



Pioneers in Quality New and Revised Requirements for Joint Commission's Stroke Certification Programs

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The learning objectives for this session are.

describe the Stroke Certification new and revised requirements and the rationale for each and locate and use available resources.

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These staff and speakers have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content. [Myself] Jessica Woodruff, Susan Funk, and Paula de la Peña.

00:04:54

Today's presentation features Paula de la Peña, Project Director from Healthcare Standards Development from Department of Standards and Survey Methods. Paula, I will turn things over to you. Please take it away.

00:05:11

Thank you so much, Jessica, and thank you all for joining us to review the upcoming standard revisions. Let's go ahead and get started.

00:05:21

Before I review the upcoming revisions to the standards, I want to first remind you that our Stroke Certification programs were developed in partnership with the American Heart Association and American Stroke Association. The program eligibility requirements and standards were derived from national clinical practice guidelines and evidence-based practice. I look forward to sharing their revisions with you over the course of this webinar.

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The four programs were developed to operate within a Stroke Systems of Care model where all the levels of Stroke Certification work together to provide high quality Stroke care and share resources



and best practices when possible. Our standards also reflect this model as each certification builds upon one another.

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In my next slide, I will briefly demonstrate this concept further.

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The Acute Stroke Ready Hospital designates organizations that have established well-developed protocols and standardized processes for the rapid evaluation, triage and transfer of Stroke patients that may require higher levels of care.

Primary Stroke Centers expand upon Acute Stroke Ready Hospitals and have established processes for the clinical diagnosis and treatment of Stroke, including advanced imaging, dedicated inpatient beds for monitoring of the Stroke patient, complication management, and care coordination. PSCs may perform thrombectomy or have access to neurological services, but it is not required. Additionally, if PSCs do not offer these services 24/7, the program has protocols for transfer to higher levels of care.

And in addition to the delivery of the aforementioned care treatment and services, Thrombectomy Capable Stroke Centers or TCSs also perform Mechanical Thrombectomy and provide 24/7 neurocritical care.

Our certifications culminate with the Comprehensive Stroke Center. CSCs provide 24/7 care for the complex Ischemic and Hemorrhagic Stroke patient and maintain a team of specialists to support the care, treatment and services required to deliver the complex Stroke care. CSCs are also committed to advancing Stroke care through the participation in clinical research.

In all levels, Stroke centers certified by The Joint Commission demonstrate a commitment to delivering safe and highly effective Stroke care in their communities in which they serve. Additionally, all levels partner with their communities to deliver awareness and prevention, education, and resources.

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Okay, now onto the real reason we are here today. As you are aware, the revisions to all four Stroke programs were released in July in our pre-publication's report on The Joint Commission extranet. I understand these documents were most likely overwhelming to look at when all we really care about is what changed and how does this affect my program specifically. The way I plan to approach these revisions is to first discuss changes that affect all four Stroke programs. Subsequently, I will go through changes that are program-specific. However, please keep in mind that the requirements I mentioned for Acute Stroke Ready, for example, do also apply to PSC, TSC, and CSC, and I will not be re-mentioning them for the sake of keeping this webinar under 10 hours long. Additionally, the exact location of each program-specific addendum may vary ever so slightly by program.

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On this slide, you'll see the nine broad areas of revisions that affect all four Stroke programs and in the coming slides I will go into each area in more detail.

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Let's begin with the Harmonization of Requirements which do affect all four programs.

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What does Harmonization of Requirements even mean? To me, that phrase sounds like there was a lot of meditating involved, but really it is just as simple as organizing the addendums appropriately. One of the first things that we did when approaching the revisions was to look at every single requirement in a one-to-one comparison across all four programs to see where there might have been discrepancies or a variation in the language of addendums. For example, between TSC and CSC programs, but the intent of requirements remain the same. We also moved some of the addendums around just to keep everyone on their toes. I'm just kidding. We moved the addendums to places that they would be a better fit under different Elements of Performance. For example, housing all of laboratory testing requirements in one place. And lastly, you will note many editorial changes to enhance clarity for both reviewers and you, our customer.

00:10:12

Next, we'll go over a new look to the standards in the E-dition or print manual.

