Preparing Your Hospital for Comprehensive Stroke Certification

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Disclosure

Lori M. Massaro, MSN, CRNP- speakers bureau for Genentech, Inc
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Objectives

To share our experiences with CSC and provide you with valuable information to undergo a successful CSC (initial or recertification) visit.

Comprehensive Stroke Center Certification

- Numbers as of 3/8/2016 – from web data
- 134 CSC certified centers
  - 103 by TJC
  - 19 by DNV
  - 2 by HFAP
- 2016 certification manual for DSC – Jan 2016
  - Very few changes
  - Clarified volume requirements
Types of Committees that are needed

- Oversight/leadership group for the program
  - Multidisciplinary
  - ?? Quarterly meeting
  - Reviews and approves CPG’s and stroke protocols/policies
- Stroke team and or Nursing/QI team
  - Meet Monthly to review data/fallouts
  - To address process issues
- Peer review/complication review
  - Smaller group – with MD involvement - quarterly or monthly
    - Medical
    - Surgical

Players who need to be at the table/need to be involved:

- Nursing – leadership to bedside
- Neuro Service Line representative
- Stroke Program leadership – to data collectors
- Medical disciplines
  - Neurology/stroke
  - Emergency Medicine
  - Neurosurgery
  - Vascular surgery
  - Neuro IR specialists
  - Rehabilitation
- Rehab services – PT/OT/SLP
- Human Resources – for all employee training
- Quality and Regulatory depts
- Case Management - very important
- Transfer Center – for transfer protocols and agreements
- Laboratory
- Pharmacy
- Radiology
Getting Started or On Your Way You Will ...

• Need to review the Joint Commission Requirements for Comprehensive Stroke Center Advanced Certification
• Changes in standards will be posted here prior to addition to the manual (Edition)
  • [http://www.jointcommission.org/standards_information/prepublication_standards.aspx](http://www.jointcommission.org/standards_information/prepublication_standards.aspx)
• Check back often for updates and make sure to connect with your regulatory team about email updates for the CSC program

It all begins with eligibility........

• Review criteria (DSPM.1 . 5)
  • Minimum #’s for SAH and IV tPA – clarified in 2016 specs.
  • Advanced Imaging
  • Neuro- intensive care
  • Peer Review Process
  • Stroke Research
  • Eligibility criteria posted here:
Explanation of SAH changes

• Based on literature and a survey sent to CSC’s - the TJC has concluded that implementation of higher volume requirements is premature.
• “Further research in ongoing and these requirements will remain in place until July 2016 and be re-evaluated as new evidence emerges.”
• CSC Survey responses
  • Proportion of clipping to coiling ranged from high of 67% to 33% - with low of 1% clip rate to high of 99% rate coil at individual institutions.
  • Significant variation coupled with evolving research treading toward increases in endovascular coil treatment make it difficulty to support any firm volume requirement
  • There is a volume to outcome relationship in care of SAH pts

2016 Updates

DSPM.3  EP 5
Current posting on JC website as of 3/14/2016 and listed in the January 2016 Edition of standards manual:

At this time, The Joint Commission will continue to use the current 2013/2014 volume requirements for all new and existing CSC customers until further notice. These current requirements (both of which are under DSPM.1, EP 5) are as follows:

• 15 clippings or coilings per year for aneurysms
• 20 aneurysmal subarachnoid hemorrhages per year

1. TPA volumes – 50 patients over 2 year period clarified
HOT OFF the PRESS UPDATE!!

• CSTK – 07 Median Time to Revascularization
  • data collection is suspended because of issues with first pass time and first pass of mechanical reperfusion device.
  • Many discrepancies amongst CSC centers

• CSTK – 09 is new measure expected to be added effective Jan 1, 2017
  • Arrival to Skin Puncture

Stay Tuned for more information!!

Logistical and Tactical Planning

• Review the 2-day agenda
• Develop 2 presentations
  • Opening presentation
  • Data system tracer Presentations
• Consider a Mobile Command Post
  • Dedicated administrative and programmatic support for onsite survey
  • Partner with Joint Commission Regulatory Team
• Assemble and organize key sources of information in binders
Review Process Guide

Available on JC website:

The Visit

Day 1
• 8:00 – 9:30 Opening Conference and Orientation to Program
• 9:30 – 10:00 Reviewer Planning Session & Protocol Review Session
• 10:00 – 10:30 Emergency Department Review
• 10:30 – 12:30 Individual Patient Tracer
• 12:30 – 1:00 Reviewer Lunch
• 1:00 – 3:30 Individual Patient Tracer
• 3:30 – 4:30 Reviewer Summary Session / Special Issues Resolution
The Visit

