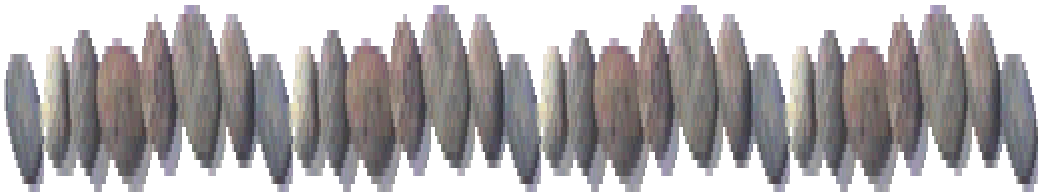
Center for Improvement
CIHQ
in Healthcare Quality

DISEASE SPECIFIC CERTIFICATION

Policies
Standards
Survey Process

Effective January 2014



INTRODUCTION

Disease specific certification is designed to recognize the provision of evidence-based best practice to targeted patient populations The Center for Improvement in Healthcare Quality (CIHQ) currently offers certification in three areas:

A. Heart Failure
The standards for disease specific certification in heart failure are based on recommendations from the American Heart Association "Get with the Guidelines® - Heart Failure 2013"

B. Hip & Knee Replacement Surgery
The standards for disease specific certification for hip and knee replacement surgery are based on recommendations by the American Academy of Orthopedic Surgeons and the National Institute of Health.

C. Primary Stroke Center
The standards for disease specific certification for a primary stroke center are based on the "Revised and Updated Recommendations for the Establishment of Primary Stroke Centers – Brain Attack Coalition, American Heart Association / American Stroke Association" - May 2011

DISEASE SPECIFIC CERTIFICATION POLICIES

Disease specific certification is an optional program offered to CIHQ accredited hospitals. Accredited hospitals are not required to obtain disease specific certification as a condition of accreditation.

ELIGIBILITY REQUIREMENTS

In order to obtain/maintain disease specific certification(s), a hospital must:

- Be accredited by CIHQ. Disease specific certification cannot be granted to a hospital that is not accredited by CIHQ
- Be in full compliance with CIHQ hospital accreditation policies
- Be in full compliance with CIHQ hospital accreditation standards or have developed and implemented an acceptable plan of correction to come into compliance in areas of deficient practice.
- Be in full compliance with the applicable CIHQ disease specific certification(s) standards or have developed and implemented an acceptable plan of correction to come into compliance in areas of deficient practice.
- Have provided inpatient care, treatment, and service to at least 5 patients within the 12 months prior to survey for initial certification; and at least 10 patients during the prior certification period for recertification. Patients must represent the applicable disease specific certification(s) sought.
- Pay disease specific certification(s) fees in a timely manner

CIHQ reserves the right to withdraw/deny disease specific certification(s) to a hospital that does not meet/maintain eligibility requirements.

AFFECT OF ACCREDITATION STATUS ON DISEASE SPECIFIC CERTIFICATION(S)

Disease specific certification(s) is tied closely to a hospital's accreditation status. If a hospital voluntarily withdraws its accreditation; or their accreditation is withdrawn/denied by CIHQ, then any disease specific certification(s) is withdrawn/denied as well.

RELATIONSHIP BETWEEN DISEASE SPECIFIC CERTIFICATION(S) & HOSPITAL ACCREDITATION SURVEYS

Disease specific certification(s) is not a separate and distinct survey activity. Rather, it is integrated into the hospital's accreditation survey. Certification standards are a set of focused requirements that a hospital must meet in addition to the accreditation standards.

A certification(s) survey occurs during the hospital accreditation survey. Assessment of compliance to certification standards is interwoven into the accreditation survey activities. In some cases, the overall length of the survey and/or the number of surveyors may be expanded in order to accomplish this function. If a hospital wishes to apply for disease specific certification, and have a focused survey outside of its initial or triennial accreditation survey, then CIHQ will work with the organization to develop a specific agenda and survey. Please contact CIHQ or details.