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As you are aware, if you are a higher-level certification, you are held to all Elements of Performance in the program-specific addendums of the lower programs. However, in the manual, for example, CSC requirements did not contain the requirements for all of the lower programs, just only the ones that were specific to CSC. We felt that this might be confusing, so to streamline what is required for each certification program, you will now only have to look in one place. If you open CSC requirements, all the requirements, including lesser programs, will be there for CSC, and the same applies to TSC and PSC as well.

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Okay, onto a little bit of a spicier topic. This is one of the major areas of revisions that applies to all four programs, the education requirements.

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So, what has happened? We are removing all of the hourly, numerical, or percentage-based education requirements from the standards. This means no more eight, four, two hours, 67%, 80% of practitioners, et cetera. The reasons behind this change are multifaceted, but really when it comes down to it, you at the organizations know that hours of education do not necessarily equal competence and the literature supports this assertion as well. We conducted an extensive systematic literature review to explore the best way to approach education without burdening programs and staff, but to also ensure that we have educated and competent staff providing Stroke care. Additionally, if you participated in our field review testing of the education requirements, you'll be familiar with the evolution of this change, and trust me, I heard you loud and clear on the subjective feedback section evaluating these requirements.

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The first thing we want to ensure is that you, the clinical experts, and program leaders are involved in the content and delivery of educational offerings related to Stroke for both patients and staff. There is a new requirement at DSPR.02 EP 2 that states the Core Stroke Team approves the program's education content for patients and also the Core Stroke Team determines the training and education content for staff based on staff's roles and responsibilities. Although the requirement of hours is gone, that does not mean that programs are no longer involved in the education that is given to staff that care for Stroke patients. When we review your program on site, we'll expect to see how the Core Stroke Team as identified by the organization is involved in education planning and delivery for those who care for Stroke patients.

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So, I mentioned all the hours are gone and what does that leave us for education? We have a new requirement at DSDF.01 EP 1 that states physicians and other licensed practitioners demonstrate knowledge and understanding of the program's protocols related to care, treatment, and services for Stroke patients. The first thing to point out is that you and the program may determine the education, which is not a change. What is new however is that we expect to see what type of education is given to who and how those that care for Stroke patients in your program are prepared to do so. When we are on site to review your program, we will have a robust discussion in the competency and credentialing session as to who receives what education and what the processes surrounding education look like.

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We have another new requirement at DSDF.01 EP 4, which states the program provides initial orientation, education, and training that is pertinent to the program-specific Stroke policies and procedures and individual licensed practitioners roles and responsibilities. This requirement speaks to how physicians and staff are brought into your program based upon their role in providing care to Stroke patients, and it is not just limited to quote "Stroke nurses or neurologists." If your program utilizes internal medicine hospitalists, for example, to admit your Stroke patients, we would expect to see how those physicians have been educated to your program and the associated protocols for care as determined by you all.

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The next requirement is very similar to the previous one, however it addresses ongoing education. DSDF.01 EP 7 states the program provides ongoing education and training activities that are pertinent to the licensed practitioners' roles and responsibilities when staff responsibilities change, when new or revised policies, procedures or guidelines are implemented, and/or other intervals defined by the program.

Now I've heard the question, well, what type of education should we be providing? And that is a great question, but it really is dependent on the care treatment and services provided by your program. Are you rolling out Tenecteplase? That's great. How are physicians and other licensed practitioners educated regarding that and where is it documented? If we're on site and you tell us, oh, we did a great in-service on Posterior Stroke Presentation in the ED, that's wonderful, but we would also expect to see the documentation of the delivery of this education. I promise you; we are not trying to make your life harder. We are trying to remove an arbitrary number barrier that may require more



resources to allow programs to work more effectively, work smarter, not harder, if you will, when it comes to delivering education.

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Lastly, we know that many of you already do this, but we also know how important Stroke symptom recognition is. That being said, we have a new requirement at DSDF.01 EP 7 that states other staff in the organization who interact with Stroke patients receive training on recognition of clinical signs and symptoms that require timely notification according to institution-specific policy and protocol. This requirement extends beyond the program, and we would expect to see that all staff who work in the organization receive at least basic Stroke symptom recognition education and how to activate the Stroke alert process.

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Moving on to the next topic, Time-based Goals for Care.