Day 2
• 8:00 – 8:30 Daily Briefing with the Organization
• 8:30 – 10:30 Individual Patient Tracer
• 10:30 – 12:30 System Tracer
• 12:30 – 1:00 Reviewer Lunch
• 1:00 – 3:00 Education, Competence Assessment & Credentialing Process
• 3:00 – 4:00 Issue Resolution & Reviewer Report Preparation
• 4:00 – 4:30 Program Exit Conference

CSTK Metrics

• CSTK1: NIHSS performed AIS
• CSTK2: mRS at 90 days
• CSTK3: Severity measure SAH/ICH (overall rate)
• CSTK4: Procoagulant Reversal Agent Initiation
• CSTK5: Hemorrhagic transformation (overall rate)
• CSTK6: Nimodipine treatment administered
• **CSTK7: Median time to revascularization - placed on ON HOLD 2/2016**
• CSTK8: TICI post-treatment reperfusion grade
CSC Additional Data

• What do you track?
  – CEA and CAS volumes – both symp and asymp
  – CEA and CAS outcomes
  – Endovascular procedures – complications and outcomes
  – EVD complication rates – infection and complications of insertion
  – SAH data – numbers clipped/coiled – mortality - complications

• What is publically reported?
  – Interventional data beyond PSC core measures

Competency Tracer

Physician and APN’s
  • Present how internal credential and privileging happens
  • Educational requirements
    • Onboarding, orientation, annual, reappointment
  • OPPE/FPPE
  • Neurocritical Care education

Sample Files of Key Team to ensure complete
Competency Tracer

Clinical Services & Allied Health

• Similar to PSC
  Included: discussion about: orientation, ongoing stroke specific education

• Expand to include:
  Imaging areas
  Rehab staff
  Rapid Response Team staff

Peer Review Process

DSPM.1 EP 2b

b. The comprehensive stroke center has an interdisciplinary program-level review, including a peer review process that is as follows:
   - Part of the comprehensive stroke center’s quality improvement process
   - Includes a performance improvement plan when needed

Note: An interdisciplinary program-level review is defined as a review at the program level to assess causes of patient adverse outcomes with the aim of decreasing the incidence of such outcomes.

c. Patient complications from an ischemic or hemorrhagic stroke that are evaluated through the interdisciplinary program-level review, including peer review, are as follows:
   - Unanticipated death
   - Hemorrhage post-stroke
   - Other severe complications as determined by the organization
What is required? What counts?

- Medical Directors/ Physicians
- Emergency Department
- Neuro ICU
- Stroke Unit
- Stroke Team
- RRT
- Other departments – what is required by job (i.e. CT / MRI)

Create a master educational plan to provide surveyors.

Helpful Tips

- Review active inpatient census daily
- Ensure extended team available – 2 rounding teams – surveyors split up
- Chart navigation & Computer Expert(s)
- Identify strong escorts and mechanism to communicate across system
- Mock prep surveys are helpful in preparing staff who will be interviewed.
- Frequently asked questions for each specific area
Top Standards Compliance Data for First Half of 2015 All Disease-Specific Care Certification

31% DSDF.3 The program is implemented through the use of clinical practice guidelines selected to meet the patient’s needs.

15% DSDF.2 The program develops a standardized process originating in clinical practice guidelines (CPGs) or evidence-based practice to deliver or facilitate the delivery of clinical care.

14% DSCT.5 The program initiates, maintains, and makes accessible a medical record for every patient.

14% DSDF.1 Practitioners are qualified and competent.

12% DSDF.4 The program develops a plan of care that is based on the patient’s assessed needs.

9% DSSE.3 The program addresses the patient’s education needs.

8% DSPR.1 The program defines its leadership roles.

8% DSPM.5 The program evaluates patient satisfaction with the quality of care.

5% DSPR.5 The program determines the care, treatment, and services it provides.

5% DSSE.1 The program involves patients in making decisions about managing their disease or condition.

The Joint Commission Perspectives September 2015 http://www.jointcommission.org

This is a continuous TEAM JOURNEY!!

• Expect that The Joint Commission will continue to refine and expand upon current processes
• Great Value in networking with other organizations on a similar path
  – Not all organizations are set up the same
  – Applying the standards to the clinical setting may require some additional interpretation
• Plug into informational offerings...always new ways of learning!!
Thank You

Questions??