### 01.00.01 Governance Plan

**What is the role of the Core Stroke Leaders and how does it differ from the Acute Stroke Response Team?**

The Core Stroke Leaders are designated by the governing body of the hospital that includes a minimum of two people — one being the physician who serves as Stroke Service Director.

The core stroke leaders are responsible for the review of the stroke protocols at least annually (and revision as necessary), including a review of the number and types of stroke patients, nature of any complications of thrombolytic therapy, compliance with certification requirements, Stroke QAPI and performance measures and the design/delivery of policy and competency driven education.

The Acute Stroke Response Team means physician(s) and other health care professionals, e.g., nurse, physician's assistant, or nurse practitioner with stroke expertise who are available to respond and evaluate patients presenting with acute stroke symptoms (the composition of the response "team" is further defined by each hospital).

### 01.03.01 Health Promotion

**What are methods for Community Education?**

Optional methods for community education:

- Newsletters/Mailing/Newspapers
- Public Service Announcements
- Stroke education/educational materials provided at locations such as community health fairs, flu/blood pressure clinics
- Education provided to area health care providers
- Speaker Forums - e.g., presentations at hospitals, community centers, senior centers, school assemblies, church groups, workplace sites

### 02.03.03 Rapid Response System

**What is required for the Acute Stroke Response Team Protocols**

- Identification of the Acute Stroke Response Team, e.g., members, qualifications and availability.
- Responsibilities of team members.
- The process to promptly notify and activate the Acute Stroke Response Team.
- Acute Stroke Response Team member guidelines on evaluation, identification and initial management of patients with acute stroke symptoms.

### 02.00.02 Laboratory Services

**If we have an accurate way of evaluating blood glucose within 45 minutes and meet that turn-around times (TAT), we meet the standard?**

This is the essential minimum along with INR, PT & PTT (if clinically indicated) and additional labs determined by stroke protocol / physician order.

We need to have a commitment letter from the Lab Director that Lab will meet the 45 minute standard 24/7 for Blood Glucose and "other labs" that we designate as necessary in our policy?

Correct

Other lab-we can determine our acceptable turn-around times for other emergency labs?

Your organization determines ‘additional’ labs, however the TAT for these labs, is surveyed according to best practice guidelines. Refer to the AHA/ASA’s most recent guidelines, note that page 12, and table 8 states “Immediate Diagnostic Tests.”

Whilst this document provides no clear reference of time, the recommendation for TAT has not changed from 45 minutes referenced in the attached Target Stroke Campaign Manual.

We need to continue to track our TAT for labs for those patients who are eligible for tPA but did not receive the tPA and report to the QI-Stroke Committee.

Correct – the reason for these patients who were eligible but did not receive tPA must be considered.

Upon closer review, is there a trend of eligible patients not receiving tPA, what is that trend linked to. Is education required? Is there an adequate stock of tPA available, etc.
02.02.02 Program Design

What are the guidelines for program design?

**Part One** entails documentation of the overarching design of the program:
- Mission
- Scope and level of care
- Process for evaluating the service annually
- Treatment and services provided (may include specialty treatments and departments involved in provision of care)

**Part Two** includes the protocols

Program design is promoted through the development and use of protocols. Hospitals must develop and implement written care protocols for the management and monitoring of ischemic stroke, hemorrhagic stroke and other (determined by facility) that are based on current clinical guidelines and/or developed by a multidisciplinary team organized by the Stroke Service.

- Hospitals identify and define their stroke population and develop protocols to meet the needs of that population.
- Telemedicine/Teleradiology Services, if applicable, are credentialed and include a notification system, physician responsibilities and availability.
- Stroke protocols require a triage plan, which includes (but not limited to): patient assessment, pre-incident history, etc. Initial and ongoing patient clinical assessments with the use of formal stroke scale or scoring system, such as the National Institute of Health Stroke Scale (NIHSS). Assessments include (but not limited to): stabilization of vital functions, ongoing monitoring, management of increased intracranial pressure and blood pressure.
- Systems are in place to promptly perform initial diagnostic tests, such as laboratory, brain computed tomography (CT) or magnetic resonance imaging (MRI), laboratory, electrocardiograms and chest x-rays as ordered.
- Use of medications, including but not limited to intravenous tissue-type plasminogen activator (IV tPA), the protocols include eligibility criteria (contraindications/warnings), management of complications and post-thrombolysis management.
- Post hospital care coordination including assessments, education, referral and follow-up.
- Patient/Family Education, e.g., potential complications, diagnostic testing, risk/benefits of treatment, risk factor and lifestyle modifications, warning signs and symptoms of stroke.

