

# Requirements for Comprehensive Stroke Certification Standards Crosswalk, 2021 edition to 2024 edition



The publication, *Requirements for Comprehensive Stroke Certification*, has been revised to reflect current standards of practice, improve clarity and flow, and reduce redundancy. The crosswalk below presents only standards with changes that influence compliance. Under each chapter title, the 2021 standard number and title are identified, followed by the 2024 number and title. Where that remains unchanged, there is only one entry. The next line indicates where the change appears (in the standard, in the required elements, or in the survey procedure) and characterizes the change (deleted, consolidated, revised, new).

The largest cell provides detail of changes that impact intent or potential compliance action. Existing text that is unchanged or changed from the prior edition only to improve clarity (e.g., grammar, eliminating redundancy, revised information flow, removal of outdated references, etc.) is not included. Text deleted from the prior edition of the manual appears (often as an excerpt) with ~~strikethrough~~ and new content appears **bolded**. An entirely new standard will be in **bold, blue font**.

Please refer to the full manual to review the complete standard, required elements, and survey procedures.

As always, contact us at [customerservice@achc.org](mailto:customerservice@achc.org) with questions or comments.

Standard # and title	
Location and Type of change	Detail of change
<b>01.00   Governance Functions: Strategic Direction</b>	
<del>01.00.01</del> <b>01.00.04</b> GOVERNANCE PLAN	
<ul style="list-style-type: none"> <li>Standard renumbered</li> <li>Required elements revised (some relocated to 01.00.03)</li> </ul>	
01.00.02 TARGET POPULATION AND SERVICE DELIVERY	
<ul style="list-style-type: none"> <li>Required elements revised (some relocated to 01.00.03)</li> </ul>	
<del>01.00.03</del> <b>01.00.01</b> LICENSURE	
<ul style="list-style-type: none"> <li>Standard renumbered</li> </ul>	
<b>01.00.03 STRATEGIC PLAN</b>	
<ul style="list-style-type: none"> <li><b>New Standard</b></li> <li>Required elements from 01.01.01 and 01.01.02 moved, clarified, and augmented with <b>new elements</b>.</li> </ul>	<p><u>Standard</u>  <b>A defined strategic plan supports the Stroke Program and the needs of the patient population.</b></p> <hr/> <p><u>Required Elements</u>            The hospital outlines a plan for the Stroke Program that includes:</p> <ul style="list-style-type: none"> <li><b>Departments involved in the provision of stroke care.</b></li> </ul>

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	<ul style="list-style-type: none"> <li>■ Strategic partnerships.                             <ul style="list-style-type: none"> <li>» Including, but not limited to, services to support continuity of care (such as rehabilitation services and medical supply companies) and to optimize care and patient outcomes.</li> </ul> </li> </ul> <hr/> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li>■ A written plan includes the required elements.</li> </ul>
<p><del>01.00.04</del> <b>01.00.05</b> GRIEVANCE PROCESS</p>	
<ul style="list-style-type: none"> <li>■ Standard renumbered</li> </ul>	
<p><b>01.01   Governance Functions: Credentialing</b></p>	
<p>01.01.01 MEDICAL DIRECTOR</p>	
<ul style="list-style-type: none"> <li>■ Required elements revised</li> </ul>	<p><u>Required Elements</u></p> <ul style="list-style-type: none"> <li>■ <del>At least five articles in peer-reviewed, specialty-related publications.</del></li> </ul> <p>The medical director completes at least <del>twelve</del> <b>eight</b> continuing medical education (CME) credits in stroke care each year. <b>This should include</b> attendance or a faculty role at one or more regional, national, or international specialty conferences or courses each year.</p>
<p>01.01.02 MEDICAL STAFFING</p>	
<ul style="list-style-type: none"> <li>■ Required elements revised (some relocated to 02.00.09)</li> <li>■ Survey procedure revised</li> </ul>	<p><u>Required Elements</u></p> <p><del>Physicians</del>  <del>Are available during all hours of operation. (Physician, or designee, is accessible by phone within 20 minutes and onsite within 30 minutes).</del></p> <p><b>PROVIDERS</b></p> <p><b>Medical providers:</b></p> <ul style="list-style-type: none"> <li>■ Are available 24 hours a day, seven days a week. All providers (surgeons, neurosurgeons, interventionalists) are onsite within 30 minutes. Physicians who can treat are available in house or via telemedicine within a time frame defined by the hospital to adequately meet stroke performance metrics, unless otherwise specified by state regulations.</li> <li>■ Include additional credentialed physicians accessible by phone and available 24 hours every day of the year including:                             <ul style="list-style-type: none"> <li>» Physician(s) with imaging experience in head computerized tomography and brain magnetic resonance imaging.</li> </ul> </li> </ul>

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	<ul style="list-style-type: none"> <li>» Diagnostic radiologist(s) (maybe via telemedicine).</li> <li>» Physician with cerebrovascular experience.</li> <li>» Physicians with neurocritical care experience. This may include using, under supervision:                             <ul style="list-style-type: none"> <li>▪ Fellows, residents, advanced practice nurses, and/or physician assistants with education and expertise in neurocritical and cerebrovascular care (provided that the clinician meets the organization’s education and experience requirements and a physician with neurology and critical care experience is available by phone and onsite within a timeframe defined by hospital policy).</li> </ul> </li> <li>» Neurosurgeon(s) with expertise in cerebrovascular surgery.</li> <li>» Surgeon(s) with expertise in carotid endarterectomy.</li> <li>» Anesthesia providers.</li> </ul> <p><b>PROVIDER QUALIFICATIONS</b> Individual physicians, APRNs, PAs, and other applicable clinicians, undergo a credentialing process (new appointments or reappointments) consistent with national standards and guidelines.</p> <p>Minimum thrombectomy case requirements: Each provider has performed at least 15 ...</p> <p><b>For thrombectomies, each provider must be privileged to perform intra-arterial revascularization and meet minimum thrombectomy case requirements as defined by the Stroke Program. Case volume requirements are established based on evidence-based guidelines and outcome data. When case volumes are not met, other means of maintaining competency must be defined. If case volumes are otherwise specified in state regulations, these volume requirements must be met.</b></p> <hr/> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li>▪ Provider case volumes meet identified thresholds.</li> </ul>

## 01.03 Governance Functions: Social Responsibility

01.03.01 HEALTH PROMOTION	
<ul style="list-style-type: none"> <li>▪ Standard revised</li> <li>▪ Required elements revised</li> <li>▪ Survey procedure revised</li> </ul>	<p><u>Standard</u> The service provides at least <del>two</del> <b>one</b> educational program...</p> <hr/> <p><u>Required Elements</u> <del>Note: Studies demonstrate ... an ambulance.</del> The stroke center takes on responsibility ...</p>

