Comprehensive Stroke Center Certification

July 17, 2012
Today’s Agenda

- Welcome and Introductory Comments
- Standards and Eligibility Questions and Answers
- Performance Measurement Questions and Answers
- On-Site Review Questions and Answers
- Certification Fees
- Application Process
Welcome and Introductory Comments

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Comprehensive Stroke Center Certification Requirements

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The objectives of this CSC presentation are to:

- Present a revision to the CSC eligibility criteria and DSPM 1, EP 2, c & d regarding the volume needed for clipping and coiling procedures for aneurysm.

- Clarify The Joint Commission’s position on the meaning of “available 24/7” for staff and licensed independent practitioners.

- Answer additional questions raised recently regarding the CSC requirements.
Organization of Presentation

Issues/questions will be addressed in the following sequence:

– Identification of the specific CSC requirement
– Issue/question about the CSC requirement
– The Joint Commission’s clarification, answer, or revision to the CSC requirement

Questions concerning how a CSC requirement applies to a specific organization will not be addressed.
1. Definition of Complex Stroke Patient

**Question:** What is a complex stroke patient?

**Answer:** The Brain Attack Coalition (BAC) defines a complex stroke patient in the following manner:

“…Complex stroke patients often require **advanced diagnostic and treatment procedures** directed by specially trained physicians and other health care professionals” (Alberts et al., 2005, p. 1598).

The Joint Commission does not currently have a formal definition of a complex stroke patient.
Patient Types at a CSC

Dr. Alberts provided an additional description about complex stroke patients during a recent CSC presentation (June, 2012):

- **Large complex ischemic strokes**
  - Endovascular therapies
  - Hemicraniectomy
  - Systemic disease with multi-organ involvement
  - High intracranial pressure (ICP)

- **Intracerebral hemorrhage**
  - ICU level care
  - Neurosurgical interventions

- **Subarachnoid hemorrhage**
  - ICU level care
  - Endovascular and neurosurgical therapies
  - Vasospasm treatments
2. Volume of Clipping & Coiling for Aneurysm

Current CSC Requirements: DSPM 1, EP 2c and d and eligibility criteria state:

c. The Comprehensive Stroke Center demonstrates that 10 or more craniotomies for aneurysm clipping procedures are performed per year.

d. The Comprehensive Stroke Center demonstrates that 15 or more endovascular coiling procedures for an aneurysm are performed each year.

Issue:

The Joint Commission has received considerable feedback that surgical clipping through craniotomies for aneurysm are being performed much less often and that coiling for aneurysm is being performed much more frequently.
The Joint Commission’s revision, effective immediately:

- CSC requirements, DSPM 1, EP 2, c and DSPM 1, EP 2, d for clipping and coiling procedures respectively, will be combined into one CSC requirement that requires a volume of 15 procedures for aneurysm per year.
- The corresponding CSC eligibility criteria will also be modified to reflect these revisions.
- Revised language:
  - DSPM 1, EP 2, c-The CSC demonstrates that 15 or more endovascular coiling or surgical clipping procedures for aneurysm are performed per year.
  - Organizations must also maintain competency in performing surgical clipping for aneurysm. See DSPR 8, EP 1, b.
3. “Available 24/7”: Licensed Independent Practitioners and Staff

CSC Requirements:
- DSPR 8, EP 3, c
- DSPR 8, EP 3, f1
- DSPR 8, EP 3, 2
- DSPR 8, EP 3, 3

Example: DSPR 8, EP 3, f1-At least one neuro-interventionalist is available 24 hours a day, 7 days a week.