Developing Protocols

When developing protocols, meet with clinical experts and consider the following:

1. **Determine your stroke population** e.g., ischemic, hemorrhagic, TIA.
2. **Determine the level of acuity** that your organization is able to care for and how each level is cared for.
3. Does your organization provide neurosurgical intervention?
   - If no, you must consider protocols for assessing patient’s eligibility for neurointervention and have transfer agreements in place to ensure that they have access to the level of care that they may require to create the most optimal outcome.
4. **Set an interventional window** (this may be 6hrs, 8hrs, 12hrs or other). This will determine what types of resources get activated immediately. For example; the Acute Stroke Response Team is activated, eligibility for interventions such as t-PA and neurosurgery are determined and all labs and neuroimaging are completed and interpreted within 45 minutes. If a patient requires transfer for neurosurgery, this is completed within 2hours of order.
   - Determine priority assessments that must take place and include timeframes (e.g., 45minutes).
   - Determine what interventional actions take place and the timeframes (e.g., 45minutes).
5. Establish protocols for patients who present with symptom onset outside the ‘interventional’ window.
   - Determine assessments that must take place and include timeframes.
   - Determine what actions take place and the timeframes.
6. Establish TIA protocols.

Note: some organizations place all patients who present with stroke like symptoms on an acute stroke protocol and all resources are activated immediately for all stroke types. Your clinical experts determine how you define and treat your stroke population.

02.02.02 Assessments

What are the guidelines for the dysphagia screening tool?

The dysphagia screening tool must be based on current clinical practice guidelines and approved by the hospital. The screening tool references must be current and available to staff.
02.02.03 Plan of Care

What if a standard is not clinically appropriate for a patient (an example would be prescribing a statin on discharge)?

Patients should be looked at on an individual basis. If the medical opinion of the physician is that the initiation of a statin is not medical appropriate/necessary, then it would not have to be ordered. The reasoning behind this decision must be documented in the medical record, in order to avoid a citation relating to that standard. Best practice and evidence-based decisions should always be practiced.

02.02.04 Rehabilitation

Who performs the physical rehabilitation assessment and when is this done?

This standard reflects the CMS measure for rehabilitation assessment. Patients receive an initial evaluation by physical therapy and additional evaluations according to clinical need/deficit. The initial time parameter for this standard was removed and the onus is now on the facility to determine when the initial assessment is done and incorporate this information into the applicable protocols.

02.03.01 Emergency Medical Service

What are the requirements for EMS integration?

- A written plan for transporting and receiving patients with acute stroke symptoms.
- Lines of communication, to notify the hospital emergency department of incoming patient to allow the Emergency Department (ED) to more efficiently prepare for patient arrival.
- The written agreement is attached to EMS guidelines on evaluation, identification and initial EMS management of patients with stroke symptoms.

What if our EMS region prohibits EMS pre-hospital notification of impending stroke arrival?

- It is essential for hospitals to determine what their EMS region limitations are around pre-hospital notification and patient care and routing.
- If your EMS region has any limitations, or a policy by which they do not pre-notify hospitals it is important to convey this at the opening conference - day of the onsite review.
- If your EMS region does not have such a policy, the facility is required to include pre-notification into the service agreement.

What is the purpose of EMS involvement in policy development and education?