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ALLOCATION OF DEFICIENCIES BETWEEN DISEASE SPECIFIC CERTIFICATION & HOSPITAL ACCREDITATION

If a deficiency is identified during the disease specific certification(s) portion of a survey, it will either be assigned to a hospital accreditation standard or to a disease specific certification(s) standard. Allocation will depend on whether or not the deficiency is pertinent specifically to the certification(s) standards.

- For example, during the certification portion of a survey for hip and knee replacement surgery it is noted that the temperature and humidity of an operating room where these procedures are performed are not being monitored. There is no specific standard under this certification program that addresses environmental conditions in operating rooms. However, the hospital is non-compliant to accreditation standard CE-11 (which addresses temperature and humidity monitoring), and would thus be cited under the hospital's accreditation survey report.
- In another example, during that same portion of the survey it is noted that a patient underwent a hip replacement and was not educated on the importance of post-operative pain management and mobility. This would be non-compliant to the disease specific certification standard HK-3, and would be cited under the hospital's disease specific certification survey report.

REQUIREMENTS FOR A CORRECTIVE ACTION PLAN

The organization is required to submit an acceptable corrective action plan (CAP) to CIHQ within 10 calendar days following receipt of their certification survey report for any deficiencies identified,

A CAP must be developed and submitted for each deficiency identified. In order for the CAP to be accepted, it must address at least the following:

- The specific steps that the organization has taken (or will take) to correct the deficiency. The plan must address both the specific finding and the processes that led to the deficiency.
- A description of how the CAP was (or will be) implemented
- The monitoring process that has been (or will be) put in place to assure ongoing implementation of the CAP. Documentation must include the frequency and duration of monitoring, sample size, and target thresholds.
- The title of the person responsible for implementing the CAP; and
- The date the CAP was (or will be) implemented.

The CAP should be implemented as quickly as possible. The expectation is that – whenever possible – corrective action has already occurred by the time the CAP is submitted. Due dates for completion of corrective actions should not exceed 45 days. If specific actions require a longer timeframe, please notify CIHQ for assistance and direction.

APPEAL PROCESS

If an organization wishes to appeal a finding, it must notify CIHQ in writing within 10 calendar days following receipt of the certification survey report. The CIHQ *Survey Finding Appeal Form* must be used to submit appeals. The form is sent along with the certification report and includes instruction for submittal. Senior staff will review the appeal, contact the organization for any questions, discussion, further information, etc. and issue a determination in writing of the organization's compliance to the standard/requirement in question.

AFFECT OF THE APPEAL PROCESS ON SUBMISSION OF A CORRECTIVE ACTION PLAN

Initiating the appeal process does not obviate the hospital from submitting an acceptable plan of correction within required time frames. The hospital may submit due dates for completion on deficiencies they wish to appeal with enough lead time to allow the appeal process to occur and still implement corrective actions in a timely manner should the appeal be denied. The organization should contact CIHQ for assistance in this regard.

CERTIFICATION DECISIONS

CIHQ disease specific certification surveys are pass/fail. Certification will be awarded provided the hospital meets/maintains the eligibility requirements noted in this policy. The decision to award a disease specific certification is separate and distinct from a decision to award accreditation to a hospital. There is no negative effect on a hospital's accreditation if it fails a disease specific certification.

DURATION OF CERTIFICATION AWARD

Disease specific certification(s) is generally awarded for a 36 month period. The award date aligns with the hospital's effective date of accreditation.

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USE OF CIHQ SURVEYORS AS CONSULTANTS

Due to the integrated nature of the disease specific certification process, CIHQ surveyors are not permitted to independently serve as consultants. Hospitals may not employ, retain, contract with, or otherwise utilize CIHQ surveyors for any of the following:

- Provide consulting services or standards interpretation to prepare the organization for a CIHQ disease specific certification survey. This does not apply to accessing CIHQ central office staff for official standards interpretation.
- Providing tools or documents to assist in certification compliance. This does not apply to organizations that utilize CIHQ officially approved documents obtained directly from the CIHQ resource library.
- Provide education programs on CIHQ disease specific certification standards. This does not apply to attendance at CIHQ officially sponsored education programs and activities
- Assist with developing and/or reviewing appeals or corrective action plans for deficiencies identified during a CIHQ disease specific certification survey.
- Conduct mock CIHQ disease specific certification surveys

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DISEASE SPECIFIC CERTIFICATION STANDARDS: HEART FAILURE

HF-1: Leadership of the Heart Failure Program

The organization provides leadership for the heart failure program

A. The organization identifies a physician leader for the heart failure program who by education, training, and experience is qualified to provide medical direction to the program. The physician leader should be a board-certified cardiologist. If the physician leader is not a board-certified cardiologist, then the organization must demonstrate that the physician leader has comparable qualification.
B. The organization identifies an administrative leader to oversee the heart failure program. There is a written document that defines the duties and responsibilities of the administrative leader.

