for AIS (as applicable)
- Stroke log (including inpatient stroke codes)
- Current stroke patients in-house

For Comprehensive Stroke Centers (CSC)

A list of stroke patients that is separated by diagnosis, date of admission, discharge location, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- TIA
- AIS no intervention
- AIS with thrombolytic therapy
- AIS with endovascular therapy
- ICH
- SAH
- Surgical intervention for AIS
- Stroke log (including inpatient stroke codes)
- Current stroke patients in-house

CARDIAC PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Acute Heart Attack Ready (AHAR), Primary Heart Attack Center (PHAC), and Comprehensive Heart Attack Center (CHAC)

A list of heart attack patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients includes (as applicable to services provided by the program):
- ST-elevated myocardial infarction (STEMI)
- Non-ST-elevated myocardial infarction (NSTEMI)
- Acute Coronary Syndrome/chest pain (Unstable angina, angina (INOCA, SCAD)
- Cardiogenic shock with advanced therapies (as applicable)
- Cardiac arrest with ROSC, TTM, & other therapies
- Cardiac rehabilitation

For Advanced Heart Failure (HF) Programs

A list of heart failure patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- A list of current admitted patients with heart failure diagnosis
- A list of discharged patients with heart failure diagnosis
- A list of heart failure clinic patients currently receiving care, treatment, and services

For Ventricular Assist Device (VAD) Program

A list of VAD patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- Implanted VADs (long term devices)
- Planned VAD placement
- Emergent VAD placement
- Inpatient and outpatient activity

SURGICAL PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Advanced Certification for Spine Surgery (ACSS) Programs

A list of spine surgery patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- Patients having spine surgery on either day of review (including name, time, type of procedure, anesthesia)
- Patients currently in hospital or ambulatory surgery center on review days
- A list of discharged patients who received care, treatment, and services from the spine surgery team.

For Advanced Total Hip and Total Knee (THKR) Certification Programs

A list of total hip and total knee patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:
- Patients having either a total hip or total knee replacement on either day of review
- A minimum of six (6) patients will be selected by the reviewer for tracer activity
  - A minimum of three (3) patients experiencing total hip replacement
  - A minimum of three (3) patients experiencing total knee replacement

NOTE: At least one of the patient tracers performed must allow for the intraoperative observation

OTHER Advanced DSC PROGRAMS as LISTED BELOW will REQUIRE the FOLLOWING:

For Advance Lung Volume Reduction Surgery (LVRS) Programs

A list of LVRS patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:

- Patients admitted or scheduled for lung volume reduction surgery
- Discharged patients who had lung volume reduction surgery as their primary or secondary diagnosis

For Advanced Inpatient Diabetes Center (IDC) Programs

A list of diabetes patients that is separated by diagnosis, date of admission, and pertinent patient demographics. For initial certification, data from the prior four (4) months is required. For re-certification, data should be population from the prior 12 months.

The list of patients include:

- Patients admitted with:
  - Patients with Type 1, Type 2, and Gestational diabetes
  - Patients with insulin pumps, if applicable to organization
  - Patient using insulin pen while hospitalized, if applicable to organization
- Discharged patients with diabetes as their primary or secondary diagnosis

Individual Tracer Activity

Objectives

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, and service through the program
- Assess the patient's active involvement in managing their disease
- Assess the impact of interrelationships among the program disciplines on patient care
- Assess the use, 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

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- Access to clinical records of selected patients
- For a review that is being conducted offsite (virtually), the organization must utilize a mobile webcam for this activity

Individual Tracer Activity

- A significant portion of the agenda is designated for individual tracer activity.

- Organization/program staff and the reviewer will move through the organization, as appropriate, visiting and speaking with staff in all the areas, programs, and services involved in the patient's encounter.

- Tracer activity follows the patient's course of care, treatment, and services. Tracer activity may vary by location of where services are provided (such as inpatient, outpatient, or remote)
  NOTE: *Clinical areas or units to be visited are based on the disease-specific needs of the patient population.*

- The organization/program staff and the reviewer will use the patient's record to discuss and map out the patient's course of care, treatment, and services.
  NOTE: *The number of staff participating in tracer activity should be limited. The rationale for limiting the number of staff participating is to reduce any distraction that the review process may have on patient care.*

- Throughout tracer activity, the reviewer(s) will:
  - 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.

- Throughout the tracer activity, the reviewer will communicate 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
  - Issues that have the potential to result in Requirements for Improvement
  - Identify staff files needed for the Competency and Credentialing Session

Intraoperative Tracer Activity

This intraoperative tracer activity only applies to Advanced Total Hip and Total Knee (THKR) and Advanced Certification in Spine Surgery (ACSS)

What to expect and/or plan for:

- Flexibility and clear communication for the intraoperative tracer activity is imperative.
  NOTE: *The organization and reviewer should confirm the timing for this activity as soon as possible since this is a **mandatory** activity for advanced THKR/ACSS certification.*

- Reviewers will change/dress per organization policy for intraoperative tracer activity

- Dependent on the volume of scheduled cases the observations may occur with more than one patient and at different times during the two-day review
  NOTE: *Reviewers most likely will not observe the entire surgical procedure*

- The reviewer will interact with anesthesia, nursing, and other healthcare providers responsible for preoperative preparation of the patient and may inquire about their roles and responsibilities (such as involvement in obtaining informed consent, assessing NPO status, continuing patient education, helping to manage the patient's pain)

- The intraoperative tracer activity will also 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 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

System Tracer- Data Use Session

Objectives

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 opportunities 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
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- Presentation of data (such as a PowerPoint)
- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity when presenting their data

Data Use System Tracer

All organizations participating in a Joint Commission core or advanced DSC certification are required to collect, analyze, report, and monitor their performance relative to standardized and/or non-standardized measures (as applicable to their program requirements) at least quarterly.