Issue: Originally, The Joint Commission’s interpretation of the term “available 24/7” was that the practitioner or service is available on site 24/7 (except for neurosurgeons).
“Available 24/7”: Licensed Independent Practitioners and Staff

**Revised position:** The Joint Commission has recently established that CSCs can determine if services are to be provided “on call” or “on site” by practitioners/technicians for CSC requirements:

- DSPR 8, EP 3, c
- DSPR 8, EP 3, f1
- DSPR 8, EP 3, 2
- DSPR 8, EP 3, 3

**Equipment** must be available on site when the term “available 24 hours a day seven days a week” is used (Example: See DSPR 8, EP 1, a).
4. Education of CSC Nursing Staff

**CSC Requirement: DSDF 1, EP 7 a:** Nurses providing care to complex stroke patients, as identified by the organization, are required to attend a minimum of eight hours of education on neurovascular disease and stroke (for example, nurses providing care in the stroke unit, intensive care unit that contains the dedicated neuro-ICU beds for complex stroke patients, and endovascular catheterization laboratory).

**Issue:** The field requested clarification regarding which nurses require the eight hours of education and how the eight hours will be reviewed during the initial CSC review.
Education of CSC Nursing Staff

Clarification of the requirement on stroke education for nurses:

- Every individual nurse who provides care to complex stroke patients does not require 8 hours of education per year.

- The organization is to determine the nurses providing complex stroke care who require the eight hours education.

- DSDF 1, EP 7 a provides examples of the type of nurses providing stroke care who may require education.
Clarification on how the eight hours of education will be reviewed:

- Education can be counted on a “rolling” year basis as determined by the organization (e.g. July 2012 through July 2013).
- During the initial CSC review if all education is not yet completed, the organization can describe how the remaining education will be accomplished during the rest of the rolling year.
- After the initial review, the plan is to review CSC education ongoing through the organization’s intracycle phone call.
- For CSC recertification the organization will need to demonstrate how all the educational requirements have been met between the initial and the recertification review.
CSC Requirement: DSDF 1, EP 7 a-A minimum of one or more nurses providing CSC care, as identified by the organization, is required to attend one regional or national meeting/seminar every other year related to comprehensive stroke care.

Question: Why can’t a physician champion or another clinician/leader attend?

Answer: This requirement is based on the BAC recommendations for CSC. (Alberts et al., 2005, p. 1599). This requirement does not exclude the organization from sending other practitioners to attend seminars or meetings.
5. Peer Review Process

**CSC Requirement:** DSPM 1, EP 1, a-The Comprehensive Stroke Center has a peer review process to review all patients that have received care, treatment, and services after a subarachnoid hemorrhage or ischemic stroke.

**Question:** Do all subarachnoid hemorrhage or ischemic stroke patients have to be reviewed through a peer review process?
Clarification: For the peer review requirement, DSPM 1, EP 1, a:

- Organizations minimally need to peer review all patients with subarachnoid hemorrhage or ischemic stroke whose outcomes differed from the expected outcomes (i.e., complications).

- In January 2013, TJC will investigate the peer review process further and will consider developing additional clarifying requirements.
Peer Review Process

Quote:

“Progressive organizations can use peer review for the purposes of understanding and spreading best practices. I would encourage the evaluation of all cases, those with exceptional outcomes as well. The learnings can potentially help the organization improve outcomes overall.”

Ana Pujols McKee, MD
Executive Vice President & Chief Medical Officer
The Joint Commission
6. Advanced Practice Nurse (APN)

**CSC Requirement:** DSPR 8, EP 3, g-The Comprehensive Stroke Center has one or more advanced practice nurses (APNs) who:

- Support delivery of evidence-based acute stroke assessment and management
- Provide expert nursing consultation and practice oversight
- Develop and deliver acute stroke continuing education programs
- Participate in performance improvement processes
- Participate in Comprehensive Stroke Center research

**Issue:** The field has requested clarification regarding the qualifications of an APN.
Advanced Practice Nurse (APN)

**Answer:** The Joint Commission has a general definition of an APN/APRN.

The American Nurses Association (ANA) states:

- APN/APRN are defined as: “certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners”.

- “While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards-governed by state regulations and statutes-are the final arbiters of who is recognized to practice within a given state”.