HF-2: Initial Assessment of Patients Presenting with Heart Failure

The heart failure patient will receive an appropriate initial clinical assessment of his or her condition

A. A history and physical examination is performed on patients presenting with heart failure that identifies cardiac and non-cardiac disorders or behaviors that might cause or accelerate the development or progression of the patient's condition.
    - The history includes current and past use of alcohol, illicit drugs, current or past standard or "alternative therapies", and chemotherapy drugs
B. The initial assessment includes an evaluation of the patient's ability to perform routine and desired activities of daily living.
C. The initial examination of patients presenting with heart failure includes assessment of the patient's volume status, orthostatic blood pressure changes, measurement of weight and height, and calculation of body mass index.
D. The various components of the initial assessment are performed within time frames defined by the organization.
    - For inpatients, the overall initial assessment must be completed within 24 hours of admission.
    - For outpatients, the overall initial assessment must be completed on the initial visit.
E. The initial assessment is performed by an individual(s) with the licensure, education, training, experience, and scope of practice to competently do so.

HF-3: Initial Diagnostic Work-Up of Patients Presenting with Heart Failure

The heart failure patient will receive an appropriate diagnostic work-up as part of an initial evaluation of his or her condition

A. Initial laboratory tests performed on patients presenting with heart failure include complete blood count, urinalysis, serum electrolytes (including calcium and magnesium), blood urea nitrogen, serum creatinine, fasting blood glucose (glycohemoglobin), lipid profile, liver function tests, and thyroid-stimulating hormone.
B. A twelve-lead electrocardiogram and chest radiograph (posterior/anterior and lateral) are performed initially on patients presenting with heart failure.
C. Two-dimensional echocardiography with Doppler are performed during initial evaluation of patients presenting with heart failure to assess left ventricular ejection fraction (LVEF), left ventricular size, wall thickness, and valve function. Radionuclide ventriculography can be performed to assess LVEF and volumes.
D. Coronary arteriography is considered for patients presenting with heart failure who have angina or significant ischemia unless the patient is not eligible for revascularization of any kind.
E. The organization determines the time frame for performing the initial diagnostic work-up

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HF-4: Ongoing Clinical Assessment of Patients with Heart Failure

The heart failure patient will receive an ongoing clinical assessment of his or her condition

A. For outpatient settings, an assessment is performed at each patient visit. At a minimum, the assessment must address:
   - The ability of the patient to perform routine and desired activities of daily living,
   - Volume status and weight,
   - Current use of alcohol, tobacco, illicit drugs, "alternative therapies," and chemotherapy drugs, and
   - Diet and sodium intake.

B. For inpatient settings, an assessment is performed on at least a daily basis. At a minimum, the assessment must address the patient's:
   - Level of activity and tolerance of activity
   - Volume status and weight
   - Diet and sodium intake.

C. As appropriate to the patient's condition and clinical presentation, ongoing assessments also include evaluation of the patient's respiratory status and oxygenation

D. Ongoing clinical assessments are performed by an individual(s) with the licensure, education, training, experience, and scope of practice to competently do so.

HF-5: Clinical Management of Patients in Heart Failure

The heart failure patient shall be clinically managed in accordance with evidence-based practice and accepted standards of care.

A. The medical staff develops, approves, and implements evidence-based clinical practice guidelines for the management of patients in various stages of heart failure.
   - Current and authoritative reference material is used in developing the clinical practice guidelines.
   - The clinical practice guidelines are reviewed on at least an annual basis to assure that they reflect current evidence-based practice.

B. Practitioners responsible for the clinical management of a patient in heart failure have been oriented to the clinical practice guidelines.

