Comprehensive Stroke Centers: A Sneak Peak at The Joint Commission Certification Requirements

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Objectives

- Relate the Brain Attack Coalition guidelines & the American Stroke Association Quality Metrics to the development of Comprehensive Stroke Center certification by The Joint Commission
- Describe the process that supports validation of CSC quality measures
- Discuss the potential implications for PSC that may emerge with operationalization of CSC certification
Disclosures

Kathy Morrison: speaker for PESI Healthcare on the topic of Strategies for Excellence in Stroke Care; AANN liaison to American Heart Association Stroke Council/Cardiovascular Nurses Committee; AANN representative on TJC Comprehensive Stroke Center Certification Technical Advisory Panel

Debbie Summers:

Anne W. Alexandrov: Member TJC Comprehensive Stroke Center Certification Technical Advisory Panel; Member TJC Primary Stroke Center Core Measures Review Panel; Speaker Bureaus – Genentech and EKR Therapeutics; Program Director, NET SMART.
We are speaking as members of The Joint Commission Technical Advisory Panel convened in June 2011.
Acute Stroke Care Milestones

- tPA approved
- Brain Attack Coalition PSC Recommendations published
- Brain Attack Coalition CSC Recommendations published
- NQF → 8 Core Measures
- TJC Comprehensive Stroke Center Designation
- tPA window expansion
- Brain Attack Coalition established
- American Stroke Association
- TJC Primary Stroke Center Designation
- Mechanical Retrieval approved
- DRG 559 created
- Coverdell & GWTG Pilot s
- NINDS Acute Stroke Treatment Guidelines published
Brain Attack Coalition’s Recommendations for Establishment of Primary Stroke Centers

Published in *JAMA*, 2000;283:3102.
Based on successful trauma model
Review of literature - > 600 articles

Numerous hospitals self-designated as PSC
with no governing body to oversee
2000-2004

Study published in *Neurology*, 2003
998 survey respondents
77% believed their hospital met criteria
Only 7% actually met

2004 Joint Commission initiated PSC certification through the Disease-Specific Care Program
Stroke Center Types Proposed by the Brain Attack Coalition

**Primary Stroke Center**
- Appropriate for stabilizing and treating most cases of acute ischemic stroke
- Can receive JC certification
- Provides quality care for most patients

**Comprehensive Stroke Center**
- More complex cases requiring advanced technology and specialized diagnosis and treatment
- Receive patients from a PSC following stabilization and/or treatment
- Advisory or educational resource for other facilities in region
## PSC Updates August 2011

<table>
<thead>
<tr>
<th>Category</th>
<th>2000</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Stroke Team (AST)</td>
<td>Minimum of physician w/expertise &amp; one other provider; 24/7, bedside in 15 min</td>
<td>No change</td>
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<tr>
<td>EMS</td>
<td>Pre-hospital notification</td>
<td>• Transport to nearest PSC</td>
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<td></td>
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<td>• Consideration of air ambulance</td>
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<td></td>
<td></td>
<td>• Telemedicine/telestroke/teleradiology</td>
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<td>ED</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Neuroimaging</td>
<td>CT scan w/in 25 min; read w/in 20 min</td>
<td>• MRI/MRA &amp; CTA available; done w/in 6 hrs of order; read w/in 2 hrs</td>
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<tr>
<td>Laboratory</td>
<td>24/7 Blood counts, chemistries, coags w/in 45 min of order</td>
<td>• Addition of EKG &amp; CXR in 45 min timeframe</td>
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<td></td>
<td></td>
<td>• Addition of HIV, tox screen, pregnancy test</td>
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<tr>
<td>Outcomes</td>
<td>Database for number/type of stroke, treatments, timelines, measurement of patient outcome</td>
<td>• Selection of minimum 2 relevant patient-care parameters for benchmarking</td>
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<td></td>
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<td>• Committees for review/practice change 2x/yr</td>
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<tr>
<td>Education</td>
<td>8 hours/year professional; 2 public events</td>
<td>• Clarification: all physicians, nurses, APN’s in direct care roles; includes nurse managers &amp; program directors for allied health services; peer education</td>
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<tr>
<td>Administration</td>
<td>Evidence of administrative commitment</td>
<td>• Call pay consideration</td>
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<tr>
<td></td>
<td></td>
<td>• Neurohospitalist consideration</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>------</td>
<td>• Assessment &amp; early initiation</td>
</tr>
</tbody>
</table>
Recommendations for Comprehensive Stroke Centers: A Consensus Statement from the Brain Attack Coalition

Published in *Stroke* 2005.