Consensus Model for APRN Regulation:
Licensure, Accreditation, Certification & Education
July 7, 2008


- APN’s are the only mid-level practitioners specifically recommended by the BAC (Alberts et al, p. 1599).
7. Assessing the CSC Patient for Depression and Cognitive Decline

**CSC Requirement:** DSDF 2, EP 4, d- The patient is assessed to identify cognitive decline, depression and other social issues prior to discharge. (Note: This requirement is not applicable to comatose patients.)

**Question:** Is a depression screen required? Are any patients exempt from cognitive screens and depression screens?
Assessing the CSC Patient for Depression and Cognitive Decline

Clarification: CSC requirement DSDF 2, EP 4, d, does not require a depression screen. The requirement calls for an assessment of cognitive decline, depression and other social issues prior to discharge.

- This requirement is not applicable to comatose patients.
- The intent is that psychosocial needs of the complex stroke patient are addressed prior to discharge.
- The organization determines the type of assessment to be conducted, and the practitioners competent to perform it, for depression and cognitive decline.
- The focus should not be on who is exempt from this requirement.
- Accreditation Standard PC.01.02.03, EP 2 states: Each patient is reassessed as necessary based on his or her plan for care or changes in his or her condition.
8. Stroke Registry

**CSC Requirement:** DSPM 2, EP 2, a-The Comprehensive Stroke Center uses a stroke registry or similar data collection tool to monitor the data.

**Question:** Several questions have focused on a definition of a stroke registry and what constitutes a stroke registry.

**Answer:** Neither The Joint Commission or The American Stroke Association has a formal definition of a stroke registry.

- The BAC Recommendations for CSC state:
  “A stroke registry is a systematic collection of data that deals with stroke care, risk factors, outcomes, and related issues. Such a registry is important for tracking outcomes and defining areas in need of improvement and is included in the recommendations for a PSC. It is recommended that a CSC have a stroke registry or another similar data collection tool”. (Alberts et al., 2005, p. 1608)

- Example: Paul Coverdell National Acute Stroke Registry-
  [http://www.cdc.gov/dhdsp/programs/stroke_registry.htm](http://www.cdc.gov/dhdsp/programs/stroke_registry.htm),

- Many states have definitions of stroke registries.
9. Follow-up Phone Calls

**CSC Requirement:** DSPM 1, EP 2, g-The Comprehensive Stroke Center monitors the percentage of complex stroke patients that receive a follow up phone call by a member of the organization’s stroke team within seven days of discharge.

**Question:** Do all patients (regardless of their disposition, e.g. home, rehab, etc.) require follow-up phone calls?

**Answer:** No, The Joint Commission is clarifying that the follow-up phone call requirement will only be applicable to CSC patients discharged home.
10. Complication Rates

**CSC Requirement: DSPM 2, EP 5, a**-The Comprehensive Stroke Center monitors complication rates of carotid endarterectomies (CEA) and carotid arterial stenting (CAS), and demonstrates aggregate complication rates of less than six percent.

**Question:** Does the requirement include all carotid endarterectomy, carotid artery stenting, aneurysm coiling and aneurysm clipping procedures OR only procedures done on symptomatic patients?

**Answer:** Both symptomatic and asymptomatic patients should be monitored separately.

– The Joint Commission will review this issue beginning with the January 2013 CSC program review investigating this issue.
– The Joint Commission will work with the AHA/ASA to resolve this issue.

**Note:** DSPM 2, EP 5, a is not a performance measure.
11. Speech Therapy Availability

**CSC Requirement: DSPR 8, EP 3, 4** - One or more speech therapists that are qualified to perform patient swallowing function assessments during the acute stroke phase are available 7 days a week.