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	<p>Community education programs...</p> <p>Education programs should focus on...</p> <p>Education is provided at least twice...</p> <p><b>The stroke program offers community education focusing on stroke prevention, symptom recognition, and care options.</b></p> <p><b>Programs are provided at least once a year and evaluations are collected, analyzed, and used to improve public education.</b></p> <hr/> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li>The service provides <del>two</del><b>one</b> community education program each year.</li> </ul>
01.03.02 AGREEMENTS WITH HEALTHCARE PARTNERS HEALTHCARE PARTNERSHIPS	
<ul style="list-style-type: none"> <li>Standard retitled</li> <li>Standard revised</li> <li>Required elements revised</li> </ul>	<p><u>Standard</u></p> <p>The comprehensive stroke Center has established...<b>When transferring acute stroke patients out of this facility, the transfer must be to a stroke center with at least equivalent capability.</b></p> <hr/> <p><u>Required Elements</u></p> <p>When developing <del>partnerships, the stroke ready or primary stroke center is to ensure timeframes for transfer. Guidelines recommend door-to-stroke unit admission within 4.5 hours.</del> <b>agreements the comprehensive stroke center defines time frames for transfer to and from other stroke centers to ensure patient needs are met. Defined time frames may vary based on clinical needs, triage, and patient outcomes.</b></p> <p>Partnership is demonstrated by one or more of the following:</p> <ul style="list-style-type: none"> <li><b>Clinical communication between hospitals.</b></li> </ul>
02.00   Clinical Functions: Service Integration	
02.00.01 EMERGENCY DEPARTMENT	
<ul style="list-style-type: none"> <li>Required elements revised and reordered (see manual for full text)</li> <li>Survey procedure revised</li> </ul>	<p><u>Required Elements</u></p> <p><del>Care that is provided using evidence-based protocols may improve patient outcomes, expedite patient care, reduce hospital length of stays, and decrease costs.</del></p> <p><b>Emergency department physicians must be available to assess the patient 24/7 and at the bedside within 10 minutes or less, or in accordance with state requirements.</b></p> <p><b>Facilities must develop, adopt, and adhere to care protocols aligned with nationally recognized standards of practice and consistent with all applicable state and federal regulations.</b></p>

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	<p>The comprehensive stroke program has, at minimum, the following protocols in place:</p> <ul style="list-style-type: none"> <li>Ischemic stroke treatment protocols to address large vessel occlusions (LVO), eligibility criteria for treatment with thrombolytics, and measures to immediately control blood pressure.</li> <li>Intracranial hemorrhage (ICH) treatment protocols to immediately control blood pressure and reversal of coagulopathy to be started in the emergency department, when appropriate.</li> <li>Patient transfer protocols to another comprehensive stroke center, when appropriate. The patient transfer protocol is compliant with the Emergency Medical Treatment and Active Labor Act (EMTALA). A transfer agreement is expected with at least one healthcare organization that offers the same level of care to stroke patients.</li> <li>Defined patient protocols to address critical care services that may be compromised if systems are not functioning properly.</li> </ul> <hr/> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li>Staff/providers are knowledgeable of <del>mechanical thrombectomy</del> regarding <b>all protocols in the required elements</b>.</li> <li>Required policies and protocols are in place and reflect nationally recognized guidelines.</li> <li>Patient medical records reflect compliance with established protocols.</li> </ul>
02.00.02 SPECIALTY UNIT: STROKE	
<ul style="list-style-type: none"> <li>Required elements revised</li> <li>Survey procedure revised</li> </ul>	<p><u>Required Elements</u></p> <p><del>American Heart Association/American Stroke Association guidelines...may share space.</del></p> <p><del>Acute stroke clinicians...are rostered for the Stroke Unit.</del></p> <p><b>Door-to-stroke unit admission time is defined by the hospital and ensures patient care is not compromised if admission cannot be accomplished within this time frame. If there is a delay in admission to the stroke unit, protocols are initiated and followed to ensure continuity of care.</b></p> <p><b>The multidisciplinary stroke team is defined by the program and includes all services required to meet the needs of the patients and the stroke performance measures. The acute stroke clinicians have training and expertise in managing patients with cerebrovascular disease.</b></p> <p><b>The stroke unit provides, at minimum:...</b></p>

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	<ul style="list-style-type: none"> <li>Continuous telemetry monitoring for a minimum of 24 hours to detect cardiac arrhythmias.</li> </ul> <hr/> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li>Stroke Unit maintains patient census (admission and discharge) records.</li> </ul> <p><u>Observation</u></p> <p>Tour the Stroke Unit to verify continuous telemetry, noninvasive blood pressure monitoring.</p> <p><b>Verify, at minimum:</b></p> <ul style="list-style-type: none"> <li>Staff education and training.</li> <li>Staff/providers are knowledgeable regarding all stroke treatment policies and protocols.</li> <li>Required policies and protocols are in place and reflect nationally recognized guidelines.</li> <li>Medical records reflect compliance with established protocols and admissions time frames.</li> <li>Management and care of stroke patients is consistent with protocols.</li> </ul>
02.00.03 SPECIALTY UNIT: INTENSIVE CARE	
<ul style="list-style-type: none"> <li>Standard revised</li> <li>Required elements revised (All existing elements replaced.)</li> <li>Survey procedure revised (All existing content replaced.)</li> </ul>	<p><u>Standard</u></p> <p><del>The intensive care unit provides</del> <b>The comprehensive stroke center has a neurointensive care unit (ICU) or designated ICU beds to provide</b> continuity of care during the immediate, hyperacute phase of acute stroke <del>and/or cerebrovascular disease</del>.</p> <hr/> <p><u>Required Elements</u></p> <p><b>In addition to meeting the stroke unit requirements at 02.00.02, the ICU also has:</b></p> <ul style="list-style-type: none"> <li>A protocol to monitor and manage stroke beds for all patients requiring ICU care.</li> </ul> <p>If stroke beds are not immediately available in the ICU, the protocol admits the stroke patient as soon as a bed is available.</p> <ul style="list-style-type: none"> <li>» There is continuous assessment of patients against internal transfer criteria for the appropriate level of care. This process assists in triaging the availability of ICU beds for stroke patients requiring a higher level of care. This process does not require keeping beds empty in case of a stroke admission.</li> <li>» Patients waiting for bed assignment must have appropriate care with a stroke trained nurse. Relevant stroke protocols are initiated and the neurocritical team must be involved.</li> </ul> <ul style="list-style-type: none"> <li>The ability to continuously monitor the neurological and</li> </ul>