The Certification Measure Information Process (CMIP) tool is available for all Disease Specific Care programs and assists certified organizations with the data collection, analysis, reporting, and monitoring requirements associated with performance measures.

During the data use session, the reviewer(s) and organization will discuss the performance measure data report that includes:

- Selection of performance measures (core DSC programs only)
- Standardized performance measures (advanced DSC programs only)
- Data collection, including validity and reliability
- Data analysis and interpretation
- Dissemination /transmission
- Data use and actions taken on opportunities for improvement
- Monitoring performance/improvement
- Action plans demonstrating the program's use of and response to data

- 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.
- Processes to ensure confidentiality and security of all types of patient data

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.

Competence Assessment & Credentialing Process

Objectives

The purpose of this session is to discuss how the program meets the need for qualified and competent practitioners. The reviewer and the organization will discuss and review the following:

- Processes for obtaining team members' credentials information
- Orientation and training process for the disease management program team
- Methods for assessing competence of practitioners and team members
- In-service and facility-defined education and training activities provided to program team members
- Personnel records based on various team members and staff encountered or referred to throughout the day

NOTE: *File reviews are not the primary objective for this session. The file reviews are an opportunity to confirm that the program/organization is following its processes or procedures for staff credentialing, onboarding, competency, and initial and ongoing education, etc. This is not an audit.*

Organization Participants

- Program leaders
- Clinical leaders
- Organization representatives responsible for human resources processes
- Organization representatives responsible for orientation and ongoing education
- Organization representatives responsible for credentialing processes, if different from above
- Individuals with authorized access to, and familiar with the format of files
- Others as applicable to the care delivery within the disease-specific program
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

Personnel or credentials files for individuals identified by the reviewer

- A representative sample of staff (physician, advanced practice provider, nurse, social work, dietician, therapist, registrar, etc.) that are involved or impact the disease-specific care program
- The reviewer will select files based on the individuals encountered during tracer activity, that is, those caring for or who cared for the patient being traced. The organization does not need to pull files for every person the reviewer encounters during tracers. Additionally, please let the reviewer know if there could be a delay in getting files for review.
- For a review that is being conducted offsite (virtually), the organization must utilize the share screen function during this activity when presenting personnel or credentials files

Competence Assessment and Credentialing Process Session

The session begins with an overview and discussion of orientation and training processes for the staff involved in disease-specific program including:

- The development and implementation of the annual educational plan
- Methods for assessing competence of practitioners and team members

- Inservice and other education and training activities provided to program team members

During the session, the reviewer and organization representatives will then review a sampling of the staff involved in the program that include the following:

Provider Files

- Licensure
- DEA Licensure
- Most recent reappointment letter
- Board certification
- Privileges and applicable supporting documents
- OPPE or FPPE (two most recent, as applicable)
- CME or attestation for program-specific CME requirements

Staff Files

- Licensure (if applicable)
- Certification (if applicable)
- Job description
- Most recent performance evaluation
- Program Specific Orientation Education/Competencies
- Program Specific Ongoing Education/Competencies

Reviewer Planning Session/Team Meeting

Note: This section only applies if there are two or more scheduled review days

Objectives

The reviewer(s) will use this session to reflect and debrief on any observations that occurred during the first day's activities. This time may also be used for any follow-up activity that could not be completed earlier in the day. They may also use this time to review and plan for the next day's activities.

Before leaving the organization, reviewer(s) will return any organization documents to the program's coordinator or liaison. If reviewers have not returned documentation, the 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
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy*.

Materials Needed for this Session

- None

Daily Briefing

Note: This section only applies if there are two or more scheduled review days

Objectives

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.

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
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials Needed for this Session

- None

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.
- Reviewers may show the current safer matrix to allow for clarification and discussion of current findings
- Ask the program representatives to clarify or help them understand what they have been hearing and observing.
- Answer questions and clarify comments when requested.
- Review the agenda for the day.
- Make necessary adjustments to plans based on program needs or the need for more intensive assessment
- Confirm logistics for the day, sites that will be visited, transportation arrangements, and meeting times and locations for any group activities
- Reviewers may ask to extend the Daily Briefing if necessary. However, they will be considerate of staff time. They will not make all program representatives stay for a discussion that is specific to a small group of individuals.

Summary Discussion

Objectives

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

Organization Participants

- Program Leadership
- Others at Program's discretion
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy*.

Materials Needed for this Session

- Will vary depending upon the review

Topics that may be discussed include:

- Any issues not yet resolved (IOUs)
- The identified Requirements for Improvement (RFIs)
- What made the review meaningful to the team
- 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)
- Did I meet the goals of your team today?