**Question:** Are speech therapists required to be on-call for those days that they are not on-site?

**Answer:** Speech therapists are not required to be available 24/7 on-site.

- A speech therapist must be available 7 days a week, however the organization is responsible for determining the times the services are available based on the patients populations’ needs.
- On call is permitted as defined by the organization.
- The swallowing function assessment is not referring to a swallowing screen.
12. Patient Satisfaction Data at a CSC

**CSC Requirement:** DSPM 1, EP 6- The program utilizes patient satisfaction data for performance improvement activities.

**Questions:** Does the organization require a stroke specific patient satisfaction tool? Is this requirement applicable to all discharged patients such as those going home or rehabilitation?

**Answer:** A specific patient satisfaction tool for stroke patients is not required.

- There must be an analysis of patient satisfaction data specific to the CSC stroke population.
- The organization determines how to accomplish this analysis.
- The Joint Commission does not require that all patients be evaluated for patient satisfaction.
13. CSC Public Reporting of Interventional Outcomes

**CSC Requirement: DSPM 1, EP 3, a** - The Comprehensive Stroke Center publicly reports outcomes related to interventional procedures, as determined by the organization.

**Question**: How can a CSC publicly report outcomes related to interventional procedures when there is no agency to report to?

**Answer**: The method used by organizations to publicly report their CSC interventional outcomes is not specified by TJC.

- The Joint Commission does not require public reporting to any specific agency.
- The organization can determine how to make outcome data available. Examples may include organization websites, newsletters, or during public education.
14. Patient Transfer Agreements

**CSC Requirement:** DSDF.4, EP 1,a-Requires that the CSC have protocols for care related to patient referrals that address:

- processes for receiving transfers;
- processes for transferring patients to another facility;
- written documentation of time parameters and transfer procedures, and
- evaluation of the receiving organization’s ability to meet the patient’s needs.

**Question:** Are corporate transfer agreements a CSC requirement?

**Answer:** There is no CSC requirement for a corporate transfer agreement or any transfer agreement. The requirement only requires protocols that address transferring processes.
15. Ability to Care for 2 or More Complex Stroke Patients

**CSC Requirement:** DSDF 2, EP 2, c-The Comprehensive Stroke Center has protocols or processes to meet the concurrent emergent needs of two or more complex stroke patients in an emergency situation (an example of this type of “emergency situation” occurs if there are two complex stroke patients that need critical assessment or advanced imaging by members of the stroke team at the same time).

**Question:** If an organization does not have the equipment or personnel to care for more than two CSC can we go on bypass?

**Answer:** CSCs must have the resources and personnel to:
- Care for more than two CSC patients.
- Meet each of the patient’s clinical needs.
References


Performance Measurement

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## CSTK Draft Measures

<table>
<thead>
<tr>
<th>Measure ID #</th>
<th>Measure Short Name</th>
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<tr>
<td>CSTK-01</td>
<td>National Institutes of Health Stroke Scale (NIHSS) Score on Arrival</td>
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<tr>
<td>CSTK-02</td>
<td>Modified Rankin Score (mRS) at 90 Days</td>
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<td>CSTK-03</td>
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<td>Hemorrhagic Complication for Patients Treated with Intra-Venous (IV) Thrombolytic (t-PA) Therapy Without Catheter-Based Reperfusion</td>
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<td>CSTK-05a</td>
<td>Hemorrhagic Complication for Patients Treated with Intra-Arterial (IA) Thrombolytic Therapy or Mechanical Endovascular Reperfusion Procedure With or Without Intra-Venous (IV)Thrombolytic (t-PA) Therapy</td>
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<td>Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade</td>
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Six-Month Pilot Test

Purpose of pilot testing:

– Obtain information about how the CSTK draft measures and specifications can be enhanced to provide more meaningful and reliable data

– Assess the reliability of the measures and associated data elements to ensure that measure results can be compared across multiple organizations

– Determine the time and resources needed for data collection.
Pilot Testing

Benefit to participating organizations:

