IDAHO TIME SENSITIVE EMERGENCY SYSTEM
TRAUMA | STROKE | STEMI

Level II Stroke Center

Application & Resource Tool Kit

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IDAHO DEPARTMENT OF HEALTH & WELFARE

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TSE Frequently Asked Questions

Why a TSE program?

The 2014 Idaho Legislature approved and funded a plan to develop a statewide Time Sensitive Emergency (TSE) system of care that addresses three of the top five causes of deaths in Idaho: trauma, stroke, and heart attack. Studies show that organized systems of care improve patient outcomes, reduce the frequency of preventable death, and improve the quality of life of the patient.

How does the TSE program work?

The Idaho Department of Health and Welfare provides oversight and administrative support for the day-to-day operation of the program.

A governor-appointed TSE Council made up of health care providers, EMS agencies, and administrators of hospitals representing both urban and rural populations is responsible for establishing Rules and Standards for the TSE system. The Council is the statewide governing authority of the system.

The state has been divided into six regions. Each of these has a Regional TSE Committee made up of EMS providers, hospital providers and administrators, and public health agencies. The regional committees will be the venue in which a wide variety of work is conducted such as education, technical assistance, coordination, and quality improvement. The Regional TSE Committees will have the ability to establish guidelines that best serve their specific community in addition to providing a feedback loop for EMS and hospital providers.

What guiding principles are the foundation of the TSE system?

- Apply nationally accepted evidence-based practices to time sensitive emergencies;
- Ensure that standards are adaptable to all facilities wishing to participate;
- Ensure that designated centers institute a practiced, systematic approach to time sensitive emergencies;
- Reduce morbidity and mortality from time sensitive emergencies;
- Design an inclusive system for time sensitive emergencies;
- Participation is voluntary; and
- Data are collected and analyzed to measure the effectiveness of the system.

How often does a center need to be verified?

Every three years.

How much does it cost to be verified and designated?

Verification is done once every three years. The on-site survey fee is $3,000 and must be submitted with the application. Designation is valid for three years. The designation fee may be paid in three annual payments of $4,000 or in one payment of $12,000.

Whom do I contact if I have questions about the application process?

Idaho Time Sensitive Emergency Program

P.O. Box 83720

Boise, ID 83720-0036

tse@dhw.idaho.gov

http://tse.idaho.gov/

Program Manager

Christian Surjan

surjanc@dhw.idaho.gov

(208) 334-6564

Application Process

To apply for designation as a Level II Stroke Center in Idaho **using Joint Commission or DNV**:

1. Print and complete the application. Submit one application per facility. A completed application includes:
   A. Facility and Personnel Profile;
   B. Certification Statement; and
   C. A copy of the JC or DNV site review
2. Obtain the required signatures on the Certification Statement.
3. Put the application in a binder with labeled, tabbed dividers between each section: Profile, Certification, JC/DNV site review.
4. Mail the completed application and year one designation fee ($4,000) to:

   Make checks payable to: Bureau of EMS and Preparedness

   Bureau of EMS and Preparedness
   Time Sensitive Emergency Program
   P.O. Box 83720
   Boise, ID 83720-0036

   Or for FedEx, UPS, etc.:
   2224 E. Old Penitentiary Road
   Boise, ID 83712

TSE Program staff will notify you within 10 business days of receipt of the application and confirm that the application is complete.

Application Process

To apply for designation as a Level II Stroke Center **using the State of Idaho for verification:**

1. Complete and print the application. Submit one application per facility. A completed application includes:
   A. Facility and Personnel Profile;
   B. Certification Statement;
   C. Pre-Survey Questionnaire; and
   D. Required Attachments
2. Obtain the required signatures on the Certification Statement.
3. Put the application in a binder with labeled, tabbed dividers between each section: Profile, Certification, PSQ (Pre-Survey Questionnaire), and Attachments.
4. Mail the completed application and on-site survey fee ($3,000) to:

   Make checks payable to: Bureau of EMS and Preparedness

   Bureau of EMS and Preparedness
   Time Sensitive Emergency Program
   P.O. Box 83720
   Boise, ID 83720-0036

   Or for FedEx, UPS, etc.:
   2224 E. Old Penitentiary Road
   Boise, ID 83712

TSE Program staff will notify you within 10 business days of receipt of the application and confirm that the application is complete.

Application for Level II Center

A. Hospital and Personnel Profile

Hospital Name:		
Mailing Address:	City:	Zip:
Physical Address:	City:	Zip:
Phone:	County:	
Application Contact and Title:		
Phone:	E-Mail:	

Hospital Administrator/Chief Executive Officer:	
Phone:	E-Mail:
Stroke Care Coordinator:	
Phone:	E-Mail:
Stroke Medical Director:	
Phone:	E-Mail
Emergency Department Medical Director:	
Phone:	E-Mail:
Emergency Department Nursing Director:	
Phone:	E-Mail:

B. Certification Statement

I, _____ (CEO/COO), on behalf of _____ (hospital), voluntarily agree to participate in the Idaho Time Sensitive Emergency system as a Level II Stroke Center. We will work with emergency medical services and other hospitals in our area to streamline triage and transport of stroke patients and participate in our Regional Time Sensitive Emergency Committee.

I certify that:

A. The information and documentation provided in this application is true and accurate.

B. The facility meets the State of Idaho criteria to be designated as a Level II Stroke Center.

C. We will participate in the Idaho TSE Registry; and

D. We will notify the Time Sensitive Emergency Program Manager immediately if we are unable to provide the level of stroke service we have committed to in this application.