C. The medical staff monitors the use of clinical practice guidelines, identifies untoward variation in practitioner practice from the guidelines, and takes action to improve adherence to the guidelines as warranted.

HF-6: Availability of Specialized Assessments & Services

Heart failure patients have timely access to specialized assessments and services

A. The organization develops criteria to identify the need for rehabilitative, nutritional, and psycho-social services specific to the heart failure population

B. Heart failure patients are screened by qualified staff using the criteria within 24 hours of admission (or as soon as feasible if the patient's condition precludes screening within 24 hours)

C. Based on the results of the screening, heart failure patients are seen by the appropriate discipline for a full assessment, and a plan of care is developed within a time frame determined by the organization.

D. Reassessments are performed as indicated and within time frames defined by the organization. The plan of care is modified when indicated by reassessment findings.

HF-7: Patient Education

The heart failure patient receives the education necessary to effectively manage his or her condition

A. As appropriate to the patient's needs, education is provided on the following:
   - The factors and causes of heart failure
   - Signs / symptoms of worsening heart failure, and when to notify his/her physician or seek care
   - Necessary lifestyle changes – including activity restrictions.
   - Heart failure related treatment – including medications
   - Smoking cessation
   - Dietary considerations – including a low sodium diet
   - Monitoring of volume status and weight change

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HF-8: Quality Assessment & Performance Improvement

The heart failure program monitors, improves, and achieves a sustainable level performance

A. The organization participates in the American Heart Association (AHA) "Get with the Guidelines® – Heart Failure" database and submits data to the AHA's web-based "Patient Management Tool"™.
   - The organization achieves and sustains an 85% (or greater) level of compliance in each of the four achievement measures promulgated by the AHA "Get with the Guidelines® – Heart Failure for at least a consecutive 90 day period. Awarding of at least a "bronze level" of achievement by AHA is required.
   - The organization identifies opportunities, and takes actions, to improve its performance in complying with the achievement measures in the AHA "Get with the Guidelines® – Heart Failure"

B. The organization participates in CMS required core measures for heart failure
   - The organization identifies opportunities, and takes actions, to improve its performance in complying with the CMS required core measures for heart failure.

DISEASE SPECIFIC CERTIFICATION STANDARDS: HIP & KNEE REPLACEMENT SURGERY

HK-1: Leadership of the Hip and Knee Replacement Program

The organization provides leadership for the hip and knee replacement program

A. The organization identifies a physician leader for the hip and knee replacement program who by education, training, and experience is qualified to provide medical direction to the program. The physician leader should be a board-certified orthopedic surgeon. If the physician leader is not a board-certified orthopedic surgeon, then the organization must demonstrate that the physician leader has comparable qualification.

B. The organization identifies an administrative leader to oversee the hip and knee replacement program. There is a written document that defines the duties and responsibilities of the administrative leader.

HK-2: Identifying Eligible Patients for a Hip or Knee Replacement

The organization assures that patients receiving hip or knee replacement meet clinical indications for these procedures.

A. Objective and industry accepted criteria are used to identify patients who may benefit from hip or knee replacement. The organization defines the criteria chosen.

B. The criteria are used consistently when selecting patients for hip or knee replacement

HK-3: Pre-Operative Preparation of the Patient Receiving a Hip or Knee Replacement

The hip or knee replacement patient will receive a clinical assessment, diagnostic work-up, and education necessary to effectively prepare for surgery

A. The organization defines the minimum scope of clinical assessment that must be completed on patients prior to surgery. Clinical assessments are consistently completed within timeframes defined by the organization. The content of the clinical assessment reflects an evidence-based standard of care. The organization identifies the reference material used to define the evidence-based standard of care.