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	<p>physiological status...</p> <ul style="list-style-type: none"> <li>▪ A written staffing plan...</li> <li>▪ At minimum, patient management protocols in place for thrombolytic administration, intracranial hemorrhage care, post-thrombectomy care and post-neurosurgery care.</li> <li>▪ Designated nursing team and medical team.</li> <li>▪ Providers with expertise in neuro-critical care. This should include:                             <ul style="list-style-type: none"> <li>» Physician(s) with neuro-intensive care training/experience.</li> <li>» Allied health practitioners with neuro-intensive care training/experience.</li> </ul> <p>Note: Residents, APNs, and PAs must be under the direction of the neuro-specialized physician, in accordance with applicable federal and state regulations.</p> </li> </ul> <p>The Stroke Program defines the stroke and neurological education and training requirements for the ICU nurse to care for stroke and cerebrovascular disease patients.</p> <hr/> <p><u>Survey Procedure</u></p> <p>Verify, at minimum:</p> <ul style="list-style-type: none"> <li>▪ Staff education and training.</li> <li>▪ Staff/providers are knowledgeable regarding all stroke care treatment policies and protocols.</li> <li>▪ Required policies and protocols are in place and reflect nationally recognized guidelines.</li> <li>▪ Leadership or responsible staff are knowledgeable about the stroke bed management process.</li> <li>▪ Staffing is consistent with the staffing plan.</li> <li>▪ Medical records reflect compliance with established protocols.</li> <li>▪ Management and care of stroke patients is consistent with protocols.</li> </ul>
02.00.04 NEUROIMAGING	
<ul style="list-style-type: none"> <li>▪ Standard revised</li> <li>▪ Required elements revised (All existing elements replaced except as noted.)</li> <li>▪ Survey procedure revised</li> </ul>	<p><u>Standard</u></p> <p>The comprehensive stroke center performs advanced imaging necessary to diagnose or rule out <b>intracerebral stroke or hemorrhagic stroke</b> 24 hours a day, seven days a week.</p> <hr/> <p><u>Required Elements</u></p> <p><b>For acute stroke patients, rapid establishment of an accurate diagnosis is vital and requires brain-imaging studies.</b></p>

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	<p><b>Neuroimaging services for acute stroke patients must always be readily available. All patients with suspected acute stroke receive emergency brain imaging on arrival before initiating any specific therapy to treat stroke. Initial imaging (CT or MRI) must be performed, interpreted, and communicated to the provider within 45 minutes or less to successfully meet defined performance metrics for the certification level. Timelines are defined and communicated to the individual(s) responsible for oversight of imaging services.</b></p> <p>Neuroimaging services available at the facility include:</p> <ul style="list-style-type: none"> <li>▪ Multimodal CT and MRI.</li> <li>▪ Head and neck CTA.</li> <li>▪ Head and neck MRI, including DW-MRI.</li> <li>▪ Magnetic resonance angiography (MRA) (head and neck).</li> <li>▪ Catheter angiography.</li> <li>▪ Carotid duplex ultrasound.</li> <li>▪ Extracranial ultrasonography.</li> <li>▪ Transthoracic echocardiography (TTE).</li> <li>▪ Transesophageal echocardiography (TEE).</li> </ul> <p><b>The director and staff of imaging services are educated, committed, and evaluated on services provided to support the Stroke Program. This may be reflected in an agreement or document that outlines services and time frames. The delivery and quality of neuroimaging services related to the Stroke Program is evaluated.</b></p> <p>A qualified physician...</p> <p><b>Because the benefit of therapy is time dependent, administration of a thrombolytic in eligible patients should be given before obtaining a follow-up MRI, unless the MRI is the initial imaging modality.</b></p> <p><b>For patients who meet the criteria for mechanical thrombectomy, noninvasive vessel imaging of the intracranial arteries is recommended during the initial imaging evaluation. Noninvasive vessel imaging should be obtained as quickly as possible, e.g., during thrombolytic administration.</b></p> <p><b>For patients with suspected large vessel occlusion (LVO) who meet thrombectomy criteria, it is reasonable to proceed with computed tomographic angiography (CTA) before obtaining a serum creatinine concentration.</b></p> <p><b>CT perfusion (CTP) or diffusion weighted (DW)-MRI with or without MRI perfusion are recommended for patients presenting with LVO within 24 hours of time last known well.</b></p> <hr/> <p><u>Survey Procedure</u> <b>Verify, at minimum:</b></p>

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	<ul style="list-style-type: none"> <li><del>• The imaging director's letter of commitment is in place.</del></li> <li>▪ <b>The neuroimaging service agreement.</b></li> <li>▪ Imaging services are available 24/7 and interpreted by a <b>qualified provider.</b></li> <li>▪ <b>Neuroimaging equipment is available at the facility.</b></li> <li><del>▪ Imaging is performed, interpreted and communicated to the provider within 45 minutes...</del></li> <li>▪ <b>Medical records reflect neuroimaging studies performed and communicated to the provider within the required time frame.</b></li> </ul>
02.00.05 LABORATORY SERVICES	
<ul style="list-style-type: none"> <li>▪ Required elements revised (All existing elements replaced except as noted.)</li> </ul>	<p><u>Required Elements</u>  <b>For all tests defined by the organization as stroke labs (blood glucose, at minimum),</b> the laboratory has the capacity to perform, interpret, and communicate test results to the provider within 45 minutes, to meet the performance measures defined for this certification level.</p> <p>The laboratory director <b>and staff are educated on,</b> committed to, <b>and evaluated on</b> laboratory services provided to support the Stroke Program. <b>This may be reflected in an agreement or document that identifies services and time frames. The delivery and quality of laboratory services related to the Stroke Program is evaluated.</b></p> <p>Lab services include, but are not limited to:...</p> <ul style="list-style-type: none"> <li>▪ Point-of-care blood glucose...</li> <li>▪ <b>CBC</b></li> <li>▪ <b>Metabolic Profile</b></li> <li>▪ <b>Troponin.</b></li> <li>▪ <b>Hemoglobin A1C.</b></li> <li>▪ <b>Lipid profile.</b></li> <li>▪ International Normalized Ratio* (INR), Prothrombin Time (PT) and Partial Thromboplastin Time (PTT), if clinically indicated.</li> </ul> <p><b>*If clinically indicated, other tests may be necessary. For example, international normalized ratio, activated partial thromboplastin time, and platelet count, may be necessary if there is suspicion of coagulopathy. Given the extremely low risk of unsuspected abnormal platelet counts or coagulation studies in a population, IV alteplase treatment should not be delayed while waiting for hematologic or coagulation testing if there is no reason to suspect an abnormal test.</b></p>

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02.00.06 MEDICATION MANAGEMENT	
<ul style="list-style-type: none"> <li>Required elements revised</li> <li>Survey procedure revised</li> </ul>	<p><u>Required Elements</u></p> <p>The stroke center establishes a goal for “Door to Needle” time for administration of tPA within current national guidelines.</p> <p>The comprehensive stroke center administers tPA 25 or more times...via telemedicine.</p> <p>Minimally, the following guidelines are available...</p> <ul style="list-style-type: none"> <li>Patients with...<b>Blood pressure management for hypertensive patients before thrombolytic therapy is initiated and throughout their hospitalization. Documentation supports any blood pressure management outside of hospital policy requirements.</b></li> <li><del>Drug spill...</del></li> </ul> <p>The stroke center protocols ensure treatment for thrombolytic-eligible patients in the fastest achievable time frame. The organization defines its goal for administration of IV thrombolytics in as timely and safe a manner as possible within 45 minutes of arrival in the emergency department. The hospital meets performance measures SM-12A and SM-12B and strives to meet SM-12C.</p> <ul style="list-style-type: none"> <li>Eligible stroke patients with mild but disabling stroke symptoms are treated within 4.5 hours of ischemic stroke symptom onset or the patient’s time last known well or at baseline state.</li> <li>Patients eligible for thrombolytic therapy should receive thrombolytics even if mechanical thrombectomy is being considered.</li> </ul> <p>The comprehensive stroke center administers thrombolytics at least 25 times per year <b>or 50 times within two years</b>. This count may include... <b>When thrombolytic administration volumes are not met, other means of maintaining competency must be defined.</b></p> <p>Quality improvement initiatives related to medication management are used to safely increase treatment frequency with IV thrombolytics.</p> <p><b>Intracerebral Hemorrhage (ICH)</b></p> <p>The organization develops patient care policies and protocols for the management of ICH patients including, but not limited to:</p> <ul style="list-style-type: none"> <li>Severe coagulation factor deficiency or severe thrombocytopenia.</li> <li>INR elevated due to Vitamin K antagonist (VKA).</li> <li>Hypertension treated initially and throughout hospitalization.</li> </ul>