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What does this mean for the standards? We have taken out the specific quote "door-to" metrics from the standards themselves. If there is a door-to measure that applies to any of the Stroke measures, STK-04 for example, those still apply and are active and what I am referring to is specifically what is within our standards. There are three requirements that address this concept, and we made these changes because we know that the target is always moving. We also know that organizations do strive to provide safe and efficient Stroke care and prevent delays. The intent of this requirement is for organizations to set their own internal goals that are derived from national guidelines and to use these goals to drive their own local Stroke care.

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The first requirement replaces the existing door-to requirements like door-to-MD or door-to-Stroke team. What we are looking for here is that your program has a process for how you respond to Stroke alerts both in-house and through the emergency department. Part of this process includes the expected response times for staff that provide Stroke care. These response times are driven by national guidelines and evidence-based practice. Here's an example. The AHA Target Stroke Phase III goal to administer thrombolytic in 45 minutes would be a door-to-Stroke team in less than 10 minutes. We look at our own internal data and find we have a median time of seven minutes. We're doing pretty well, but is there an opportunity to improve and shave off time in our acute Stroke response process? We use our internal programs data to drive performance improvement initiatives to aim for a door-to-Stroke team in less than five minutes. When The Joint Commission comes on site to evaluate our Stroke program, we discuss this data, the PI project maybe associated challenges and pertinent outliers so that reviewers can partner with us to help us on our road to continual improvement.

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The next requirement has a similar intent to the one we just talked about and is not markedly different from how the review process is currently. We expect you to derive protocols from nationally recognized clinical practice guidelines. Ongoing assessment of the patient including time intervals for those processes is included in Stroke protocols and those processes are reviewed for process improvement opportunities.



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The next requirement speaks towards our shift in evaluating processes and how that should look when monitoring data. We encourage Stroke programs to set goals for care including administration of thrombolytic therapy as fast, but of course as safely as possible. It is important to be concurrently monitoring processes including outliers to understand where opportunities for improvement may lie.

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Hopefully, everyone's heads aren't exploding and you're still with me and next we'll be moving on to the theme of streamlining their requirements.

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I know there has been some confusion surrounding this revision and hopefully I can help to clarify. We have removed eligibility criteria and Stroke measures from the requirements. We did not remove eligibility criteria. Programs are still responsible for their associated eligibility criteria, it's just not in the standards themselves. This was done for clarity and also if there's an eligibility issue, we really shouldn't be on site to review your program. This would be something addressed before.

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The next few requirements all kind of fall under the same theme of Interdisciplinary Team Requirements. We know that Stroke care hardly falls under the purview of just the Stroke team, and we acknowledge the critical role our Interdisciplinary Team plays in the delivery of Stroke care.

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The first requirement is DSPR.01 EP 1. The program appoints an individual who is qualified through education, training, or experience and who collaborates with the Medical Director to define, implement, and direct the program. This new requirement is a recognition of the invaluable contribution that Stroke coordinators and others with a similar role and maybe slightly different title play in the success of Stroke programs. We at The Joint Commission acknowledge the importance of this role and are now requiring programs and organizations to appoint someone into this or a similar role to work alongside the Medical Director to operationalize the program.

00:21:19

Another new requirement is at DSPR.02 EP 3 requiring at least quarterly representatives of the Interdisciplinary Team to meet to review performance of the Stroke program and identify quality improvement opportunities. Documentation includes attendance records and meeting minutes. We know that many programs meet more often than this and that is completely acceptable. However, we want to ensure that the key stakeholders of the program are coming together at least quarterly to evaluate the Stroke program.



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Now looking at the new requirement at DSD.F.02 EP 3, which requires the Interdisciplinary Team to review clinical practice guidelines and current evidence at least annually and to revise protocols for Stroke care to remain in alignment. We did also note that current evidence may seem a little vague, so to clarify, this includes clinical trials, current research, or scientific statements. We know that new Stroke guidelines are not released every year, but again, this is about the process of keeping the team engaged in what is currently happening in Stroke care and asking programs to reflect at least annually on new evidence that may help them to optimize their programs.

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The last topic that applies to all programs are the new IV Thrombolytic Therapy Requirements. We know that many organizations have chosen Tenecteplase now as their thrombolytic of choice, but we do also recognize that there are programs in health systems that have not made this switch and may have both medications or one or the other available for a variety of reasons.

