




Joint Commission Certification of Comprehensive Stroke Centers

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Comprehensive Stroke Center Certification

- ▀ Our newest Advanced Certification
- ▀ Developed in collaboration with the American Heart/American Stroke Association
- ▀ Requirements derived from the Brain Attack Coalition recommendations published in *Stroke*, 2005.
- ▀ Launched September 1, 2012




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PSC vs. CSC

- ▀ Primary Stroke Center
 - Stabilize and provide emergency care for patients with acute stroke
 - Either admit or transfer to a CSC
- ▀ Comprehensive Stroke Center
 - Provide all needed levels of care to patients with strokes, including
 - Special interventions
 - Highly technical procedures



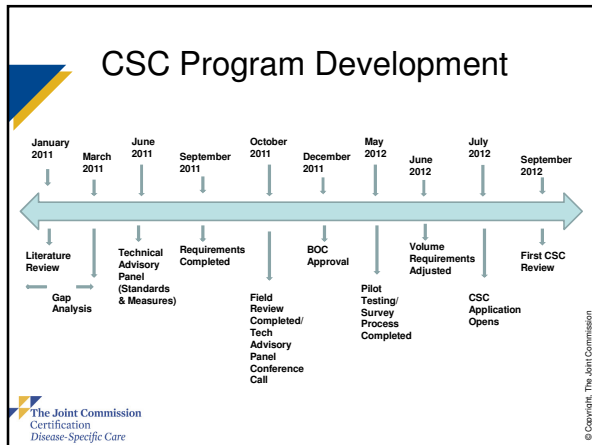
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CSC Certification Program Development

- ▀ Requirements substantially derived from the Brain Attack Coalition (Alberts et al, *Stroke*, 2005; and Leifer et al, 2011); and the American Heart Association (Miller et al, *Stroke*, 2011)
- ▀ A 21-member Technical Advisory Panel including representatives nominated by AHA, AACCN, ACEP, SSCM, ENA, CMS, SVIN, AAN, SVS, AANS/CNS, ASN participated in an initial 2-day meeting at TJC Headquarters, and several follow-up phone calls
- ▀ Field review was conducted September-October, 2011 with proposed requirements
- ▀ TJC Board of Commissioners approval 12/14/11
- ▀ First reviews September, 2012

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CSC Case Volume Requirements

- ▀ Case volumes:
 - A minimum of 20 SAH patients per year
 - A minimum of 15 endovascular coiling or surgical clipping procedures for aneurysm per year
 - Administer IV tPA to an average of at least 25 eligible patients per year

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Continuous Evolution

- ▶ This is a rapidly evolving area of medicine
- ▶ Additional revisions to these requirements are anticipated
- ▶ Global review of all CSC requirements to begin in January 2013

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Program Components

Structure
JC DSC Standards + BAC CSC Recommendations

Quality & Safety of Care

Process Outcome

Clinical Practice Guidelines Performance Measures

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Structure:

Disease-Specific Care Standards

- ▶ Program Management
 - 10 Standards
- ▶ Delivering or Facilitating Clinical Care
 - 4 Standards
- ▶ Supporting Self-Management
 - 3 Standards
- ▶ Clinical Information Management
 - 5 Standards
- ▶ Performance Measurement and Improvement
 - 6 Standards

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**Brain Attack Coalition
Recommendations for CSCs**

- ▶ Personnel and Clinical Expertise
- ▶ Diagnostic Imaging: Techniques and Personnel
- ▶ Neurosurgery and Vascular Surgery
- ▶ Infrastructure

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Process:
Clinical Practice Guidelines

- ▶ Current evidence-based guidelines are embedded in the CSC standing orders.
- ▶ Evaluated thru patient tracer activity
- ▶ Most frequently-cited requirement for improvement: 21% of reviews in 2012 have been cited for not delivering care according to CPGs

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Outcome:
Performance Measurement

- ▶ CSCs are currently required to collect and report data on the PSC Measure Set
- ▶ CSC Measure Set being pilot tested
 - Discharges October 2012 – March 2013
 - 83 hospital sites
- ▶ Final CSC Measures to be announced in 2013, and will include the PSC measures.

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CSTK Draft Measures

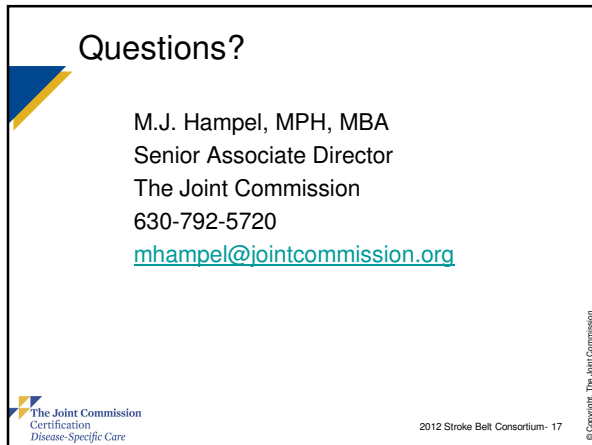
Measure ID #	Measure Short Name
CSTK-01	NIHSS Score on Arrival
CSTK-02	Modified Rankin Score at 90 days
CSTK-03	Severity Measurement on Arrival
CSTK-04	Median Time to Treatment with a Procoagulant Reversal Agent
CSTK-04a	Median Time to INR Reversal
CSTK-05	Hemorrhagic Complication for Patients Treated with Intra-Venous (IV) Thrombolytic (t-PA) Therapy Without Catheter-Based Reperfusion
CSTK-05a	Hemorrhagic Complication for Patients Treated with Intra-Arterial (IA) Thrombolytic (t-PA) Therapy or Mechanical Endovascular Reperfusion Procedure With or Without Intra-Venous (IV) Thrombolytic (t-PA) Therapy
CSTK-06	Nimodipine Treatment Initiated
CSTK-07	Median Time to Recanalization Therapy
CSTK-07a	Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade