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	<p><u>Survey Procedure</u> Verify, at minimum:</p> <ul style="list-style-type: none"> <li>▪ <b>Required patient care protocols and policies are developed collaboratively with pharmacy and acute stroke clinicians to align with nationally recognized guidelines.</b></li> <li>▪ <b>Medical records are consistent with facility policies, protocols, and nationally recognized guidelines.</b></li> <li>▪ <b>IV thrombolytics are administered at least 25 times/year or 50 times/2 years.</b></li> </ul> <p><b>Quality Measure Benchmark</b></p> <ul style="list-style-type: none"> <li>▪ <b>SM-12C Door-to-Needle Time 30 Minutes</b></li> <li>▪ <b>SMA-4 Procoagulant Reversal Agent Initiated for ICH</b></li> </ul>
<p><b>02.00.07 SURGICAL Services- STAFFING</b></p>	
<ul style="list-style-type: none"> <li>▪ Standard retitled</li> <li>▪ Standard revised</li> <li>▪ Required elements revised (Some moved to 01.01.02 MEDICAL STAFFING and 02.02.02 PATIENT ASSESSMENT)</li> <li>▪ Survey procedure revised (All existing elements replaced except as noted.)</li> </ul>	<p><u>Standard</u> <del>Processes are in place to provide surgical services.</del> <b>The Stroke Program is appropriately staffed to perform a defined minimum number of stroke and cerebrovascular procedures.</b></p> <p><u>Required Elements</u> The comprehensive stroke center has a written <b>policy</b> that outlines neurosurgical <b>and neurointerventional</b> staffing coverage, including support personnel... <b>For thrombectomies, staffing includes a nurse and a technician trained in the procedure.</b></p> <p>A call schedule for neurosurgery and <b>neurointerventional radiology</b> is available to <b>all departments, providers, and staff involved in stroke care.</b> Neurosurgeons, <b>neurointerventionalists</b>, surgical and <b>interventional</b> qualified support personnel... Surgical and <b>interventional</b> staff must be onsite within 30 minutes...</p> <p>The comprehensive stroke center:</p> <ul style="list-style-type: none"> <li>▪ <del>Cares for at least 20 subarachnoid...</del></li> <li>▪ <del>Performs at least 10 clippings...</del></li> <li>▪ <del>Performs at least 20 carotid stents...</del></li> </ul> <p>For thrombectomy patients</p> <ul style="list-style-type: none"> <li>▪ <del>Physicians are privileged...</del></li> <li>▪ <del>Mechanical thrombectomy is...</del></li> <li>▪ <del>Post procedural pedal pulse and groin checks are...</del></li> <li>▪ <del>Observation for clinical response after tPA...</del></li> <li>▪ <del>At least 15 thrombectomies...</del></li> </ul> <p><b>To maintain proficiency, annual case volume requirements per provider should minimally include the following:</b></p> <ul style="list-style-type: none"> <li>▪ Subarachnoid hemorrhage (excluding trauma).</li> </ul>

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	<ul style="list-style-type: none"> <li>▪ Elective and emergent aneurysmal clippings and/or endovascular coilings.</li> <li>▪ Carotid stents and/or endarterectomies.</li> <li>▪ Thrombectomies.</li> </ul> <p><b>The goal of the thrombectomy procedure is reperfusion as early as possible within the therapeutic window. When appropriate mechanical thrombectomy should not be delayed for thrombolytic administration and should be performed for acute ischemic stroke (AIS) patients with large vessel occlusion (LVO) within 24 hours of time last known well.</b></p> <p><b>Case volume requirements should align with evidence-based guidelines and outcome data. When case volumes are unmet, other means of maintaining competency must be defined. If case volume requirements are otherwise specified in state regulation, these volumes must be met.</b></p> <hr/> <p><u>Survey Procedure</u></p> <p><b>Verify, at minimum:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Written policy and its approval for neurosurgical and neurointerventional coverage.</b></li> <li>▪ <b>Neurosurgery and neurointerventional call schedule.</b></li> <li>▪ <b>Neurosurgeon, neurointerventionalist, and qualified support personnel are available 24/7.</b></li> <li>▪ <b>Staffing is appropriate for surgical and interventional procedures.</b></li> <li>▪ <b>Medical records reflect procedural time frames consistent with policies/protocols.</b></li> <li>▪ <b>Case volume requirements are met.</b></li> </ul> <p>Quality Measure Benchmark</p> <ul style="list-style-type: none"> <li>▪ <del>SM-16 Neurosurgical Services</del></li> <li>▪ <b>SMA-8 Thrombolysis in Cerebral Infarction</b></li> <li>▪ <b>SMA-9 Door-to-Skin Puncture Time</b></li> <li>▪ <b>SMA-11 Timeliness of Reperfusion From Hospital Arrival</b></li> <li>▪ <b>SMA-12 Timeliness of Reperfusion From Skin Puncture</b></li> <li>▪ <b>SPG 1A Door to First Pass or Device Time</b></li> <li>▪ <b>SPG 1B Door to First Pass or Device Time</b></li> </ul>
<b>02.00.08 Surgical Procedures STROKE SURGICAL AND INTERVENTIONAL CARE</b>	
<ul style="list-style-type: none"> <li>▪ Standard retitled</li> <li>▪ Standard revised</li> <li>▪ Required elements revised</li> <li>▪ Survey procedure revised</li> </ul>	<p><u>Standard</u></p> <p><del>Procedures are in place for patients receiving surgical services.</del></p> <p><b>Care for stroke patients meets nationally recognized guidelines for pre-operative, intra-operative, and post-operative care.</b></p> <hr/> <p><u>Required Elements</u></p>