- Unique opportunity to influence the approach that may ultimately be crafted to ensure the quality of care provided by Joint Commission designated Comprehensive Stroke Certification programs.
Pilot Testing

- Data collection October 1, 2012 through March 31, 2013
- Call for pilot site volunteers open until July 31, 2012
  
  
  - Sites randomly selected to participate from group of volunteers
Measure Specifications

Full draft specifications will be pilot tested for all ten CSTK measures

Specifications include:

- Measure information forms and algorithms
- Data element definitions
- Other appendices as needed (e.g., ICD-9-CM diagnosis and procedure codes)
Sampling

> Sampling will be allowed for two measures (i.e., CSTK-1; CSTK-2)

> Sampling methodology will be the same as that currently used for the stroke core measures

> All other measures will require 100% of the population. No sampling.
Introduction of the Measure Set

Final comprehensive stroke (CSTK) measures to be announced in 2013.

- Data collection for the eight stroke (STK) core measures will remain a requirement for comprehensive stroke certification in addition to the CSTK measures.

Measure specifications will not be publicly available until finalized.

- Vendors will not have access to the measure specifications until they are publicly available.
On-site Review Process

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Environment for CSC reviews

- There have been questions about the overall atmosphere of reviews for Comprehensive Stroke. Will these reviews be more focused on details?

- As always, DSC reviewers will support the standards and promote excellence in the medical community. All reviews are conducted to support the best outcomes for patients in an atmosphere that embodies a collegial and collaborative approach while challenging organization to always strive for excellence.
Facility-Specific Definitions

- There are concerns as to the mechanism for scope and definition of standards items that indicate “define per each hospital”.
- The substance of this issue resides in evidence-based practice and for Comprehensive Stroke there is a wealth of available information. As always facilities will be asked and should be prepared to support how they came to a particular decision. Always be prepared to support decisions with literature and recommendations. How did this decision improve the outcomes for your patients?
PSC Recertification/CSC Application Timing

- Questions have been raised concerning the possibility of two adjacent surveys if an organization is due for PSC and applies for CSC.
- The main issue here is that any facility committed to being certified as a Comprehensive Stroke center needs to first ensure they meet all of the eligibility requirements and are prepared to satisfy the standards. Their commitment at that point is to be CSC certified. We encourage organizations to be cognizant of their PSC recertification date and take that into consideration when considering their application timing to avoid two adjacent surveys.
Comprehensive Review Timing

- There have been some questions concerning the notice that will be received for a Comprehensive Review.

- An organization that is already PSC certified would receive a 7 day notice for CSC review. Any new program would receive a 30 day notice. CSC reviews will be scheduled in the order that we receive an organization’s application for certification, dependent on application completion. Submission is scheduled to open July 23rd. Reviews will be scheduled at the earliest possible dates in the order that they are received.
Certification Fees

The Joint Commission and The American Heart Association / American Stroke Association Comprehensive Stroke Center Certification includes a new and exclusive suite of benefits.

The total fee for certifying a Comprehensive Stroke Center will be $55,000 for the two-year certification cycle. This consists of

- A two-day on-site fee of $5,600
- Annual subscription fee of $24,700
Exclusive Suite of Benefits for CSCs

- Joint Commission Comprehensive Stroke Center Certification
- National Comprehensive Stroke Center Forum
- Marketing/Communication Campaign
- Communications/Marketing Tool Kit
- Special Recognition at the annual International Stroke Conference
- Full details are at www.jointcommission.org/CSC
How to Apply

- For organizations seeking a review as soon as possible
- Unique process for applications on July 23 only
  - Submit form electronically via Joint Commission web page
  - Time stamped
  - Processed in the order received
- Link to application form “How to Apply” at www.jointcommission.org/CSC
How to Apply

- For organizations requesting reviews in October, 2012 or later
- Contact Business Development to review timing options and application process: DSCinfo@jointcommission.org
Questions?

If not answered during the call, please submit questions to DSCinfo@jointcommission.org