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Before I discuss this new requirement, we have removed DSPR.05 EP 1 that states the organization's formulary or medication list must include an IV thrombolytic therapy medication approved by the FDA for the treatment of Ischemic Stroke and we've replaced it with the following. The program's formulary or medication list includes an IV thrombolytic therapy for the treatment of acute Ischemic Stroke. There is also a note that states if a program maintains more than one IV thrombolytic on formulary for the treatment of acute Ischemic Stroke, written protocols are in place that define medication selection and administration. I would like to clarify that I have received some questions regarding this requirement. We at The Joint Commission are not recommending or suggesting that organizations utilize multiple thrombolytics in the treatment of Acute Ischemic Stroke. We are stating that if for whatever reason an organization is requiring to keep both on formulary that there is a protocol in place for medication selection and administration.

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At this point in the webinar, I'm going to move through specific program requirements and again, just as a reminder, if you are a PSC, Acute Stroke Ready requirements apply to you. If you are a TSC, Acute Stroke Ready and PSC requirements apply to you, and if you are a CSC, you are fortunate enough to have all of the following slides of requirements apply to you. I have structured the slides for each program by the chapter that they belong to to help you follow along and to know where these things live.

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The first chapter revisions that I will discuss for Acute Stroke Ready Hospitals is the DSSE or Supporting Self-Management Chapter.

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This is a new requirement for Acute Stroke Ready but is not a new requirement to Stroke certified programs overall as this requirement was in other levels of certification. We do understand that many Acute Stroke Ready programs transfer the majority of their Stroke patients to higher level care. However, in those instances that a patient may stay at an organization, we would expect to see some post-hospital care coordination, when applicable, including assessment of those who would be assuming care of the patient.

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The same holds true for this requirement. It's new to Acute Stroke Ready, but it is not new to Stroke Certification. Knowing that there are instances when Stroke patients may stay for whatever reason, we would expect to see that patients are receiving the education they need on some of the key things post-discharge. Of course, if you transfer 100% of your Stroke patients out, this may not apply to your program.

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Next, we will be moving into the Clinical Information Management Chapter.

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At DSCT.05 EP 4, we have added a new requirement that states documentation indicates the reason potentially eligible Ischemic Stroke patients were not transferred for endovascular therapy. Why did we add this? We know how important documentation is and we oftentimes document why we did things. However, it is just as important to collect information on why we did not do these things. This allows programs to collect data, look for trends, and ultimately work towards improving processes and the program overall.

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In the following few slides, I will talk about PSCs in general and then afterwards I will break out into PSCs who perform Mechanical Thrombectomy.

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We will first begin with the Program Management chapter DSPR and the associated revisions.

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The first is a revised requirement at DSPR.03 EP 4 that now states that a Primary Stroke Center develops standardized protocols and processes for the timely assessment, diagnosis, and management of patients who present with or develop signs and symptoms of large vessel occlusion. The intent behind this requirement is to ensure equitable standardized care. We will be looking to see what the standardized workflow for patients that are suspected of experiencing a large vessel occlusion.

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Next, I will review any revisions for PSC and the delivery and facilitation of care or the DSDF chapter.

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This is similar to the addition in Acute Stroke Ready hospitals regarding care coordination where these are not new concepts to Stroke or even too many PSCs, but it is now formally added to the requirements. We know that many PSCs keep their patients who are not eligible for Mechanical Thrombectomy and that these patients require robust care coordination and discharge planning.

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Now moving into the clinical information management or DSCT chapter and there is one requirement to review.

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This is a new requirement for PSC at DSCT.05 EP 5 that states the Primary Stroke Center has a process for obtaining the emergency medical system records. I know that we field reviewed this requirement and received some mixed feedback from you all about the feasibility of this and are we requiring 100% of EMS records to be in the medical record and at what point do we require it, et cetera. As you're starting to see a common theme with the revisions here, we're really interested in the process. There's evidence in the literature to support the accuracy and value of the pre-hospital Stroke assessments, and I'd liken this new requirement to this next example. Just as every once in a while, and I know it would never happen at your hospital, but there's a rogue neuro-assessment that isn't documented. We get it. We know. We know that the care of the patient comes first and there may be contributing factors to that specific lonely missing assessment, but overall, we look at the processes surrounding your assessments and reassessments and if many assessments or reassessments are missing, you may receive a finding for that as there is something bigger going on than a one-off missing NIHSS. There may be a process issue at hand. This is really no different. We're looking for that collaborative relationship with EMS and the process that your program has to make pre-hospital data available for clinicians to use in decision support. Also, as an added bonus, if it isn't already clear how much I love data and process improvement, there is a wealth of knowledge in that pre-hospital data to help enhance existing program processes.