Numerous hospitals designated as CSC by individual states 2006-2012

*Stroke* 2010: Effectiveness of PSC & CSC
*Stroke* 2011: Metrics for Measuring Quality of Care
*JAMA* 2011: Stroke Center Hospitalization AIS & Mortality

2012 Joint Commission initiated CSC certification through the Disease-Specific Care Program
Outcomes: Stroke Center Care

Improved Quality Care
- Performance measure compliance
- Reduced LOS
- Higher rate of tPA administration

Reduction in Mortality
- 30-day fatality rate down
- Median survival increased by 1 year

Lower Rate of Institutional Care
- Lower readmission rate
- More likely to live at home @ 1 year
Outcomes Data Sources


BAC CSC Key Concepts

- Advanced imaging
- Advanced Intervention
- Key personnel – w/appropriate expertise
- Outcomes
- Protocols
- Transition of Care
61.9% of Medicare beneficiaries discharged after ischemic stroke died or were re-hospitalized within one year.

Stroke is 2\textsuperscript{nd} leading cause of hospitalization.

Comprehensive Stroke Center Standards
Comprehensive Stroke Center Measure Testing and Federal Adoption

Anne W. Alexandrov
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Assistant Dean & Professor
NET SMART Program Director & DNP Program Coordinator
University of Alabama at Birmingham

Collaboration
Pathway to Success
TJC Measure Testing

- Historical background in relation to TJC Primary Stroke Center measure testing
- Measurement period likely to be dependent on:
  - Volume of designated CSCs
  - Sample size of patients at designated CSCs
- Measure submission to the National Quality Forum (NQF)
NQF Measure Endorsement Criteria

- Impact, Opportunity, Evidence—Importance:
  Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-impact aspect of healthcare where there is variation in or overall less-than-optimal performance.

- Reliability and Validity—Scientific Acceptability of Measure Properties:
  Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.
NQF Measure Endorsement Criteria

- **Feasibility:** Extent to which the required data are readily available or could be captured without undue burden and can be implemented for performance measurement

- **Usability:** Extent to which intended audiences (e.g., consumers, purchasers, providers, policymakers) can understand the results of the measure and find them useful for decision making
Robust Measures

- Elimination of measures met by “documentation” (i.e. documentation of teaching or counseling provided)
  - Patient change in knowledge level
  - Change in patient behavior (smoking cessation)

- Endorsement of measures with broad specificity (i.e. cross-cutting measures; measures for an entire population – stroke, vs. measures for stroke patients with dysphagia)
Robust Measures

- Electronic health record accessible
- Measure definitions and codes fully specified
  - Exclusions must be evidence-based
  - Risk models should not contain disparity factors
  - Adults should not have an upper age limit
- Measure is used for both:
  - Public reporting
  - Quality improvement
“Topped Out” Measures

- Measure meets all criteria for endorsement except...
  - Performance gap: Evidence of quality problems and opportunity for improvement
  - Topped out measures have high level performance with little variation, therefore, there is not a great chance for improvement

- Measure may be moved to “Reserve Status” by the NQF
  - Measure remains in the endorsed catalog
  - Not recommended for “Pay for Performance” by CMS

- NQF decisions are separate from TJC decisions
  - Reserve status does not necessarily mean TJC will drop the measure requirement
  - Example: Discharged on antithrombotic therapy
Summary

- What we can expect...
  - Active measure testing period for new CSC measures
  - TJC submission of measures to NQF
  - NQF Stroke Committee “re-activation”
  - NQF Stroke Committee recommendations submitted to NQF Consensus Standards Approval Committee (CSAC)
  - NQF CSAC recommendations for endorsement sent to NQF Board of Directors (BOD)
  - NQF BOD vote for endorsement
  - CMS adoption of NQF BOD endorsed measures

**Timeline = 2.5 - 4 years from now**
Questions?

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