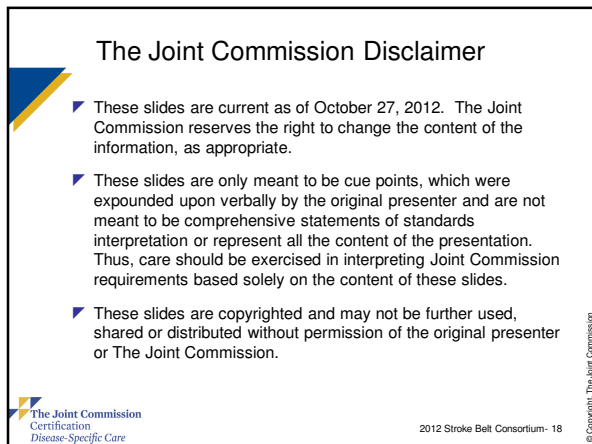
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- ### Onsite Review Process
- ▶ 2 stroke reviewers for 2 days. Some activities together, some separate
 - ▶ Focus on individual patient tracers
 - ▶ Additional activities include:
 - Emergency department review
 - Education and Competence assessment and Credentialing Process
 - System tracer on data use, research and Performance Improvement
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- ### Benefits of Certification
- ▶ Improves the quality of patient care by reducing variation in clinical processes
 - ▶ Provides an objective assessment of clinical excellence
 - ▶ Creates a loyal, cohesive clinical team
 - ▶ Promotes a culture of excellence across the organization
 - ▶ Facilitates:
 - Marketing, contracting and reimbursement
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Personnel and Clinical Expertise

Required practitioners: DSPR.8, EP 3(f)

- Neuro-interventionalist*
- Neuroradiologist*
- Neurosurgeon*
- Certified radiology technologist*
- MRI technologist*
- Endovascular technician*
- Endovascular professional nurse*
- Therapists: physical, occupational, speech
- Advanced practice nurse

*available 24/7
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Personnel and Clinical Expertise

Additional staff members: DSDF.1, EP 1(e)

- Pharmacist
- Data collection personnel
- Nurse case managers and social workers with expertise in:
 - Neurology/stroke care
 - Care coordination
 - Levels of rehabilitation and referrals
 - Community resources

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Specific Education and Training

DSDF.1, EP 7

Staff	Minimum Hours/Year	No. Educational Programs/Year
Medical Director	8	
ICU Medical Director	8	
Members of Core Stroke Team	8	
ED Staff	2	1
Nurses providing stroke care	8	
At least one nurse providing stroke care		1 regional/national seminar every other year

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Neuro-ICU Nurse Competencies

DSDF 1, EP 6

- Neurologic and cardiovascular assessment
- Ventriculostomy device management (pressure monitoring and drainage)
- Treatment of intracranial pressure
- Nursing care of hemorrhagic stroke patients
- Nursing care of patients treated with IV and IA tPA
- Managing malignant ischemic stroke with craniectomy
- Using therapeutic hypothermia protocols
- Using intravenous vasopressor, antihypertensive, and positive inotropic agents
- Methods for systemic and intracranial hemodynamic monitoring
- Methods for invasive and noninvasive ventilatory management

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Diagnostic Imaging: Techniques

DSPR.8, EP 1

- Carotid duplex ultrasound
- Catheter angiography
- CT angiography
- MRI, including diffusion-weighted MRI
- Extracranial ultrasonography
- MR angiography
- Transcranial doppler
- Transesophageal echocardiography
- Transthoracic echocardiography

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Diagnostic Imaging: Staff

DSPR.8, EP 3 (f2)

- One or more certified radiology technologists available 24/7
- One or more certified radiology technologists available to assist with cerebral angiogram 24/7
- One or more qualified MRI technologists available 24/7

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Neurosurgery and Vascular Surgery: Required Protocols

DSD.F.2, EP 2(b)

- ▀ Intra-arterial fibrinolytics
- ▀ Endovascular recanalization
- ▀ Interdisciplinary protocols for reducing peristroke complications
- ▀ Initiation of endovascular procedures

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Neurosurgery and Vascular Surgery: Complication Rates

DSPM.1 , EP 2
DSPM.2, EP 5

- ▀ CSC monitors periprocedure complication rates
- ▀ CSC monitors complication rates of carotid endarterectomies and carotid arterial stenting and demonstrates aggregate complication rates less than 6%
- ▀ Periprocedure stroke and death rate of less than or equal to 1% for diagnostic catheter angiography
- ▀ Aggregate serious complication rate of less than or equal to 2% for diagnostic catheter angiography


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Infrastructure (1 of 2)

Requirement	Standard Citation
ED/EMS Communication	DSD.F.1, EP1 (a) DSD.F.2, EP2 (a)
Dedicated neuro-ICU beds	DSPR.8, EP1(c)
Ability to meet needs of 2+ stroke patients simultaneously	DSD.F.2, EP2,(c)
Process for informed consent	DSSE.1, EP1 (a)

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Infrastructure (2 of 2)	
Requirement	Standard Citation
Post-discharge follow-up call within 7 days	DSPM.1, EP2 (g)
Participates in IRB-approved patient-centered stroke research	DSPR.8, EP5 (c)
At least two public educational activities per year	DSSE.3, EP6
Uses a stroke registry	DSPM.2, EP2
Peer review process	DSPM.1, EP1


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