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Next, we'll touch on requirements that affect PSCs who perform Mechanical Thrombectomy. Some of these requirements currently exist for TSC and CSC programs but are now also being applied to PSCs who choose to provide Mechanical Thrombectomy. The intent behind this is that Stroke patients do not choose where they go for treatment when they're experiencing a life-threatening emergency like a large vessel occlusion. In that regard, patients should have access to the same care and treatment at any location that offers these services.

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The first revisions we will discuss are in the Stroke program requirements chapter, DSPR.

00:30:24

This is a revised requirement at DSPR.05 EP 7, which now states a physician privilege to perform Mechanical Thrombectomy is available onsite within 30 minutes during the hours in which Mechanical Thrombectomies are performed. This requirement is not a novel change in that current requirement state, surgeons, neurosurgeons, and other neurosurgical staff are available onsite within 30 minutes to perform and support the performance of emergent neurological procedures. We expanded the requirement to include those that perform Mechanical Thrombectomy because we know it is not always a neurosurgeon. During the onsite review, we will evaluate call schedules to look at coverage and we encourage programs to collect and monitor all contributing factors to outlying door-to-reperfusion times for opportunities for improvement including provider availability.

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The next requirement looks very busy on this slide, and I apologize, but what we are essentially looking at here is a revised requirement regarding neurocritical care coverage. For PSCs who perform Mechanical Thrombectomy, TSCs and CSCs, the requirement to provide 24-hour Neurointensive Care has not changed, but now we have clarified that the program director for the Stroke program in conjunction with the Medical Director of the Intensive Care Unit may determine who is competent to provide onsite critical care. This ties in closely with the other education requirements and that we would expect to see written documentation of the education and competency for these providers.

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Next, we will examine requirements that are applicable to PSC with MT, TSC and CSC in the DSDF chapter and we have one requirement to review.

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This requirement is new to PSC with MT, but is not new to the Stroke requirements, and this is found at DSDF.02 EP 2 which states the Primary Stroke Center has written protocols based on clinical practice guidelines including time parameters for the care of patients with acute Ischemic Stroke requiring endovascular interventions. I have reviewed the rationale for holding PSCs who perform Mechanical Thrombectomy to the same requirements as TSC and CSC, and it is expected that programs have protocols including time goals for care for patients that receive Mechanical Thrombectomies at their organization.

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In the next chapter, Supporting Self-Management, there are two requirements to review.

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The first is a new requirement for PSCs who perform Mechanical Thrombectomy and is not new to the other Stroke program requirements and it is regarding informed consent. We know that Mechanical Thrombectomy is a medical emergency in a vulnerable patient population, and we are looking to standardize processes across all certifications who provide these interventions.

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The next requirement is new to PSCs who perform Mechanical Thrombectomy, TCS and CSEs, and this requirement replaces the traditional seven-day follow-up phone call. What we are interested in here is that the programs again have a process to follow up with patients and not just monitor the percentage of patients who receive a phone call after discharge. This change is derived from examining literature and reflecting on current evidence-based practices. We do not want to burden programs and have them obsess over getting 100% of patients called but instead develop and implement a robust process to ensure that patients who received care at these organizations has smooth transitions to prevent readmission, decreased morbidity, and mortality and subsequent Strokes. I will note that for PSCs who perform MT and TSCs, the requirement applies to patients who received Mechanical Thrombectomy and discharged home. However, for CSC, it applies to all complex Stroke patients who discharged home and as you will see here in this note, follow-up can be obtained in a variety of ways.

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Okay, is everyone still awake and hanging in there? If you've made it this far, we are almost done, I promise. Just a few more revisions to address for TSC and CSC.

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There is one new requirement for TSC, and it is not a new requirement for CSC and that is going to fall in the Delivering or Facilitating Clinical Care chapter.