Reviewer Report Preparation

Objectives:
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
- None; private workspace for the reviewer with access to an electrical outlet and internet connection, if available
- For a review that is being conducted offsite (virtually), the reviewer will be off camera during this activity and will advise when they will resume for the next session

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 Preliminary Certification Report and plan for the Exit Conference.

Program Exit Conference

Objectives:
The Program Exit Conference is the final activity when the organization receives a Preliminary Certification Report of findings from the reviewer.

In addition to the preliminary report, the reviewers will:
- Review the Preliminary Certification 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
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy*.

Materials needed for this Session
- None required

Program Exit Conference
This activity takes place at the completion of a program review. The reviewer(s) will provide a summary of their observations, review any findings, requirements for improvement, and where these are appearing on the SAFER™ matrix.

During the exit conference or at the close of day, the reviewer will post to the organization's *Joint Commission Connect* extranet site the Preliminary Certification Report.

The Final Certification Report and certification decision is made by central office within 10 days of the review and will be posted on the *Joint Commission Connect* secure extranet site.

NOTE: 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.

PART III- Post Review Activities

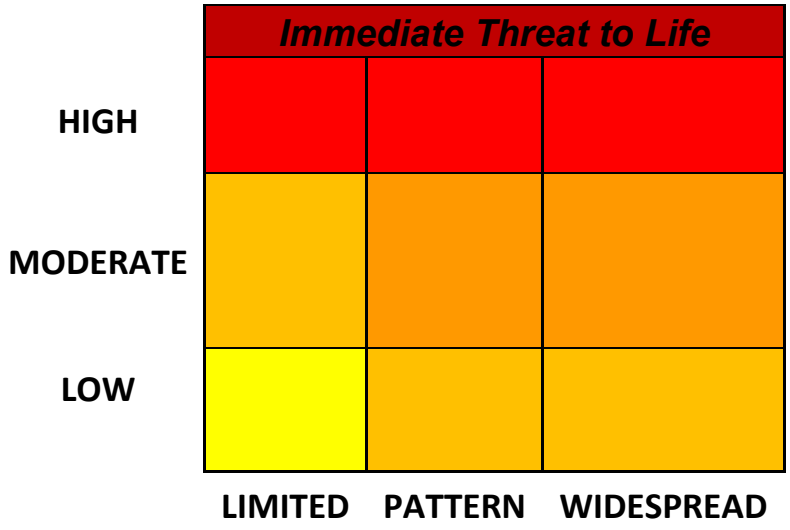
Evidence of Standards Compliance

Objectives:
All noncompliant EPs will be cited as a Requirement for Improvement (RFI) and will be placed on the SAFER® Matrix, illustrated below, as determined by the risk level associated with each RFI.

SAFER® is the Survey Analysis for Evaluating Risk® process, a scoring approach used for the DSC program review of health care organizations. SAFER is a transformative approach for identifying and communicating risk levels associated with deficiencies cited during the review.

All observations of noncompliance will be documented within the SAFER Matrix and require implemented corrective actions that are submitted within the Evidence of Standards Compliance (ESC). The amount of information required within an ESC is reflective of the risk-level and associated SAFER placement of each RFI.

All RFIs must be addressed via the Evidence of Standards Compliance (ESC) submission process. The time frame for completing the ESC submission is within sixty (60) calendar days. The organization should work with their account executive to ensure that these submissions are submitted timely. For assistance, please contact your account executive.



Intra-cycle Evaluation Process

Objectives:

All certified organizations who are participating in a Joint Commission core or advanced DSC certification program are required to participate in the intra-cycle conference meeting.

The intra-cycle meeting is the organization's opportunity to have an interactive discussion with Joint Commission's reviewer to assure the organization is 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 the organization has not actively engaged in performance measurement and improvement activities since the time of the most recently completed initial or recertification review.

Prior to the Intra-cycle Event

- The organization will receive an automated email to the primary certification contact and the CEO approximately 90 days in advance of the mid-point of the program's cycle (Approx. 12 months after the review).

- The program 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 the performance improvement plan and CPGs 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 Joint Commission for the intra-cycle event. If the tool is not submitted on time, the organization will receive an email reminder to submit the tool or risk having the certification decision changed.

- If the organization is using a vendor to submit the standardized performance measure data, there may be a delay in data submitted to CMIP. Please be prepared to discuss and respond to questions from the reviewer regarding the performance measures and be able to provide current data.

Intra-cycle Evaluation Logistics

This virtual meeting will take place as close as possible to the one-year mid-point of the current two-year certification cycle.

The virtual meeting 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.