Studies have identified two factors that impact pre-hospital delay:

- Patient transport to the ED by ambulance. It was determined that this group had almost half the pre-hospital delay and three-fours the delay to CT scan as compared to patients who arrived by other means.
- Delay in taking action. Studies show that patients who wait 90 minutes from onset of symptoms before calling the EMS might not arrive to the ED in time to be eligible for thrombolytic therapy.
- Integrating with EMS through policy development and educational fosters a working partnership.

02.03.02 Clinical Deterioration

Clinical Deterioration refers to in-patients or ED patients or both?

This standard relates to both the inpatient population and those that present to the emergency department.

02.03.03 Rapid Response System

Who makes up the Acute Stroke Response Team?

The Acute Stroke Response Team members are determined by the organization. The Acute Stroke Response Team document/protocol includes the following additions:

- List of stroke team response members, their role and their level accessibility (bedside or telephone) including on-call and staffing requirements.
- Informed consultation with a physician privileged to diagnose and treat stroke (may include telemedicine access) within 15 minutes of the Acute Stroke Response activation.
03.00.03 Orientation and Education

What are Education Requirements for the Primary Stroke center?

Annual Calendar
The annual training calendar dates are determined by the service. This may be in line with the hospital-wide training calendar or it may be based on 12 months prior to your anticipated onsite visit. Either way, it is documented on your calendar and evidence of compliance is made available at the time of survey.

Bi-annual competency in a recognized stroke scale must be incorporated into training program.

Education Needs Assessment
Education needs are identified by the service and incorporated into an annual training calendar. Organizations demonstrate how the educational needs of their clinicians were determined. This can be demonstrated through: an education needs assessment survey, review of incidents related to stroke patient care, review of changes to protocols and best practice guidelines, open Q&A forums, results and feedback from previous education sessions or competencies. The calendar is then developed.

Development of Education Program
Education is developed/delivered by an identified core program leader, who is responsible for undertaking eight (8) hours of continued education credits annually specifically related to the specialty program. Education may be developed by clinicians other than the stroke coordinator; however, they must also have 8 hours of CME/CEU specific to cerebrovascular disease.

Type and Mode of Education
Education must be specifically related to diagnosis/assessment and management of specialty program (may be protocol/competency driven). Education may be policy or competency driven and include in-house training, on-line learning, seminars, CEUs. The organization determines what modes of stroke education are recognized in their organization; this is documented and evidenced at the time of survey. You may include this question in your education needs assessment.

What is the required completion of education at the time of review?
Organizations should aim for 100% compliance with education; otherwise, individual clinicians must achieve 80% of their training requirements.

If all files reviewed at the time of the survey meet this requirement (80% of training completed by each individual) then this standard is scored as compliant.

How is compliance with physician and nursing education demonstrated?
- Attendance sheets/CME/CEU records.
- Topic and content outline.

If not a live presentation:
- A post-test is given and the results of the post-tests are maintained
- Post-tests are used as part of an educational needs assessment
- Post-tests are trended and used to improve the presentation
- A system is in place for participants to ask questions and receive answers

03.01.03 Clinical Measures

Is participating in a stroke registry such as “Paul Coverdell” / “Get With The Guidelines” (GWTG) mandatory?
This is not a requirement, however it is recommended. There are several advantages of submitting data to a registry such as opportunity to network and benchmark. CMS require organizations to indicate if they participate in a registry or not when submitting data.

How much data is required at the time of the first onsite review for new applications?
New applications must have a minimum of three to four months of recent data by the time of the onsite review. The data must be entered into the HFAP data reporting tool and available to the reviewers on request.

If I am with Get With The Guidelines, How do I organize data submission?
Stroke Measures 1-14 are to be collected by the organization and quarterly reports submitted to HFAP.
If the hospital is with GWTG or PCR the hospital submits a quarterly GWTG/PCR report to HFAP.

Measures not included in GWTG: The hospital must maintain a database for measures not included in GWTG/PCR and all required data must be available for the reviewer at the time of survey (including the mid-cycle review).

If I am NOT with Get With The Guidelines, How do I organize data submission?
Stroke Measures 1-14 are to be collected by the organization on the HFAP data tool and quarterly reports submitted to HFAP.