B. The organization defines the minimum clinical laboratory, imaging, and other diagnostic studies that must be performed on patients prior to surgery. The studies are consistently obtained within timeframes defined by the organization

C. The patient receives at least the following education prior to surgery:
   - The purpose and nature of the procedure being performed
   - The anticipated post-operative course of care
   - Steps that will be taken to reduce the risk of post-operative infection and the role of the patient in that process
   - Steps that will be taken to reduce the risk of post-operative complications such as thrombosis
   - The importance of post-operative pain management and mobilization

   Provision of this education is documented in the patient's medical record

HK-4: Qualifications of Practitioners Performing Hip and Knee Replacement Surgery

The medical staff assures that only qualified physicians perform hip and knee replacement surgery

A. The medical staff defines the criteria for granting clinical privileges for hip and knee surgery. In establishing these criteria, the medical staff takes into account the education, training, and experience that will be required of physicians to competently perform these procedures.

B. Clinical privileges to perform hip and knee replacement surgery are granted only to physicians who meet established criteria.

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HK-5: Qualifications and Training of Operating Room Staff

The organization assures that operating room staff is competent in the intraoperative care of a patient undergoing hip or knee replacement surgery.

A. The organization establishes the minimum qualifications of operating room staff that will provide intraoperative care. In establishing these qualifications, the organization takes into account the education, training, and experience that will be required of staff to competently provide care.
B. Only qualified operating room staff provides intraoperative care.
C. Appropriate to job function, the organization assures that operating room staff have been oriented and trained to at least the following:
    - The equipment and surgical instrumentation used in performing hip or knee replacement surgery
    - Intraoperative techniques and environmental controls to reduce the risk of an intraoperative infection
    - Patient positioning for surgery and safety related needs

HK-6: Post-Operative Clinical Management of Patients Receiving a Hip or Knee Replacement

The hip or knee replacement patient shall be clinically managed in accordance with evidence-based practice and accepted standards of care.

A. The medical staff develops, approves, and implements evidence-based clinical practice guidelines for the post-operative management of patients following hip or knee replacement surgery.
    - Current and authoritative reference material is used in developing the clinical practice guidelines.
    - The clinical practice guidelines address both the expected normative course of care as well as preventing/addressing post-operative complications such as infection or thrombosis.
    - The clinical practice guidelines are reviewed on at least an annual basis to assure that they reflect current evidence-based practice.
B. Practitioners responsible for the clinical management of a patient with a hip and knee replacement have been oriented to the clinical practice guidelines.
C. The medical staff monitors the use of clinical practice guidelines, identifies untoward variation in practitioner practice from the guidelines, and takes action to improve adherence to the guidelines as warranted.

HK-7: Availability of Specialized Assessments and Services

Hip and knee replacement patients have timely access to specialized assessments and services

A. The organization develops criteria to identify the need for rehabilitative services specific to the hip and knee replacement patient population
B. Hip and knee replacement patients are screened by qualified staff using the criteria within 24 hours after surgery.
C. Based on the results of the screening, hip and knee replacement patients are seen by the appropriate rehabilitative discipline for a full assessment, and a plan of care is developed within a time frame determined by the organization.
D. Reassessments are performed as indicated and within time frames defined by the organization. The plan of care is modified when indicated by reassessment findings.

HK-8: Post-Discharge Rehabilitation Services

When indicated, the hip or knee replacement patient receives post-discharge rehabilitation services

A. The organization establishes criteria that identify patients who require post-hospitalization rehabilitation services either on an outpatient or extended care / rehabilitation facility basis.
B. Patients requiring post-hospitalization rehabilitation services are identified by using the established criteria
C. If a patient requires post-hospitalization rehabilitative services, the organization either provides the service (directly or through contractual arrangement), or refers/transfers the patient to an entity/setting that provides rehabilitative services.

HK-9: Medical Device Failures / Recall of Implants

The organization effectively responds to recall notifications regarding hip and knee replacement medical devices

A. The organization tracks each medical device implanted into the patient
B. The organization develops and implements a system to receive recall alert notifications from the device manufacturer and/or the FDA, and takes appropriate action.
C. Device failures are reported to the FDA in accordance with Safe Medical Device Act (SMDA) requirements.

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HK-10: Quality Assessment and Performance Improvement

The hip and knee replacement program monitors and improves its performance

A. The organization develops specific indicators to monitor the effectiveness of its hip and knee replacement program. At least one of these measures addresses the incidence of post-operative infection.
B. Data on indicators is collected, aggregated, analyzed and integrated into the organization's quality assessment and performance improvement program.
C. The organization takes action to improve the effectiveness of its hip and knee replacement program based on identified opportunities for improvement.