Organization Participants

- Staff involved in data collection and analysis
- Program leaders that implement performance improvement plans
- For a review that is being conducted offsite (virtually) all participants are expected to have their cameras on during this activity or via a conference room with webcam capabilities

NOTE: *For all reviews (onsite or offsite) electronic recordings, including AI or other transcribing platforms, are **not** allowed per Joint Commission policy.*

Materials needed for this Session

- Prior 12-24 months data

Intra-cycle Evaluation Process

During the intra-cycle conference meeting, the reviewer will start with introductions and will then begin a discussion of the following topics:

- Review the total number of patients the program served in the past year
- Discuss any changes to the program/organizational leadership who support the program
- Discuss any changes in the scope of the program (such as new technology or new procedures being utilized)
- Discuss any additions/deletions of the selected Clinical Practice Guidelines
- Review of the program's data collection and IRR processes and discuss data and ongoing approaches to performance improvement
- Review any additional performance measures implemented by the program
- Review any new/revised patient education
- Review any new/revised and/or completion of staff education
- Review data related to patient's perception of care
- Answer any questions regarding compliance with Joint Commission standards or performance measures

Part IV: New York State's Stroke-specific Requirements

New York State Stroke Services Certification — Primary Stroke Centers (PSC)

Note: This section is intended only for stroke programs located in New York State and provides additional guidance for stroke review that would not be applicable to other states.

New York State stroke requirements may be different than Joint Commission's requirements. Organizations are expected to meet the more stringent requirements.

Introduction

NYSDOH recognizes that Joint Commission's stroke requirements and related documents meet the necessary NYSDOH requirements to be an approved "certifying organization." These requirements are specific to hospitals designated or seeking designation as either a primary, thrombectomy-capable, or comprehensive stroke center.

Primary Stroke Center Definition

NYSDOH defines a primary stroke center (PSC) as a general hospital with the resources and processes to care for acute stroke patients, including administration of intravenous thrombolytic therapy.

Eligibility and Volume Requirements

Primary stroke centers do not have volume requirements. See Table A: **Requirements for Stroke Center Designation** for specific eligibility requirements.

Additional Requirements

In addition to Joint Commission's Disease-Specific Care standards, New York State stroke centers will also be reviewed for all requirements listed in Table A.

Reporting Requirements

All designated stroke centers (primary, thrombectomy-capable, and comprehensive stroke centers) are required to collect and report the performance measures and time targets in **Table B: Performance Measures and Time Targets**, to the specifications indicated in the table, to the NYSDOH on a quarterly basis. Certifying organizations are not required by the NYSDOH to collect these measures on behalf of the New York State Stroke Designation Program.

Designated stroke centers must use a stroke registry to collect and report required measures to NYSDOH. The stroke center must give the NYSDOH permission to access their stroke registry for purposes of electronically transmitting data to NYSDOH and for NYSDOH to review performance measure and time target data. Designated stroke centers are also required to report information specified by the NYSDOH (e.g., contact information, tele stroke, etc.) to the Health Electronic Response Data System (HERDS) on an annual basis. The Stroke Designation HERDS survey is accessible in the Health Commerce System (HCS) annually.

Previously edited and retired performance measures can be found in **Table C: Performance Measures and Time Targets Change Log**.

New York State Stroke Services Certification — Thrombectomy-Capable Stroke Centers (TSC)

Note: This section is intended only for stroke programs located in New York State and provides additional guidance for stroke review that would not be applicable to other states.

New York State stroke requirements may be different than Joint Commission's requirements. Organizations are expected to meet the more stringent requirement.

Introduction

NYSDOH recognizes that Joint Commission's stroke requirements and related documents meet the necessary NYSDOH requirements to be an approved "certifying organization". These requirements are specific to hospitals designated or seeking designation as either a primary, thrombectomy-capable, or comprehensive stroke center.

Thrombectomy-Capable Stroke Center Definition

NYSDOH defines a thrombectomy-capable stroke center (TSC) as a general hospital that performs endovascular thrombectomy procedures and provides post-procedural care.

Eligibility and Volume Requirements

Thrombectomy-capable stroke centers have volume requirements. See Table A: Requirements for Stroke Center Designation for specific eligibility and volume requirements.

Additional Requirements

In addition to Joint Commission's Disease-Specific Care standards, New York State stroke centers will also be reviewed for all requirements listed in Table A.

Reporting Requirements

All designated stroke centers (primary, thrombectomy-capable, and comprehensive stroke center) are required to collect and report the performance measures and time targets in Table B: Performance Measures and Time Targets, to the specifications indicated in the table, to the NYSDOH on a quarterly basis. Certifying organizations are not required by the NYSDOH to collect these measures on behalf of the New York State Stroke Designation Program.

Designated stroke centers must use a stroke registry to collect and report required measures to NYSDOH. The stroke center must give the NYSDOH permission to access their stroke registry for purposes of electronically transmitting data to NYSDOH and for NYSDOH to review performance measure and time target data. Designated stroke centers are also required to report information specified by the NYSDOH (e.g., contact information, tele stroke, etc.) to the Health Electronic Response Data System (HERDS) on an annual basis. The Stroke Designation HERDS survey is accessible in the Health Commerce System annually.

Previously edited and retired performance measures can be found in Table C: Performance Measures and Time Targets Change Log.

New York State Stroke Services Certification — Comprehensive Stroke Center (CSC)

Note: This section is intended only for stroke programs located in New York State and provides additional guidance for stroke review that would not be applicable to other states.

New York State stroke requirements may be different than Joint Commission's requirements. Organizations are expected to meet the more stringent requirement.

Introduction

NYSDOH recognizes that Joint Commission's stroke requirements and related documents meet the necessary NYSDOH requirements to be an approved "certifying organization". These requirements are specific to hospitals designated as either a primary, thrombectomy-capable, or comprehensive stroke center.