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	<p>The policies and protocols are consistent with ..., if indicated:</p> <ul style="list-style-type: none"> <li>Prophylactic antibiotic..</li> <li>Hair removal...</li> <li>Perioperative glucose...</li> <li><b>Criteria for mechanical thrombectomy procedures.</b></li> <li><b>Management of thrombectomy patients.</b></li> </ul> <p><b>Patients undergoing stroke-specific procedures must have appropriate care before, during, and after the procedure. Procedural assessments are performed in accordance with hospital policy and include physiological and neurological monitoring, assessment of pedal or radial pulses, where applicable, and surgical site assessment.</b></p> <hr/> <p><u>Survey Procedure</u></p> <p><b>Verify, at minimum:</b></p> <ul style="list-style-type: none"> <li><b>Policies align with nationally recognized guidelines.</b></li> <li><b>Medical records include required documentation.</b></li> <li><b>The following items are observable:</b> <ul style="list-style-type: none"> <li>» <b>The time-out process is completed in accordance with all required elements and hospital policy.</b></li> </ul> </li> <li>Medical records <b>reflect time frames</b> for pre- and post-procedural assessments <b>that are consistent with policies/protocols.</b></li> </ul>
<b>02.00.09 ANESTHESIA SERVICES</b>	
<ul style="list-style-type: none"> <li>Required elements revised</li> </ul>	<p><u>Required Elements</u></p> <p><b>Intraoperative documentation follows hospital policy, and includes at least:</b></p> <ul style="list-style-type: none"> <li><b>Name, dosage, route and time of administration of drugs and anesthesia agents.</b></li> <li><b>Time based documentation of vital signs, oxygenation, ventilation parameters.</b></li> </ul>
<b>02.00.10 CONTRACTED TELEMEDICINE SERVICES</b>	
<ul style="list-style-type: none"> <li>Standard retitled</li> <li>Standard revised</li> <li>Required elements revised</li> <li>Survey procedure revised</li> </ul>	<p><u>Standard</u></p> <p><del>Access to specialists and provision of specialty consultation via telemedicine is through a credentialed provider.</del></p> <p><b>Specialty consultation through contracted telemedicine services is through a credentialed and privileged provider.</b></p> <hr/> <p><u>Required Elements</u></p> <p><del>Telemedicine has been used...administration of medication therapy.</del></p> <p><del>In certain remote and underserved areas, telemedicine may be used to assess patients.</del> <b>Services contracted through</b></p>

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Standard # and title	
Location and Type of change	Detail of change
	<p>telemedicine in accordance with state regulation can assist in recommending treatment when onsite expertise is not available.</p> <ul style="list-style-type: none"> <li>▪ Teleradiology systems can offer rapid imaging interpretation in patients with suspected acute stroke to support timely IV thrombolytic administration.</li> <li>▪ Telestroke services can triage patients with acute stroke. Consultation with a neurologist, neurosurgeon, or neuro-interventionalist privileged to diagnose and treat stroke must be within the time frame defined by policy. Telemedicine physicians must be credentialed and privileged at the healthcare organization. If the remote healthcare organization is across state lines, the medical staff may need licensure in both states.</li> </ul> <p>When <del>teleradiology</del> <b>contracted telemedicine</b> is used, the written agreement <b>defines the availability of the service to cover any hours that the hospital does not provide onsite staffing</b> so that resulting coverage is 24 hours a day, 7 days a week, and <b>results are ready within 45 minutes</b> <del>the time frames defined by the hospital to meet the quality measure benchmarks.</del></p> <p>Training is provided, at least twice a year minimum, <b>during orientation for personnel involved with telemedicine technology at the patient location.</b></p> <hr/> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li>▪ <del>Services are available 24 hours...</del> <b>The contract agreement provides for appropriate coverage and actual coverage is consistent with the agreement.</b></li> <li>▪ Credential files include:             <ul style="list-style-type: none"> <li>» <del>License to practice medicine in all applicable states the location of the Stroke Program.</del></li> <li>» <del>Includes physicians at the remote location.</del></li> <li>» <b>Appropriate credentialing and privileging by the healthcare organization.</b></li> </ul> </li> </ul>

## 02.01 | Clinical Functions: Standards of Care

02.01.01 Reserved for Future Use- PATIENT RIGHTS	
<ul style="list-style-type: none"> <li>▪ Standard renumbered and retitled</li> <li>▪ Required elements revised</li> <li>▪ Survey procedure revised (with no change to the intent)</li> </ul>	<p><u>Standard</u>  <del>The patient is made aware of his/her rights.</del> <b>The patient or their representative is notified of their rights.</b></p> <hr/> <p><u>Required Elements</u></p> <ul style="list-style-type: none"> <li>▪ <b>Information regarding risks associated with treatment options</b> and consequences of non-compliance with</li> </ul>

# Requirements for Comprehensive Stroke Certification Standards Crosswalk, 2021 edition to 2024 edition



Standard # and title	
Location and Type of change	Detail of change
	<p>recommended treatment options.</p> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li><del>▪ Organizational protocols for informed consent and advanced directives are available, relevant and current.</del></li> <li><del>▪ Evidence of informed consent is in medical records.</del></li> <li>▪ <b>Medical records are consistent with policy.</b></li> <li>▪ <b>Patients understand their rights and treatment options.</b></li> </ul>
02.01.02 ACCESS TO CARE	
<ul style="list-style-type: none"> <li>▪ Standard retired</li> </ul>	
02.01.03 PATIENT RIGHTS	
<ul style="list-style-type: none"> <li>▪ Standard relocated to 02.01.01</li> </ul>	
<b>02.02   Clinical Functions: Delivery of Care</b>	
02.02.01 POLICIES, PROTOCOLS, AND GUIDELINES	
<ul style="list-style-type: none"> <li>▪ Standard revised</li> <li>▪ Required elements revised (Some elements relocated to 01.00.03 STRATEGIC PLAN)</li> <li>▪ Survey procedure revised (All existing elements replaced.)</li> </ul>	<p><u>Standard</u></p> <p><del>The program design is written and protocols are available and developed based on published, current, and evidence-based guidelines, when possible, and tailored to the needs of the stroke patient by the multidisciplinary team members that provide care and treatment.</del> <b>Policies, protocols, and guidelines are current, and evidence-based.</b></p> <p><u>Required Elements</u></p> <p><b>Policies, protocols provide and clinical practice guidelines are based on nationally recognized standards of practice, such as the Brain Attack Coalition and AHA/ASA guidelines, reviewed annually, and resource references are available to staff.</b></p> <p>Patient care protocols address, at minimum:</p> <ul style="list-style-type: none"> <li>▪ <b>Carotid stenosis.</b></li> <li>▪ <b>Mechanical thrombectomy.</b></li> <li>▪ <b>Aneurysmal coiling and clipping.</b></li> <li><del>▪ Increased intracranial pressure.</del></li> <li><del>▪ Systemic and intracranial hemodynamic monitoring.</del></li> <li><del>▪ Respiratory management for invasive and non-invasive ventilation.</del></li> </ul> <p><del>There is a designated stroke program staff member responsible for:</del></p> <ul style="list-style-type: none"> <li><del>▪ Ensuring timely and...</del></li> <li>▪ <b>Collaborating with...</b></li> </ul>