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Again, this is new for TSC but not for CSC and describe some of the required personnel. The thrombectomy capable Stroke center has the following licensed practitioners and staff members providing care as indicated by patient need. Pharmacists with expertise in neurology and Stroke care, data collection personnel and nurse case managers and social workers with expertise in neurology and Stroke care, care coordination, the different levels of rehabilitation. and expertise in making referrals to the appropriate level of rehabilitation. Additionally, nurse case managers and social workers with knowledge of community resources. What we are trying to ensure here is standardization of care for complex Stroke patients that are under the care of TSC and CSCs to ensure that the correct staff is in place to support patients through the continuum of care.

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Lastly, we'll move into the requirements that only affect Comprehensive Stroke Centers.

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The last two requirements I will review are both in the program requirement DSPR chapter.

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The first is a change that was effective in July of this year, and I wanted to draw your attention to it, and that is we have changed the language regarding treatment of intracranial aneurysms. We have removed the words clipping and coiling and replaced it with an FDA-approved device. We have received questions regarding flow diverters or other devices, and we wanted to make sure that the language was more inclusive to reflect current trends in aneurysm securement. Secondly, you will note that we broadened the language to include carotid artery procedures. Additionally, we do not require 24/7 call schedules for carotid procedures as we know the majority of these cases are urgent, not emergent, but we do require organizations to have the capacity to be able to provide this treatment if clinically indicated.

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The very last requirement I'll review today, yay, is a revised requirement at DSPR.05 EP 1. In this requirement, we clarified the note further to state that patient-centered research refers to research focusing on clinical patient studies. Participating solely in an audit registry for Stroke data and measure outcomes, laboratory-based or humanitarian used device research does not meet this requirement. Yes, you may participate in device trials, however that cannot be your only research participation.

00:37:30

And lastly, just to wrap up, I wanted to discuss a few Frequently Asked Questions that have come up in the past few weeks.

The first question is about the qualifications for the Medical Director, and this can be found at DSPR.01 EP 1. The question that we've been getting is what is considered extensive knowledge and expertise in neurology and cerebrovascular disease?

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And the answer is it's really at the discretion of the organization to determine appropriate qualifications for their Stroke Medical Director. Our definitions of sufficient versus extensive knowledge and expertise are derived from Brain Attack Coalition recommendations for establishment of Certified Stroke Centers.

The Brain Attack Coalition is a group of nonprofit, professional, voluntary, and/or governmental agencies dedicated to setting direction, advancing knowledge, and communicating the best practices to prevent and treat Stroke. As you know, their recommendations are foundational to the establishment of Stroke programs. You can find their publications online by searching the Brain Attack Coalition, but here are some examples of qualifications for say a CSC Medical Director. It may include two or more of the following criteria, a board-certified neurologist or neurosurgeon who has completed a Stroke fellowship or vascular neurosurgery fellowship or has equivocal experience. Board certified in vascular neurology, a fellow of the Stroke Council of the American Heart Association, a clinician who diagnoses and treats over 50 patients with cerebral vascular disease every year. A clinician with over ten peer reviewed publications surrounding cerebrovascular disease, a clinician with over twelve continuing medical education credits each year in areas directly related to cerebrovascular disease, and then other criteria as determined by the local healthcare system.

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The next Frequently Asked Question we've been getting is about telemedicine, and this refers to DSPR.03 EP 4. The question is is a live interactive physical exam with real time viewing of the patient required for every telemedicine encounter?

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And the answer is that the program is required to have access to Stroke expertise 24/7 either in person or telemedicine. If the onsite providers are privileged to diagnose and treat acute Stroke, then telemedicine or live interactive physical exam is not necessary unless deemed appropriate by the treating physician. What we are talking about here is the capability to have a live physical exam with real-time viewing of the patient. It may not be deemed necessary for all encounters, and in some cases a telephonic consultation may be appropriate. It's ultimately at the discretion of the program and the telemedicine contracted service, whether that be external or another Stroke center to determine the process that will be used.

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The next question is regarding DSPR.05 EP 7 and the requirements surrounding the neurointerventionist and neuro IR teams that support them. The question is, if the neurointerventionist has to be on site within 30 minutes, does the entire team need to be there as well?