Comprehensive Stroke Center Definition

NYSDOH defines a comprehensive stroke center (CSC) as a general hospital with the necessary personnel, infrastructure, expertise, and programs to diagnose and treat stroke patients who require a high intensity of medical and surgical care, specialized tests, or interventional therapies. Additional functions of a CSC would be to act as a resource center for other facilities in their region, such as PSCs. This might include providing expertise about managing particular cases, offering guidance for triage of patients, making diagnostic tests or treatments available to patients treated initially at a PSC, and being an educational resource for other hospitals and health care professionals in a city or region.

Eligibility and Volume Requirements

Comprehensive Stroke centers have volume requirements. See Table A: Requirements for Stroke Center Designation for specific eligibility and volume requirements.

Additional Requirements

In addition to Joint Commission's Disease-Specific Care standards, New York State stroke centers will also be reviewed for all requirements listed in Table A.

Reporting Requirements

All designated stroke centers (primary, thrombectomy-capable, and comprehensive stroke center) are required to collect and report the performance measures and time targets in Table B: Performance Measures and Time Targets, to the specifications indicated in the table, to the NYSDOH on a quarterly basis. Certifying organizations are not required by the NYSDOH to collect these measures on behalf of the New York State Stroke Designation Program.

Designated stroke centers must use a stroke registry to collect and report required measures to NYSDOH. The stroke center must give the NYSDOH permission to access their stroke registry for purposes of electronically transmitting data to NYSDOH and for NYSDOH to review performance measure and time target data. Designated stroke centers are also required to report information specified by the NYSDOH (e.g., contact information, tele stroke, etc.) to the Health Electronic Response Data System (HERDS) on an annual basis. The Stroke Designation HERDS survey is accessible in the Health Commerce System (HCS) annually.

Previously edited and retired performance measures can be found in Table C: Performance Measures and Time Targets Change Log.

Table A: New York State Requirements for Stroke Center Designation

Table A denotes the needed infrastructure and capabilities required by NYSDOH to be designated as a stroke center with an 'X' in the respective stroke center level column.

Table A: New York State Requirements for Stroke Center Designation

Table A requirements must be included in the certifying organizations' stroke center standards manual for all stroke center certification surveys in NYS.

	Stroke Center Level		
	PSC	TSC	CSC
Eligibility / Volume Requirements			
Administers IV thrombolytic and provides acute care to stroke patients	X	X	X*
* Administered IV thrombolytic to at least 25 eligible patients over the past 12 months or at least 50 patients over the past 24 months. (IV thrombolytic given at another hospital based on tele-stroke recommendation by the CSC and transferred to the CSC or if the patient is not transferred to the CSC and there is evidence of follow-up monitoring, that patient can be counted in the eligibility number)			X
Performed mechanical thrombectomy and post-procedural care for at least 15 patients with ischemic stroke over the past 12 months or 30 over the past 24 months		X	X
Provided care to 20 or more patients over the past 12 months with a diagnosis of subarachnoid hemorrhage, with a minimum of 10 of those cases caused by an aneurysm; or provided care to 40 or more patients over the past 24 months with a diagnosis of subarachnoid hemorrhage, with a minimum of 20 of those cases caused by an aneurysm			X
Accomplished greater than or equal to 10 endovascular coiling or surgical clipping procedures per year for the treatment of a brain aneurysm			X
Leadership: The Stroke Center provides leadership for the stroke program through a stroke coordinator and medical director.			
The Stroke Coordinator must be a: • Full-time member of hospital staff (can be concurrently assigned to other role in the hospital) • Liaison with EMS, who coordinates and evaluates pre-hospital care for stroke services, ensures timely and accurate data submission to EMS as requested, and complies with monitoring programs that are established by regional EMS providers • Responsible for the collection, storage, and reporting of stroke data and for quality improvement of the stroke program	X	X	X
The Stroke Medical Director must be available 24/7 to provide leadership and attend to difficult medical, logistical, and administrative issues. A call schedule to designate an acting director should be utilized when the director is unavailable.	X	X	X
The Stroke Medical Director is a physician leader, on the hospital staff, with sufficient knowledge in cerebrovascular disease and experience caring for stroke patients, licensed in NYS, and Board-Certified in Family Medicine, Internal Medicine, Emergency Medicine, Neurology, Neuroradiology, or Neurosurgery.	X		
The Stroke Medical Director is a physician leader, on the hospital staff, with extensive experience and expertise in neurology and cerebrovascular disease, licensed in NYS, and Board-Certified in Neurology, Vascular Neurology, Critical Care, Neuro-Critical Care, Interventional Neuroradiology, or Neurosurgery.		X	X
The Stroke Medical Director only serves a single Comprehensive Stroke Center			X
Pre-Hospital Services (EMS)			