DISEASE SPECIFIC CERTIFICATION STANDARDS: PRIMARY STROKE CENTER

ST-1: Leadership of the Stroke Program

The organization provides leadership for the stroke program

A. The organization identifies a physician leader for the stroke program who by education, training, and experience is qualified to provide medical direction to the program. The physician leader should be a board-certified neurologist. If the physician leader is not a board-certified neurologist, the organization must demonstrate that the physician leader has comparable qualification.
B. The organization identifies an administrative leader to oversee the stroke program. There is a written document that defines the duties and responsibilities of the administrative leader.

ST-2: Coordination of Pre-Hospital Services with the Emergency Medical System (EMS)

Stroke patients have access to timely and effective pre-hospital care

A. The organization demonstrates collaboration and communication with area EMS in the pre-hospital management of stroke patients.
B. When able, policies and procedures are developed in collaboration with area EMS in the transporting of stroke patients to the hospital for timely assessment, intervention, and care. These policies include an understanding that the stroke patients are to be transported to the nearest Primary Stroke Center that can provide appropriate care unless there is another life threatening emergency that would necessitate taking the patient to the closest facility.
C. Evidence-based treatment guidelines for the pre-hospital management of a stroke patient are provided to area EMS personnel.
D. The organization collaborates with area EMS in the identification and resolution of quality of care issues addressing the timely and appropriate management of stroke patients in the pre-hospital setting.
E. Cooperative educational activities between the organization and area EMS in the coordination, care, and management of stroke patients in the pre-hospital setting is provided at least twice a year.

ST-3: Availability of an Acute Stroke Team (AST)

There is an acute stroke team available to respond to patient care needs in a timely manner

A. At a minimum, the AST should include one physician and one other qualified healthcare provider (i.e., registered nurse, physician's assistant, nurse practitioner) who are available on a 24 hours/day, 7 days/week (24/7) basis.
B. The AST responds to patients with acute stroke in the emergency department (ED) and inpatient care areas. A member of the AST should be at the patient's bedside within 15 minutes of being called. Although it is preferred that members of the AST be in-house on a continual basis, a rapid response from outside the hospital is permitted as long as the response time remains ≤15 minutes.
C. Members of the AST must have familiarity and expertise with the recognition, diagnosis, stabilization, and acute care of all types of patients with stroke. Evidence-based protocols should be used by the AST members to guide acute care and determine which patients should be transferred to other facilities. The protocols should apply to all major stroke types.
D. Evidence-based treatment guidelines, in the form of pre-printed or electronic order sets, are used in the clinical management of the stroke patient. These guidelines must address at least the emergent care of patients with ischemic and hemorrhagic strokes, including stabilization of vital functions, initial diagnostic tests, and the use of various medications.
   - The guidelines are available to members of the AST. The guidelines are reviewed on at least an annual basis to assure they reflect current standards of care.
   - The organization assures that at least 80% of AST members have been oriented to the current treatment guidelines.
E. There must be a specific and well-organized system for rapidly notifying and activating the AST to evaluate patients presenting with symptoms suggestive of an acute stroke (i.e., pager, cell phone, overhead calling).

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ST-4: Care of the Stroke Patient in the Emergency Department

Stroke patients have access to timely and effective emergency department care

A. Emergency department physicians have knowledge and expertise in the identification and clinical management of a patient presenting with an acute hemorrhagic and/or acute ischemic stroke. This includes, but is not necessarily limited to:
   - Effective communication both externally and internally in marshaling resources necessary to provide appropriate and timely care.
   - The medical management of stroke patients during the acute phase of illness
   - The recognition, assessment and management of acute stroke complications

B. For ischemic stroke patients who meet criteria for IV thrombolytic therapy (e.g. patients presenting within three (3) hours of symptom onset);
   - The organization assures 24/7 availability of IV thrombolytic medications, associated supplies, and other necessary items in the emergency department.
   - Emergency department physicians and nursing staff are trained on the appropriate management of IV thrombolytic therapy – including indications for use, contraindications, administration, monitoring requirements, post-therapy neurologic deterioration, and education to the patient and/or family.
   - If an eligible ischemic stroke patient does not receive IV thrombolytic therapy, the reason is documented in the patient's medical record.