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Standard # and title	
Location and Type of change	Detail of change
	<p>There is a peer review...by the organization.</p> <p>Patient hand-off and transfer protocols and procedures ensure safe and efficient patient care within and between departments and hospitals. Protocols for interhospital transfer are established and approved so that timely patient transfers can be accomplished at all hours, in the least amount of time.</p> <hr/> <p><u>Survey Procedure</u></p> <p>Verify, at minimum:</p> <ul style="list-style-type: none"> <li>▪ All required stroke policies and protocols are:           <ul style="list-style-type: none"> <li>» Developed using nationally recognized guidelines in collaboration with a multidisciplinary team.</li> <li>» Reviewed annually.</li> <li>» Available to program staff.</li> </ul> </li> </ul>
<p>02.02.02 <b>PATIENT ASSESSMENT</b></p>	
<ul style="list-style-type: none"> <li>▪ Standard retitled</li> <li>▪ Standard revised</li> <li>▪ Required elements revised</li> <li>▪ Survey procedure revised (All existing elements replaced.)</li> </ul>	<p><u>Standard</u></p> <p>Assessments are based on <b>current, evidence-based practice guidelines</b> and include time frames, where applicable. Consideration is given to right patient, right clinician, right assessment, right time frame.</p> <hr/> <p><u>Required Elements</u></p> <p>Assessments on arrival to the Emergency Department include, but are not limited to: <b>Physiological and neurological assessment, monitoring, and management includes:</b></p> <ul style="list-style-type: none"> <li>▪ Airway support and ventilatory assistance for the treatment of patients with decreased consciousness or who have bulbar dysfunction that causes compromise of the airway.</li> <li>▪ Hyperglycemia treatment to achieve blood glucose levels in a range of 140 to 180 mg/dl; hypoglycemia. <b>Management of hyperglycemia and hypoglycemia.</b></li> </ul> <p>Assessments are performed to evaluate individual patients before and after surgery/interventional procedures. <b>Hospital policy defines the assessment elements and time frames for acute stroke patients, in alignment with standards of practice and evidence-based guidelines. Consideration is given to the right patient, right clinician, right assessment, and right time frame.</b></p> <p>Patients are assessed and monitored for signs of neurological deterioration after stroke using an evidence based standardized neurological assessment tool, such as:</p> <ul style="list-style-type: none"> <li>▪ Glasgow Coma Scale (GCS) or other baseline severity score used as part of the initial evaluation of patients with</li> </ul>

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Standard # and title	
Location and Type of change	Detail of change
	<p>intracerebral hemorrhage</p> <ul style="list-style-type: none"> <li>▪ ICH Score used as part of the initial evaluation of patients with intracerebral hemorrhage prior to procedure or within six hours of admission.</li> <li>▪ Hunt and Hess Score or WFNS Score used as part of the initial evaluation of patients with subarachnoid hemorrhage prior to procedure or within six hours of admission.</li> </ul> <p>Dysphagia screening is performed before the patient eats, drinks, or receives any oral medications using a hospital-approved dysphagia screening tool. If a patient fails initial dysphagia screening, a speech pathologist performs a swallow evaluation and provides a recommendation.</p> <p>Skin assessments are performed in accordance with hospital policy to monitor for skin breakdown.</p> <hr/> <p><u>Survey Procedure</u></p> <p>Verify, at minimum:</p> <ul style="list-style-type: none"> <li>▪ The use of evidence based, standardized, assessment tools.</li> <li>▪ Patient assessments are documented per protocol and include all required elements.</li> </ul> <p>Quality Measure Benchmark</p> <ul style="list-style-type: none"> <li>▪ SM-11 Dysphagia Screening</li> <li>▪ SMA-1 NIHSS for Ischemic Stroke</li> <li>▪ SMA-3 Severity Measure for Nontraumatic SAH &amp; ICH Stroke</li> </ul>
02.02.03 PLAN OF CARE	
<ul style="list-style-type: none"> <li>▪ Required elements revised (All existing elements replaced except as noted.)</li> <li>▪ Survey procedure revised</li> </ul>	<p><u>Required Elements</u></p> <p>The plan of care is multidisciplinary and includes all treatments/ protocols relating to the care of the patient, including supportive care, treatment, and outcomes of any acute complications. <b>The plan of care is initiated within the time frames established by the hospital and is updated whenever there are notable changes in patient condition.</b></p> <p>The plan of care includes:</p> <ul style="list-style-type: none"> <li>▪ Antiplatelet therapy administered to patients with acute ischemic stroke (AIS) or transient ischemic attack (TIA) within 48 hours after onset unless contraindicated.</li> <li>▪ In immobile patients without contraindications, intermittent compression devices are used beginning the day of hospital admission to reduce the risk of DVT, including patients with ICH. Elastic compression stockings are not used.</li> <li>▪ Early range of motion activities with monitoring and</li> </ul>

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Standard # and title	
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	<p>safety measures as soon as possible with advancement, unless medically contraindicated.</p> <ul style="list-style-type: none"> <li>▪ For patients with AIS with atrial fibrillation/flutter, oral anticoagulation is initiated by day 14 after the onset of neurological symptoms unless contraindicated, or prescribed at time of discharge, whichever comes first.</li> <li>▪ Antithrombotic therapy administered by end of day 2 and prescribed at discharge, unless contraindicated.</li> <li>▪ Intensive statin therapy is prescribed at discharge, unless medically contraindicated.</li> <li>▪ Monitoring for complications, including hemorrhagic transformation, during and after thrombolytic therapy administration.</li> </ul> <p>Multidisciplinary care of stroke patients means the following must be assessed and treated as applicable, based on nationally-recognized guidelines:</p> <ul style="list-style-type: none"> <li>▪ Cardiac monitoring is performed for at least 24 hours to screen for atrial fibrillation <b>and other potentially serious cardiac arrhythmias that would necessitate emergency cardiac interventions.</b></li> <li>▪ Physiological and neurological monitoring is required for at least 24 hours and until physiologically and neurologically stable.</li> <li>▪ Glucose is monitored and hypoglycemia and hyperglycemia are treated.</li> <li>▪ Sources of hyperthermia (temperature greater than 38 degrees C) are identified and treated.</li> <li>▪ Oral hygiene protocols are implemented to reduce the risk of pneumonia, as indicated.</li> <li>▪ Enteral (oral or tube fed) diet is started as soon as possible, but no later than seven days after admission for acute stroke patients.</li> <li>▪ Nutritional supplements are provided to patients who are malnourished or at risk of malnourishment.</li> <li>▪ Patients with AIS are managed according to the current ACC/AHA cholesterol guidelines, which include lifestyle modification, dietary recommendations, and medication management.</li> <li>▪ Nicotine replacement therapy is initiated when applicable.</li> </ul> <p>Risk factors are identified...but are not limited to...</p> <hr/> <p><u>Survey Procedure</u></p> <p>Verify at minimum:</p> <ul style="list-style-type: none"> <li>▪ <b>All applicable elements are assessed and treated based on nationally recognized guidelines.</b></li> </ul>