	Stroke Center Level		
	PSC	TSC	CSC
Documents and monitors pre-notification by EMS of all suspected stroke patients	X	X	X
Has a QI process for providing education and feedback on the pre-notification process and outcomes to local EMS agencies at a predetermined frequency	X	X	X
24/7 Provider Availability – The following providers must be available 24/7 and within the time frames indicated:			
Acute Stroke Team • Composition is defined by the hospital but must include an individual that is privileged to make treatment decisions • At bedside within 15 minutes of patient arrival/activation	X	X	X
Neurologist • Must be available in person or via telemedicine (see definition of telemedicine under *Availability of Specialized Assessments and Services*) 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	X**	X	X
Emergency Medicine Physicians and Nurses trained in the administration and monitoring of IV thrombolytic[2]	X	X	X
Diagnostic Radiologist with complex stroke experience and/or a physician privileged to interpret CT, CTA, and MRI of the brain	X	X	X
Physicians with training in critical care or neurocritical care for managing the care of complex stroke patients in the designated neurointensive care unit or designated intensive care beds		X	X
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 working on a stroke unit or ICU for complex stroke patients are knowledgeable in NIHSS	X	X	X
Radiology Technician able to perform CT/CTA	X	X	X
Radiology Technician able to perform MRI/MRA/CA		X	X
Vascular Neurologist, who is fellowship trained		X	X
Neurointerventionist: All neurointerventionists (those who take call to perform emergency mechanical thrombectomy) must: • Be available by phone with access to images within 10 minutes of contact and on site within 30 minutes of team activation		X	X

[2] For hospitals that meet criteria outlined in Title 10 NYCRR 405.19 (d)(1)(ii) (those with less than 15,000 unscheduled emergency visits per year), the supervising or an attending physician need not be present but shall be available within 30 minutes of patient presentation, in person or by telemedicine, provided that at least one physician, nurse practitioner, or licensed physician assistant shall be on duty in the emergency service 24 hours a day, seven days a week. The hospital shall develop and implement protocols specifying when physicians must be present.

	Stroke Center Level		
	PSC	TSC	CSC
• Have performed, as the primary operator, at least 15 mechanical thrombectomies over the past 12 months or at least 30 over the past 24 months (in evaluating the number of mechanical thrombectomies performed, procedures performed at hospitals other than the one applying for certification can be included in the total). • Be Committee on Advanced Subspecialty Training (CAST) certified **or** meet all the following criteria: ○ completed an Accreditation Council for Graduate Medical Education (ACGME) accredited or equivalent residency in neurosurgery, neurology, or radiology, **and** ○ completed a stroke or neurocritical care fellowship (for neurologists) or neuroradiology fellowship (for radiologists) supervised by ACGME, CAST, the United Council of Neurologic Subspecialities (UCNS), or other equivalent oversight body, **and** ○ completed neuroendovascular procedure training in a CAST- accredited program or similar training program			
Endovascular Team must be onsite (including neurointerventionist) within 30 minutes of team activation. The endovascular team should perform mechanical thrombectomies together as frequently as possible. The team must consist of at least: • One endovascular RN, • One endovascular catheterization laboratory technician, and • A physician privileged to perform mechanical thrombectomy		X	X
General Neurosurgeon on call 24/7 to respond to complications of mechanical thrombectomy		X	
Neurosurgeon with expertise in cerebrovascular surgery on call 24/7 • Surgeon, neurosurgeons, and other neurosurgical staff are available on site within 30 minutes of notification to perform and support the performance of emergency neurosurgical procedures 24/7			X
Vascular Surgeon with experience in carotid endarterectomy			X
Availability of Specialized Assessments and Services			
PT and OT are available as needed.	X	X	
PT and OT are available 6 days a week and on-call on the 7th day to perform patient assessment during the acute stroke phase.			X
SLP is available as needed. However, the Stroke Center must have staff with the ability to perform a bedside swallowing screen 24/7. This can be done by a SLP, or other staff trained to perform a bedside swallow screen.	X	X	X
All inpatient stroke patients (unless transferred to another acute care facility or hospice) must be assessed for rehabilitation services.	X	X	X
Nurse case managers and social workers with expertise in neurology/stroke care, care coordination, different levels of rehabilitation, and community resources are available.	X	X	X
The rehabilitation services are directed by a physician with expertise and experience in neurorehabilitation.			X

	Stroke Center Level		
	PSC	TSC	CSC
If utilized for consultation, telemedicine is available 24/7 and able to be connected 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.	X	X	X
Neurosurgical Availability and/or Coverage			
Written documentation shows evidence of neurosurgical coverage or protocol for transfer to an appropriate facility with 24/7 neurosurgical capabilities.	X	X	
General neurosurgery coverage that can respond onsite 24/7.		X	
24/7 operating room availability with capacity and staff availability to handle a general neurosurgery case and a stroke at the same time.			X
Surgeons, neurosurgeons, and other neurosurgical staff are available on site within 30 minutes of notification to perform and support the performance of emergent neurosurgical procedures 24/7.			X
Transfer Agreement[3]			
Written transfer protocol and transfer agreement with at least one facility capable of providing timely neurosurgical, cerebral endovascular, and neuro ICU services 24/7. • PSC/TSC must, at a minimum, have a transfer agreement with at least one CSC. • The TSC shall have a transfer agreement with referring PSCs within their catchment area for 24/7 receipt of patients needing cerebral endovascular services. 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.	X	X	
Transfer agreements for receiving and transferring facilities at a minimum must address: • 24/7 emergency contact information of acute stroke team and/or receiving team at the receiving facility authorized to accept transfers. • The ability of the sending facility to transfer the patient and the ability of the receiving facility to accept the transferred patient 24/7. • The ability to affect a transfer in a timely manner as appropriate for patient needs (target timeframe for transfer must be identified in the transfer agreement for both 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).	X	X	X

[3] Hospitals can demonstrate required elements of the transfer agreement through references in the transfer agreement to hospital policies and procedures that incorporate these elements. Policy and procedure documents should be appended to the transfer agreement.