C. Evidence-based treatment guidelines, in the form of pre-printed or electronic order sets, are used in the clinical management of the stroke patient. These guidelines must address at least the emergent care of patients with ischemic and hemorrhagic strokes, including stabilization of vital functions, initial diagnostic tests, and the use of various medications.
   - Treatment guidelines address at least current Class 1-A and Class 1-B recommendations contained in the *Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association.*
   - The guidelines are available to physicians and staff in the Emergency Department. The guidelines are reviewed on at least an annual basis to assure they reflect current standards of care.
   - The organization assures that at least 80% of emergency department physicians and nursing staff have been oriented to the current treatment guidelines.

D. When needed, emergency department physicians have 24/7 timely access to consultation with a neurologist granted privileges by the hospital medical staff and governing body. Timely access is defined as within 30 minutes of need for the consult being communicated by the emergency department physician. Consultation may performed by the neurologist in person or by telemedicine.

E. Stroke patients are monitored while undergoing care. Monitoring includes at least;
   - Heart rate/rhythm with automatic arrhythmia detection
   - Blood pressure with noninvasive blood pressure monitoring
   - Oxygenation via oximetry

ST-5: Availability of Diagnostic Services

Stoke patients have timely access to diagnostic services both in the emergency department and the inpatient setting.

A. Diagnostic brain imaging (e.g. CT, MRI) is available 24/7 for acute stroke patients. A brain image study is performed, preliminarily interpreted, and reported to the requesting practitioner within 45 minutes of order.
   - Preliminary interpretation can either be performed on-site or through telemedicine services.
   - The preliminary interpretation must definitively rule out or detect intracranial hemorrhage or other causes of the stroke syndrome
   - There should be written documentation that such scans were performed and read within the specified times
   - For facilities without in-house imaging interpretation expertise, teleradiology systems approved by the Food and Drug Administration (or equivalent organization) are available for timely review of brain computed tomography (CT) and magnetic resonance imaging (MRI) scans in patients with suspected acute stroke

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B. Laboratory testing is available 24/7 for acute stroke patients. Laboratory studies are obtained, run, resulted, and communicated to the requesting practitioner within 45 minutes of order
   - Laboratory tests include, but are not necessarily limited to;
     - Complete blood counts (CBC)
     - Platelet count
     - Prothrombin time (PT)
     - International Normalization Ratio (INR)
     - Blood chemistries

C. ECG and chest x-rays for acute stroke patients are available 24/7. The studies are performed and the results made available to the requesting practitioner within 45 minutes of order

D. Transthoracic echocardiography and/or trans-esophageal echocardiography) to image the heart is available for all admitted patients with stroke.

ST-6: Availability of Emergent Neurosurgery

The applicable stroke patient has timely access to neurosurgery in an emergency.

A. If the organization does not provide neurosurgical services, it has a written agreement with a hospital that provides said service. The agreement addresses the timely transfer of the patient to that facility for emergent intervention.
   - Transfer is initiated in a timely manner so that the neurosurgeon at the receiving facility can see the patient within two hours of identified need.
   - The organization evaluates the effectiveness of the transfer agreement on at least an annual basis. At a minimum, the evaluation includes reviewing patient transfers to see if they occurred in a timely manner.

B. If the organization provides neurosurgical services, it assures there is a fully functional and staffed operating room, with a neurosurgeon available, within two hours of recognized need for emergent intervention

ST-7: Stroke Unit & Nursing Care

Stroke patients receive inpatient care in a setting designed, staffed, and operated to meet their unique care needs

A. The organization identifies an inpatient care unit(s) (stroke unit) that will provide care to stroke patients during their hospitalization. To the extent possible, stroke patients are admitted / transferred to this care unit(s).

B. The stroke unit is under the direction of a physician who by education, training, and experience is qualified to provide medical direction to the stroke population. This may be the same individual who provides medical direction for the overall stroke program.

C. The stroke unit(s) has sufficient equipment and supplies to provide an appropriate level of care for the stroke population, including multi-channel telemetry (preferably computerized) capable of monitoring blood pressure, pulse, respiration, and oxygenation.

