



Questions from the Primary Stroke Center Certification Program Webinar August 9, 2011

1. How much data is required in order to apply for Primary Stroke Center certification?
HFAP requires 12 consecutive months of data in order to apply.

2. Can there be a sampling of data or does it have to be collected on all stroke patients?
If you have 30 patients or less per month, the expectation is 100% data collection. More than 30 patients per month is a 10% sampling with a minimum of 30 patients.

3. Does the 8 hour CME requirement apply to ED physicians? Many are Board certified and have CME requirements to maintain that certification. Would those CME be sufficient?
If included in the hours of CME received, there is a dedicated 8 hours, it would be sufficient. If not, then an additional 8 hours would be required. This gives the facility the credibility that is needed to be considered a Primary Stroke Center.

4. Is there a mechanism for facilities to query other stroke centers and pose questions about how they meet turnaround time benchmarks?
HFAP has created a discussion group forum for facilities to ask each other question, share best practices, and so on. Anyone who is interested in joining should email info@hfap.org and request the link.

5. The first 24-48 hours of a stroke patient's hospital admission can be very busy and when rehab staff tries to evaluate the patient they are often not available. Do you have a possible solution?
HFAP has seen facilities schedule an appointment or time that can be worked out with the members of the healthcare team to coordinate all of the evaluation and treatment that is needed.

6. What is the yearly continuing educational requirement for nurses that care for stroke patients but are not part of the acute stroke team?
The standard indicates that nurses in the stroke unit (or if there is not a designated stroke unit, those caring for stroke patients) have a minimum of two educational sessions per year. (01.04.03)

7. What is the HFAP definition of a stroke registry?
HFAP does not have a specific definition due to the fact that there are several registries throughout the country and we don't want to be too prescriptive that would exclude any of them. Two examples that are fairly well known are the AHA Get with the Guidelines and Coverdell.

8. Who is on the Acute Stroke Team?
Standards 01.00.05 and 01.00.07 discuss the membership of the stroke team. Different facilities utilize a variety of professionals. Minimally, there is a qualified physician and another healthcare professional that might be another physician, a Registered Nurse, a Physician Assistant or Nurse Practitioner. Some facilities use their Rapid Response Team for inpatient strokes and the ED staff for those presenting to that department.
9. 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.
10. Please explain the rationale in the difference between imaging and laboratory standards. Both have a 45 minute total time limit but imaging must be completed within 25 minutes and interpretation within 20 minutes of scan completion.
The reason it is separated is so that you can identify where there may be a lag time, in either the performance of the CT scan or the reading of it by the radiologist.
11. Do you require use of 3 - 4.5 hour time frame for tpa although it's not FDA approved for this timeframe?
HFAP does not require the use of the 3-4.5 hour timeframe for administration of tPA. It is a possibility for a group of patients that fall within specific criteria. HFAP still maintains that the sooner it is administered, the better.
12. Why is pt stroke education not included on data submission tool?
It is not included on the submission tool because it is not a measure. It is an activity that is monitored during the survey.
13. HFAP measures are slightly different from the new CMS Core Measures, specifically PT prior to DC not 2 days. Are we considering linking them? Also, HFAP includes TIA under Ischemia but there is confusion on CMS Core Measures that TIA is ischemia. Are we able to specifically address that TIA is an ischemic event in the HFAP standards?
HFAP measure for PT within 2 days of admission is because we feel it is prudent to initiate therapy as soon as possible. We have no plans to link it at this time. You may specifically address TIA as an ischemic event.
14. Also, some CMS Times are from arrival such as CT & Lab but HFAP is from order time, is that being rectified?
This measure has been revised in the 2011 manual to reflect time of arrival.

15. Pt must be evaluated by PT, OT, ST by 48 hours. Is it by all or any one of them that qualifies?
At a minimum, the patient is evaluated by PT with a screen for the other disciplines. Typically, the PT evaluation includes this.
16. If patient did not receive tPA is an exclusion NIHSS of zero? ie. pt arrives within 3 hours but NIHSS = 0
It would seem that if a patient scored 0 on the NIHSS, then they would not qualify as a candidate to receive tPA as they have no symptoms.
17. What are the defining criteria for HTN stable at discharge? Seems this is in subjective information. What if the MD states adjusting medications?
The defining criteria for stable HTN would be industry standards along with patient history. The MD wanting to adjust medications is a clinical decision that is going to be patient specific and situation dependent.
18. Does all CME need to be category 1 or can it include category 2?
HFAP does not distinguish between categories.
19. Our facility recently partnered with the Wisconsin Nurses Association, and is currently working on Contact hours for nursing. Our education, last year, was heavily focused on stroke, but we did not have the ability to attach contact hours, is this a risk with accreditation?
The HFAP requirement for education is CME for physicians and CEU for nurses.
20. Is HFAP working with other states to make sure that HFAP is able to certify centers in all states?
HFAP has the ability at present to certify Stroke Centers in all states. If you encounter an issue in your state, please notify HFAP.
21. When it comes to initial patient assessment through a rapid response team, when the term Medical staff is used, are residents acceptable?
Residents are acceptable if they have been identified by the facility as part of the acute stroke team/rapid response team and have the required education.
22. Looking at Standard 01.07.01, part 2 states 45 minutes of patient arrival for the listed tests yet the explanation section states that the Lab Director collaborates to identify the tests and an acceptable TAT for results and that we need to meet the agreed upon timelines. So, is it 45 minutes from patient arrival, 45 minutes from time ordered (as stated in today's presentation), or do we decide?
The maximum timeline is 45 minutes from patient arrival. If the Lab Director chooses to have an earlier timeframe, that is also acceptable.

23. Standard 01.00.05 Medical Staff privileges granted for the treatment of acute stroke, does that need to be specifically spelled out or can it be in core privileges.
Treatment of acute stroke must be clearly identified in the physician privileges.
24. If a neurologist is an attending MD but there is also an internist on the case, do they need the 8hrs of CME? Meaning if we always have a neurologist on the case do we need the education for the other potential physicians?
Please refer to standard 01.04.03. The explanation column state-The professional staff, including the leadership, physicians, intensivists, fellows, registered nurses and physical rehabilitation personnel, receives training in order to remain current with advancements in the treatment of acute stroke.
25. Can you better define the content for "twice a year" education for nurses? Approved continuing education credit or in-house offerings?
This education does not have to be formal CEU education. It can be offered in-house. It could include education on your protocols.
26. We are accredited by AOA to provide CME for DO's but not for MD's. If an MD physician attends an in house CME event on CVA can that go to fulfilling his/her requirement?
If the MD submits their certificate to their association, they should get credit for the program. Make sure that the file in your facility reflects attendance to the CME event/education.
27. If you have a stroke unit and no beds are available and a stroke is placed in a unit elsewhere. How does the 8 CME for anyone who cares for a stroke patient come in to play?
If your facility has the situation that stroke patients may be cared for by staff in other than the stroke unit, then the twice a year education (standard 01.04.03) would be applicable.
28. Does a respiratory tech need CEU's also?
It would depend on if the respiratory tech is part of your acute stroke team, then yes they would require it. At a minimum, they would require the two educational sessions per year.