	Stroke Center Level		
	PSC	TSC	CSC
• The transfer agreement shall clearly delineate which facility has responsibility for performing a CTA (the sending or receiving facility) and under which clinical circumstances. The imaging capabilities of the sending facility must be clearly articulated in the agreement. • 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 Stroke Center has a contract with a transportation vendor that covers expeditious transfer by both ground ambulance and air ambulance transfer options as applicable.	X	X	X
Has a transfer agreement with referring TSCs and PSCs within their catchment area for intake purposes. The CSC must identify another CSC 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.			X
Availability of Diagnostic Services			
Neuroimaging			
CT available 24/7 • Initiate neuroimaging (brain imaging) within 25 minutes of patient arrival. • Read by a diagnostic radiologist or physician privileged to interpret CT neuroimaging within 45 minutes of patient arrival.	X	X	X
MRI: Recommended (not required) to be available and utilized when clinically indicated. Administration of IV thrombolytic or transfer for definitive care for acute stroke should not be delayed for MRI.	X		
MRI: Required to have the capability to perform and read an MRI 24/7 when clinically indicated.		X	X
Vascular Imaging			
CTA: 24/7 CTA of the head and neck to assess for a large vessel occlusion and identify candidates for endovascular therapy. CTA imaging must be reviewed by a diagnostic radiologist or physician privileged to interpret CTA for a large vessel occlusion in order to identify candidates for endovascular therapy within 45 minutes of patient arrival. Administration of IV thrombolytic or transfer for definitive care for acute stroke should not be delayed for CTA.	X	X	X
MRA: Must be able to perform and read MRA 24/7. Administration of IV thrombolytic or transfer for definitive care for acute stroke should not be delayed for MRA.		X	X
CA: Must be able to perform and read CA 24/7.		X	X
CTP: Must be able to perform and read CTP 24/7.		X	X
Other Imaging (available when clinically indicated)			
TTE	X	X	X
Carotid Duplex Ultrasound, Extracranial Ultrasonography, Transcranial Doppler, TEE		X	X
Treatments, Services and Procedures (24/7 Availability)			
IV Thrombolytics	X	X	X

	Stroke Center Level		
	PSC	TSC	CSC
IA Thrombolytics		X	X
Mechanical Thrombectomy		X	X
Microsurgical Neurovascular clipping of aneurysms, Neuroendovascular coiling of brain aneurysm, Stenting of extracranial carotid arteries, Carotid endarterectomy			X
Laboratory and Pharmacy (24/7 Availability)			
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	X	X	X
Pharmacy: Formulary must include availability of IV thrombolytic 24/7.	X	X	X
Stroke Unit/ICU			
Stroke unit or designated stroke beds with the capability to monitor acute stroke patients continuously and simultaneously. The stroke unit has sufficient equipment and supplies to provide an appropriate level of care for the stroke population, including multi-channel telemetry capable of monitoring blood pressure, pulse, respiration, and oxygenation.	X	X	X
Designated neurointensive care unit or designated intensive care beds for the care of complex stroke patients available 24/7.		X	X
Stroke Education			
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 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 Stroke Center 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	X	X	X
The Stroke Center provides annual training and education, including a formal orientation, on evidenced-based acute stroke assessment and recognition of signs and symptoms of stroke, management of stroke patients, and protocol for	X	X	X

	Stroke Center Level		
	PSC	TSC	CSC
the activation of the acute stroke team, for all nurses, physicians, NPs, and PAs who provide care in the emergency department, acute stroke unit, intensive care unit (ICU), and catheterization laboratory.			
Patient education materials about stroke are provided to all stroke and TIA patients and/or their family/caregivers and documented in the medical record. Educational materials should be tailored to the patient and family/caregiver (i.e., be culturally appropriate, available in multiple languages, and at the appropriate reading level) and 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.	X	X	X
Two (2) evidence-based public education activities (e.g., Hip-Hop Stroke) with a focus on stroke prevention, done annually with data on type and numbers reached reported to the certifying organization. Public education and health promotion may also focus on diagnosis, secondary prevention, and/or the availability of acute therapies.	X	X	X
Performance Measures and Quality Improvement			
The Stroke Center must have an internal QI group specific to stroke care that meets at least monthly with recorded minutes. This group is minimally expected to review stroke quality benchmarks, indicators, evidence-based practices, patient outcome data (e.g., mortalities, etc.), and delays in patient care, and take actions as necessary. The Stroke Center must have an interdisciplinary team with a peer review process that includes the stroke medical director, stroke coordinator and a quality facilitator charged with conducting quality reviews.	X	X	X
The Stroke Center must collaborate with external partners to work to improve the quality of stroke care and outcomes. Such external collaborators could include but are not limited to the Regional Emergency Medical Advisory Committee (REMAC), Stroke Center Regional Stroke Coordinator Consortiums, community-based organizations or services, other stroke centers, or the New York State Coverdell Stroke Program.	X	X	X
Must have a quality representative that is responsible for monitoring requirements of the program. There must be a written document defining quality review processes, how to measure objectives and goals and how to engage PSCs and TSCs in regional quality improvement initiatives			X
Must participate in IRB-Approved Patient-Centered Stroke Research			X
Maintains a stroke log that includes response times, along with patient diagnoses, treatments, and outcomes	X	X	X