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And the answer is that this requirement is really referring to the capability of the physician to be onsite within the required timeframe. The intent is to allow equal, timely access to care for eligible Mechanical Thrombectomy patients. The requirement does not call out the endovascular team specifically, however, the organization needs to have protocols for team arrival that reflect the ability to support the cases.

Ultimately, we note that there are sometimes factors outside of our control that may lead to outliers in this requirement. What we are expecting to see here is that call schedules, support this requirement and that programs are able to afford Mechanical Thrombectomy patients timely access to treatment.

00:41:32

Additionally, I've gotten some questions about whether the time requirement for 30 minutes refers to patient arrival to the hospital or 30 minutes from notification to the provider, and we're talking about the ladder here, so 30 minutes from notification.

We know that our neurointerventionists are all wonderful, but we also know that they're not superheroes that live at the hospital. At least we hope that they don't, and we expect that programs monitor their data and their associated time-to metrics for Mechanical Thrombectomy cases. In outliers, one of the data points to evaluate would be physician arrival to case to look for any outliers or opportunities for improvement in their processes.



00:42:12

I've also gotten some questions as to whether IR support staff can be on call for cardiac and Stroke cases, and we know that multiple MTs at one time is a relatively less frequent occurrence, but really what we're interested in seeing is how your coverage model supports the needs of your patients, including multiple presenting patients, because although it doesn't happen often, it does happen and we need to see what your program's protocols are to address this.

00:42:41

And lastly, the requirement at DSD.F.01 EP 1 about Stroke scales. The question that we've received is, do all registered nurses who care for Stroke patients have to complete NIHSS certification training?

00:42:55

The short answer is no. However, this is not a new requirement, but the language has changed to registered nurses who care for Stroke patients demonstrate comprehension of the Stroke scales used in the program. It's at the discretion of the organization to determine who will perform the NIHSS and as such would need to complete subsequent certification training. This decision is made based upon protocols for care derived from national guidelines. This specific requirement refers to nurses comprehending the measurements of the Stroke skills utilized. For example, what are they used for? What do changes mean and how is it going to guide the plan of care? We know that different programs choose different groups of licensed practitioners to be NIHSS certified. However, it is the expectation that nurses who provide Stroke care look beyond what the number of a Stroke scale is and understand the intent behind it. This also applies to hemorrhagic Stroke scales used as well.

00:43:57

Okay, we made it, I think I have reviewed 99.999% of all revisions for the upcoming standards effective January 1st of 2024, but if I've left something out, you still have a burning question, or need further clarification, please use this link to submit your inquiries. Alright, thank you everyone for hanging in there with me and I appreciate having the opportunity to discuss the revised Stroke Certification requirements with you all. I will now hand it back to Jessica to close out this learning activity.

00:44:30

Paula, thank you so much for presenting the content for this webinar. Included a resource slide here to provide direct links for participants to access.

We wanted to take a few moments to inform the audience about how to ask questions regarding today's webinar content.

To ask questions about the standards or resources, please use the inquiry form at this address, dssminquiries.jointcommission.org. Joint Commission staff closely monitor this portal.

To review the pre-publication standards, please visit the link on the screen.

For questions regarding webinar operations or CEs, please submit them via email to pioneersinquality@jointcommission.org.



00:45:20

Pioneers in Quality webinar recording links, slides, transcripts, and Q&A documents can be accessed on The Joint Commission's webpage via this link.

After this webinar is no longer available for CE credit, the recording and materials will remain accessible at the link.

00:45:41

Before this webinar concludes, a few words about the CE survey. We use your feedback to inform future content and assess the quality of our educational programs. As explained earlier in the webinar, a QR code will appear on the final slide and you can use your mobile device to access it. After the recording concludes, a pop-up will also display within the webinar platform that includes the link to the survey. Cut and paste that link into your browser to go immediately into the survey. If you prefer to take the CE survey later, an automated email also delivers the link to the survey.

At the end of the survey, when you click Submit, you'll be redirected to a page from which you can print or download a PDF CE certificate. In case you missed that opportunity to download, an automated email will also be sent to you that includes the link to the CE certificate. That email is sent to the email that you provide within the CE survey.

00:46:44

Thank you to Paula for presenting this content. We hope the information provided today will help to prepare you to meet the Stroke Certification requirements. Have a great day.