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Standard # and title	
Location and Type of change	Detail of change
02.02.04 REHABILITATION	
<ul style="list-style-type: none"> <li>Standard revised</li> <li>Required elements revised</li> <li>Survey procedure revised (All existing elements rewritten; no change in intent)</li> </ul>	<p><u>Standard</u> The patient's rehabilitation needs are <b>evaluated, and therapy services are available to be</b> incorporated into the plan of care.</p> <hr/> <p><u>Required Elements</u> <del>Following a stroke, a majority of patients regain...after their stroke. Studies demonstrate...The</del> <b>A Modified Rankin Score is assessed for patients who received an intravenous or intraarterial thrombolytic</b> <del>Early mobilization...after the stroke.</del></p> <hr/> <p><u>Survey Procedure</u> Quality Measure Benchmark</p> <ul style="list-style-type: none"> <li><b>SMA-10 Modified Rankin at Discharge</b></li> </ul>
02.02.05 DISCHARGE COORDINATION	
<ul style="list-style-type: none"> <li>Survey procedure revised</li> </ul>	<p><u>Survey Procedure</u> <b>Verify, at minimum:</b></p> <ul style="list-style-type: none"> <li><b>The medical record includes a discharge plan created on admission and updated as needed.</b></li> <li><b>Discharge-related documentation is consistent with requirements and protocols/policies.</b></li> <li><b>The patient/patient representative was included in the discharge planning process and informed of their choices.</b></li> </ul>
02.02.06 PATIENT AND PATIENT REPRESENTATIVE EDUCATION	
<ul style="list-style-type: none"> <li>Required elements revised</li> </ul>	<p><u>Required Elements</u> <del>The patient's representative is assessed... ability to provide the required care.</del> <b>When appropriate, the patient representative should receive all required education.</b></p>
<b>02.03   Clinical Functions: Responsive Care Systems</b>	
02.03.01 EMERGENCY MEDICAL SERVICES (EMS)	
<ul style="list-style-type: none"> <li>Required elements revised</li> <li>Survey procedure revised</li> </ul>	<p><u>Required Elements</u> <b>Regional systems of stroke care should be developed and identify Comprehensive, Thrombectomy, Primary, and Stroke Ready Centers to and among which rapid transport can be arranged when needed.</b> <b>The comprehensive stroke center offers EMS stroke training at least <del>twice</del> once a year.</b></p>

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Standard # and title	
Location and Type of change	Detail of change
	<p>Training includes, but is not limited to:</p> <ul style="list-style-type: none"> <li><del>▪ Contraindications of tPA.</del></li> <li>▪ <b>Clinical communication between the EMS and the hospital emergency department regarding potential stroke patients and ETA.</b></li> <li>▪ <b>Thrombolytic eligibility, such as last time known well (LTKW) within the last 4.5 hours, CT scan negative for bleed, diagnosis of ischemic stroke by physician.</b></li> <li>▪ <b>Management of patients in transit during or post-thrombolytic administration which includes, but is not limited to, neuro checks for changes in neurological status and vital sign assessment.</b></li> </ul> <hr/> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li>▪ <b>One</b> EMS educational activity is conducted and evaluated every year.</li> <li>▪ <b>EMS provides prehospital notification to the hospital of a suspected stroke patient.</b></li> <li>▪ <b>Assessment and care provided during transport is consistent with written transport plan/document of cooperation.</b></li> <li>▪ <b>Medical records document that a pre-hospital stroke assessment tool is used and the LTKW time is documented by first responders, including EMS.</b></li> </ul>
02.03.02 CLINICAL DETERIORATION	
<ul style="list-style-type: none"> <li>▪ Required elements revised (Some elements relocated to 02.03.01 EMERGENCY MEDICAL SERVICES, 03.00.03 ORIENTATION AND EDUCATION, or 03.01.02 DATA COLLECTION)</li> <li>▪ Survey procedure revised (All existing elements rewritten; no change in intent)</li> </ul>	<p><u>Required Elements</u></p> <p>This document includes (but is not limited to):</p> <ul style="list-style-type: none"> <li>▪ Signs, symptoms and elements of deterioration, <b>including neurological changes.</b></li> <li>▪ <del>Rapid assessment procedures.</del></li> <li>▪ <b>Neurological and</b> physiologic parameters which include heart rate/rhythm, blood pressure, oximetry, temperature, <b>and glucose.</b></li> <li>▪ <del>Clinical communication with EMS and hospital.</del></li> <li>▪ <del>Education of the clinical workforce.</del></li> </ul> <p><del>Deaths or adverse events for a patient without a Do Not Resuscitate order are reviewed by the core leaders to identify the effectiveness/any failures in the system.</del></p> <hr/> <p><u>Survey Procedure</u></p> <p><b>Verify, at minimum:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Written policy and protocol(s) for recognition and management of clinical deterioration include all required elements.</b></li> <li>▪ <b>Staff knowledge of policy and protocol(s).</b></li> </ul>

Standard # and title	
Location and Type of change	Detail of change
02.03.03 RAPID <b>STROKE</b> RESPONSE SYSTEM	
<ul style="list-style-type: none"> <li>Required elements revised</li> <li>Survey procedure revised (All existing elements rewritten; no change in intent)</li> </ul>	<p><u>Required Elements</u></p> <p>The acute stroke response team members are identified by the hospital <b>but at minimum should include a physician and a nurse.</b></p> <p>A written policy defines:...</p> <ul style="list-style-type: none"> <li>The process for activating a stroke code. <b>The stroke alert window should be such that the patient can receive acute interventions as soon as possible, and up until 24 hours since last time known well (LTLW), in order to treat large vessel occlusion (LVO) stroke patients.</b></li> <li>Response time for stroke team members, e.g., “A member of the acute stroke response team is at the patient bedside within 15 minutes of being called.” <b>The time frames defined for physician and stroke team arrival to a rapid stroke response code. Time frames align with evidence-based guidelines and outcomes, unless otherwise specified by state regulation. Inpatient physicians may respond by telemedicine or phone call.</b></li> </ul> <p>Hospitals can adjust the response times for the physician and stroke team to meet door-to-needle (DTN) times. The AHA Target: Stroke Phase III Suggested Time Interval Goals for door to physician and stroke team are:</p> <ul style="list-style-type: none"> <li>30 minute DTN Goal: (SM 12-C) <ul style="list-style-type: none"> <li>Door-to-physician ≤2.5 minutes</li> <li>Door-to-stroke team ≤5 minutes</li> </ul> </li> <li>45 minute DTN GOAL: (SM 12-B) <ul style="list-style-type: none"> <li>Door-to-physician ≤5 minutes</li> <li>Door-to-stroke team ≤10 minutes</li> </ul> </li> <li>60 minute DTN GOAL: (SM 12-A) <ul style="list-style-type: none"> <li>Door-to-physician ≤10 minutes</li> <li>Door-to-stroke team ≤15 minutes</li> </ul> </li> </ul> <ul style="list-style-type: none"> <li>Consultation with a <b>neurologist, neurosurgeon, or neuro-interventionalist</b> privileged to diagnose and treat stroke (may include telemedicine access) within <del>15 minutes</del> <b>the hospital’s defined timeframes for the acute stroke rapid response activation to meet the stroke performance metrics.</b></li> </ul> <p>Refer to standard 03.02.01 for response log documentation requirements.</p> <p><u>Survey Procedure</u></p> <p><b>Verify, at minimum:</b></p> <ul style="list-style-type: none"> <li>Written protocols include all required elements.</li> <li>Medical record documentation is consistent with</li> </ul>