Table B: New York State Performance Measures and Time Targets

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Performance Measures	Measure Steward	PSC	TSC	CSC
NYS PSC 1: VTE prophylaxis	GWTG Achievement	X	X	X
NYS PSC 2: Discharge on antithrombotic therapy	GWTG Achievement	X	X	X
NYS PSC 3: Anticoagulation therapy for AFIB/Flutter	GWTG Achievement	X	X	X
NYS PSC 4: Thrombolytic therapy (arrive by 3.5 hours, treat by 4.5 hours)	GWTG Achievement	X	X	X
NYS PSC 5: Antithrombotic therapy by end of hospital day two	GWTG Achievement	X	X	X
NYS PSC 6: Discharged on statin medication	GWTG Achievement	X	X	X
NYS PSC 7: Stroke education	GWTG Quality	X	X	X
NYS PSC 8: Smoking cessation	GWTG Achievement	X	X	X
NYS PSC 9: Assessed for rehabilitation	GWTG Quality	X	X	X
NYS PSC 10: Dysphagia screening	GWTG Quality	X	X	X
NYS PSC 12: mRS on discharge	GWTG Reporting	X	X	X
NYS PSC 13: Pre-notification: Percent of cases of advanced notification by EMS for patients transported by EMS from scene	GWTG Reporting	X	X	X
NYS PSC 14: EMS Pre-Hospital Stroke Scale: Percent of patients arriving via EMS who had pre-hospital stroke scale performed	GWTG New York State	X	X	X
NYS PSC 15: Pre-notification content	GWTG New York State	X	X	X
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	GWTG New York State	X	X	X
NYS PSC 17: Door to MD/DO/NP/PA assessment (10 minutes)	GWTG New York State	X	X	X
NYS PSC 18: Door to Stroke Team (15 minutes)	GWTG New York State	X	X	X
NYS PSC 19: Door to Brain Image Initiated (25 minutes)	GWTG New York State	X	X	X
NYS PSC 20: Door to Brain Image Read (45 minutes)	GWTG New York State	X	X	X
NYS PSC 21: Door to IV thrombolytic (60 minutes)- 85%	GWTG Quality	X	X	X
NYS PSC 22: Door to IV thrombolytic (45 minutes)- 50%	GWTG Reporting	X	X	X
NYS PSC 23: Door-in-door-out time at first hospital prior to transfer for acute therapy (≤ 90 minutes)	GWTG Reporting	X	X	X
NYS PSC 24: NIHSS Reported	GWTG Quality	X	X	X
NYS TSC 1: mRS at 90 days: documented	The Joint Commission (CSTK-02)		X	X
NYS TSC 2: mRS at 90 days: following mechanical endovascular reperfusion therapy, favorable outcome	The Joint Commission (CSTK-10)		X	X
NYS TSC 3: Hemorrhagic transformation (overall rate)	The Joint Commission (CSTK-05)		X	X
NYS TSC 4: Mechanical Endovascular Reperfusion Therapy for Eligible Patients with Ischemic Stroke	GWTG MER		X	X
NYS TSC 5: Thrombolysis in Cerebral Infarction (TICI Post-Treatment Reperfusion Grade)	The Joint Commission (CSTK-08)		X	X
NYS TSC 7: Timeliness of reperfusion: arrival time to TICI 2B or higher (120 minutes)	The Joint Commission (CSTK-11)		X	X

Table B: New York State Performance Measures and Time Targets

Performance Measures	Measure Steward	PSC	TSC	CSC
NYS TSC 8: Timeliness of reperfusion: skin puncture to TICI 2B or higher (60 minutes)	The Joint Commission (CSTK-12)		X	X
NYS TSC 9: Door to Puncture Time	The Joint Commission (CSTK-09)		X	X
NYS TSC 10: Imaging to Puncture Time	GWTG MER		X	X
NYS CSC 1: Severity measurement for SAH and ICH	The Joint Commission (CSTK-03)			X
NYS CSC 2: Nimodipine treatment within 24 hours	The Joint Commission (CSTK-06)			X

Table C: NYS Performance Measures and Time Targets Change Log

Table C. NYS Performance Measures and Time Targets Change Log

Performance Measure	Change(s) Made	Effective Date
NYS PSC 4: Thrombolytic therapy (arrive by 2 hours, treat by 3 hours)	Changed Measure to: NYS PSC 4: Thrombolytic therapy (arrive by 3.5 hours, treat by 4.5 hours)	2020
NYS PSC 17: Door to MD/DO (can include midlevel) assessment (10 minutes)	Changed Name to: NYS PSC 17: Door to MD/DO/NP/PA assessment (10 minutes)	1/1/2025
NYS PSC 11: Initial NIHSS reported	Retired Measure	1/1/2025
NYS PSC 24: NIHSS Reported	Added Measure	1/1/2025
NYS TSC 6: NIHSS at Discharge	Retired Measure	1/1/2025