D. There is a written protocol that details how changes in a patient's status are detected, how they are documented, and how medical staff' are notified of such changes. Notification of the medical staff of any changes or worsening in vital signs and/or neurological status defines who gets called initially (house officer, advanced practice nurse, attending) and when and how additional personnel are notified as well as expected response times.

E. Nursing care provided on the stroke unit is under the clinical direction of a registered nurse who by education, training, and experience is qualified to direct nursing care to the stroke population

F. Nursing staff on the stroke unit follow accepted standards in the assessment, care, and education of the stroke patient
   - The National Institute for Health (NIH) Stroke Scale is used when performing a neurological assessment
   - If nursing staff perform an aspiration risk (swallowing) screening, they are specifically trained to do so

G. Nursing staff caring for stroke patients on the stroke unit receive initial training and assessment of their competency to care for stroke patients – appropriate to their level of responsibility – upon hire or transfer to the stroke unit. While the organization determines the specific content of this training, it must address the physical, psychosocial, and educational needs of this patient population.

H. All physicians, physician assistants, advanced practice nurses, and nurses on the stroke unit who provide direct patient care or supervise such care must receive at least 8 hours per year of medical education (continuing medical education or other types of education) related to cerebrovascular disease

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ST-8: Availability of Specialized Assessments & Services

Stroke patients have timely access to specialized assessments and services

A. The organization develops criteria to identify the need for rehabilitative (physical therapy, occupational therapy, speech therapy), nutritional, and psycho-social services specific to the stroke population
B. Stroke patients are screened by qualified staff using the criteria within 24 hours of admission (or as soon as feasible if the patient's condition precludes screening within 24 hours)
C. Based on the results of the screening, stroke patients are seen by the appropriate discipline for a full assessment, and a plan of care is developed within a time frame determined by the organization.
D. Stroke patients are provided with post-hospitalization rehabilitative services (physical therapy, occupational therapy, speech therapy) as warranted. If these services are not provided by the organization, the patient is referred to another care provider as part of discharge planning.

ST-9: Patient Education

The stroke patient receives the education necessary to effectively manage his or her condition

A. As appropriate to the patient's needs, education is provided on the following:
    - The risk factors and causes of stroke
    - Lifestyle changes that can reduce the risk of stroke
    - Stroke related treatment – including medications – provided to the patient

ST-10: Community Education

The organization promotes public education on stroke prevention, recognition, and access to services

A. The organization provides at least two education programs annually to the public in its primary service area about stroke prevention, diagnosis, and/or the availability of stroke care services.

ST-11: Quality Assessment & Performance Improvement

The stroke program monitors and improves its performance

A. There is a database or registry for tracking the number and type of patients with stroke seen, their treatments, timelines for receiving treatments, and some measurement of their outcomes. A written system is in place whereby such data can be systematically collected, reviewed, and acted on.
    - Specific benchmarks for comparisons are established. At least two relevant patient-care parameters for benchmarking are selected each year. Data is collected, aggregated, analyzed, and actions taken to improve performance if indicated.
B. A multidisciplinary quality improvement committee reviews and monitors stroke care quality benchmarks, indicators, evidence-based practices, and outcomes

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DISEASE SPECIFIC CERTIFICATION SURVEY PROCESS

OVERVIEW

Caring for a specific patient population does not occur in a vacuum. While patients certainly do receive care unique to their needs, there is a commonality of need that applies to all patient populations. The CIHQ disease specific certification process is designed to reflect this reality.

There are no separate and distinct survey procedures for disease specific certification(s). Assessing compliance to certification standards is interwoven into the hospital accreditation survey process. The specific procedures and activities are outlined in the *CIHQ Hospital Accreditation Survey Activity Guide.*

- For example, a disease specific certification(s) assessment will involve a review of selected documents. These documents will be reviewed at the same time as the accreditation survey document review.
- In another example, surveyors will review both open and closed medical records of patients who reflect the disease specific population. For open records, this will occur during the accreditation survey activity of visiting patient care areas. Closed records will be pulled as part of the accreditation survey closed record review activity.

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