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	<p>requirements and consistent with policies/protocols.</p> <ul style="list-style-type: none"> <li>Personnel files of the rapid response team members reflect qualifications consistent with facility protocols or job descriptions.</li> </ul>
<b>03.00   Support Functions: Human Resources</b>	
<b>03.00.01 NURSES, ADVANCED PRACTICE NURSES, AND PHYSICIAN ASSISTANTS</b>	
<ul style="list-style-type: none"> <li>Required elements revised</li> </ul>	<p><u>Required Elements</u> Nursing staff are competent (as applicable to services provided) in:</p> <ul style="list-style-type: none"> <li><b>Thrombolytic preparation.</b></li> </ul> <p>Nursing personnel files include:...</p> <ul style="list-style-type: none"> <li>Criminal history background check, <b>based on hospital policy and applicable laws.</b></li> <li>Periodic <b>Annual</b> appraisal and <b>evaluation of</b> competencies.</li> </ul> <p><b>Note: For APRN and PA credentialing file requirements see standard 01.01.02 MEDICAL STAFFING.</b></p>
<b>03.00.02 <del>NON-PHYSICIAN PROFESSIONAL SERVICES</del> ANCILLARY/SUPPORT SERVICES</b>	
<ul style="list-style-type: none"> <li>Standard retitled</li> <li>Standard revised</li> <li>Required elements revised</li> </ul>	<p><u>Standard</u> The <del>non-physician professional</del> <b>ancillary/support</b> staffing of the Stroke Program is appropriate to the scope of services offered.</p> <p><u>Required Elements</u> <b>A supportive infrastructure is demonstrated through the availability of qualified ancillary/supporting staff in adequate numbers to treat patients within the appropriate time frames.</b></p> <p><del>Non-physician professionals</del> Ancillary/support staff include:...</p> <ul style="list-style-type: none"> <li>Endovascular/<del>cardiac catheterization</del> technicians</li> <li>Others (social workers, <del>psychologists,</del> case managers (who may be employed nurses).</li> </ul> <p>All <b>ancillary/support staff</b> participating in assessment, care, and treatment of acute stroke patients, require:</p> <ul style="list-style-type: none"> <li><b>Annual</b> <del>periodic</del> performance appraisal and evaluation of competencies.</li> </ul>
<b>03.00.03 ORIENTATION AND EDUCATION</b>	
<ul style="list-style-type: none"> <li>Required elements revised</li> </ul>	<p><u>Required Elements</u></p> <ul style="list-style-type: none"> <li><del>Every two years</del> <b>Annual competency in National Institutes of Health Stroke Scale (NIHSS) must be incorporated into the education program for those performing the NIHSS assessment. Providers and nurses who do not perform the</b></li> </ul>

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Standard # and title							
Location and Type of change	Detail of change						
	<p><b>NIHSS assessment receive annual education.</b></p> <ul style="list-style-type: none"> <li>Applicable staff have orientation and training to ensure competence in neurosurgical <b>or neurointerventional</b> care and procedures.</li> <li>The hospital monitors staff education and competency.                             <ul style="list-style-type: none"> <li>At least 80% of staff <b>in each category</b> must have completed the education requirements.</li> </ul> </li> </ul> <table border="1"> <thead> <tr> <th>Team role</th> <th>CME/CEU or equivalent hours</th> </tr> </thead> <tbody> <tr> <td>Stroke Program medical director</td> <td>12.8</td> </tr> <tr> <td>Doctors, nurses and physician assistants who work in: ED/stroke unit/neuro-ICU/stroke step-down/endovascular laboratory</td> <td>68</td> </tr> </tbody> </table> <p><u>Survey Procedure</u></p> <ul style="list-style-type: none"> <li><del>Training and competencies were developed/delivered by a clinical leader who has maintained eight hours of continued education credits annually specifically related to acute stroke/cerebrovascular disease.</del></li> </ul>	Team role	CME/CEU or equivalent hours	Stroke Program medical director	12.8	Doctors, nurses and physician assistants who work in: ED/stroke unit/neuro-ICU/stroke step-down/endovascular laboratory	68
Team role	CME/CEU or equivalent hours						
Stroke Program medical director	12.8						
Doctors, nurses and physician assistants who work in: ED/stroke unit/neuro-ICU/stroke step-down/endovascular laboratory	68						

## 03.01 | Support Functions: Integrated QAPI and Risk Management System

### 03.01.01 QUALITY AND PERFORMANCE IMPROVEMENT AND RISK MANAGEMENT

<ul style="list-style-type: none"> <li>Required elements revised</li> <li>Survey procedure revised (All existing elements rewritten; no change in intent)</li> </ul>	<p><u>Required Elements</u></p> <p>...QAPI plan that addresses:</p> <ul style="list-style-type: none"> <li><b>Outcomes from the peer review process, if quality improvement needs are identified.</b></li> <li><b>Evaluation of contracted services that support the stroke program.</b></li> </ul> <p>[the QAPI Committee]</p> <ul style="list-style-type: none"> <li><b>This committee reviews and monitors stroke care quality benchmarks, indicators, evidence-based practices and outcomes. Gaps in care and performance measures below benchmarks are identified and specific interventions are initiated to address these issues.</b></li> </ul>
03.01.02 DATA COLLECTION	
<ul style="list-style-type: none"> <li>Survey procedure revised</li> </ul>	<p><u>Survey procedure</u></p> <ul style="list-style-type: none"> <li><b>Meeting minutes and quality reports indicate data collection, trending, analysis, reporting, and actions taken if needed.</b></li> </ul> <p><b>Quality Measure Benchmark</b> <b>SMA-5 Hemorrhagic Transformation (Overall Rate).</b></p>

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Standard # and title	
Location and Type of change	Detail of change
03.01.03 CLINICAL MEASURES	
<ul style="list-style-type: none"> <li>Required elements revised</li> </ul>	<p><u>Required Elements</u></p> <ul style="list-style-type: none"> <li><b>SM-12C Door to Needle Time, 30 minutes</b></li> <li>SM-14 <b>Laboratory</b> Results</li> <li><del>SM-16 Neurosurgical Services</del></li> <li><b>SPG-1A Door-to-First Pass/Device Time, 90 Minutes for Direct ED Arrival</b></li> <li><b>SPG-1B Door-to-First pass/Device Time, 60 minutes for Hospital Transfers</b></li> </ul> <p>Note: If the hospital submits data to GWTG/PCR, it may submit the GWTG/PCR report <b>plus the number of stroke patients per month to ACHC</b> in place of the ACHC data tool.</p>

## 03.02 | Support Functions: Information Management

03.02.01 PATIENT REGISTRY	
<ul style="list-style-type: none"> <li>Standard revised</li> <li>Required elements revised (Some elements relocated to 02.00.06 MEDICATION MANAGEMENT OR 02.00.08 STROKE SURGICAL AND INTERVENTIONAL CARE)</li> </ul>	<p><u>Standard</u></p> <p>A registry of all patients <b>who are evaluated and diagnosed with an ischemic stroke, hemorrhagic stroke, or TIA</b> is maintained.</p> <p><u>Required Elements</u></p> <ul style="list-style-type: none"> <li><del>Documentation of why eligible patients did not receive tPA or thrombectomy.</del></li> </ul>

## Comprehensive Stroke Center Performance Measures

All performance measures updated.

New measures added:

- SM-12C Door to Needle Time, 30 minutes**
- SPG-1A Door-to-First Pass/Device Time, 90 Minutes for Direct ED Arrival**
- SPG-1B Door-to-First pass/Device Time, 60 minutes for Hospital Transfers**

Measure deleted:

- ~~SM-16 Neurosurgical Services~~