_____ _____

Chair, Governing Entity (Hospital Board) Date

_____ _____

Chief Executive Officer Date

_____ _____

Stroke Medical Director Date

_____ _____

Stroke Program Manager Date

C. Pre-Survey Questionnaire

Answer every question. If you require additional space, please include a separate sheet. Once complete, print and sign the application (Certification Statement). Label all attachments and place them in the "Attachments" section. Do not hesitate to contact the TSE program staff if you have any questions regarding your application. (208) 334-4904

1. Personnel

1.1 Do you have a stroke care coordinator? ◯ Yes ◯ No

Is he or she at minimum an RN? ◯ Yes ◯ No

Do you have supporting documentation ? ◯ Yes ◯ No

1.2 Do you have a stroke medical director? ◯ Yes ◯ No

Is he or she a physician? ◯ Yes ◯ No

Attach a copy of the stroke medical director's job description and CV. Label as "Attachment #1".

If he or she oversees more than one center's stroke program, explain how he or she is involved in program decision-making at each hospital.

1.3 Do you have a defined stroke leadership team? ◯ Yes ◯ No

Does your team consist of, at minimum, a physician and an RN? ◯ Yes ◯ No

Attach a list of all positions on your stoke leadership team. Label as "Attachment #2".

1.4 Do you have organizational and administrative support for your stroke program? ◯ Yes ◯ No

Attach letters of support from your medical staff and hospital board. Label as "Attachment #3".

1.5 Do you have clinical personnel trained in diagnosing and treating acute stroke on-site 24/7?

◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

2. Training and Education

2.1 Do the members of your stroke leadership team have a minimum of 8 hours of annual education on stroke diagnosis and treatment to ensure compliance? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

2.2 Are all of your facility's staff educated annually on the signs and symptoms of stroke and the process to activate the stroke team? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

2.3 Does your stroke unit's clinical staff demonstrate evidence of initial and ongoing training in the care of acute stroke patients? ◯ Yes ◯ No

Note: Stroke units may be defined and implemented in a variety of ways. The stroke unit does not have to be a specific enclosed area, but must be a specified unit to which most stroke patients are admitted.

Do you have supporting documentation? ◯ Yes ◯ No

3. Stroke Services

3.1 Do you have a neurologist or physician experienced in cerebrovascular care available on-site or via telemedicine or telephone within 20 minutes of patient's arrival 24/7 with an 80% achievement rate?

◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.2 Do you have:

a. An ICU? ◯ Yes ◯ No

b. Physical therapy? ◯ Yes ◯ No

c. Occupational therapy? ◯ Yes ◯ No

d. Speech therapy? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.3 Do you have a CT tech on-site 24/7? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.4 Do you perform CT or MRI within 25 minutes of patient arrival with an 80% achievement rate? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.5 Do you have staff, on-site or via telemedicine, to read and report CT/MRI within 45 minutes of patient arrival 24/7 with an 80% achievement rate? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.6 Do you have intracranial and extracranial vascular imaging? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.7 Do you have EKG and chest x-ray capability 24/7? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.8 Do you have laboratory or point-of-care testing 24/7 with results in 45 minutes or less with an 80% achievement rate? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.9 Do you have FDA-approved IV thrombolytic therapy for stroke available 24/7? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.10 Do you have written stroke protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes for:

a. Stroke team activation process? ◯ Yes ◯ No

b. Initial diagnostic tests? ◯ Yes ◯ No

c. Administration of medication? ◯ Yes ◯ No

d. Swallowing assessment prior to oral intake? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

3.11 Is your pharmacy adequately staffed by qualified personnel to ensure effective medication management services including emergency services available 24/7? ◯ Yes ◯ No

Explain:

3.12 Do you have transfer protocols or guidelines that include criteria specific to transferring stroke patients? ◯ Yes ◯ No

Does it include hemorrhagic stroke patients, stroke patients outside of the IV t-PA treatment window, etc.? ◯ Yes ◯ No

3.13 Do you have a written transfer protocol with at least one Level I Stroke Center? ◯ Yes ◯ No

3.14 Do you coordinate with EMS on stroke care and transport policy and procedures, system activation, training, data collection and quality improvement? ◯ Yes ◯ No

Explain:

3.15 Do you provide annual public education on stroke-related topics such as prevention, risk factors, signs and symptoms, and the importance of getting treatment right away and calling 911?

◯ Yes ◯ No

Attach a list of all public education for the most recent 12-month period. Label as "Attachment #4".

3.16 Do you provide stroke education to stroke patients and their caregivers? ◯ Yes ◯ No

Attach a copy of your stroke education material. Label as "Attachment #5".

5. Performance Measurement and Quality Improvement

5.1 Do you participate in the Idaho TSE Registry? ◯ Yes ◯ No

Are at least 80% of cases submitted within 180 days of treatment? ◯ Yes ◯ No

Do you have supporting documentation? ◯ Yes ◯ No

5.2 Do you have internal QI activities related to stroke care? ◯ Yes ◯ No

Explain:

5.3 Do you meet the benchmark of door-to-needle time in less than 60 minutes with a 75% achievement rate? ◯ Yes ◯ No

Do you have supporting documentation ? ◯ Yes ◯ No

5.4 Do you participate in your Regional TSE Committee? ◯ Yes ◯ No

Explain:

Modified Rankin Scale

MODIFIED Patient Name: _____

RANKIN Rater Name: _____

SCALE (MRS) Date: _____

Score	Description
0	No symptoms at all
1	No significant disability despite symptoms; able to carry out all usual duties and activities
2	Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
3	Moderate disability; requiring some help, but able to walk without assistance
4	Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5	Severe disability; bedridden, incontinent and requiring constant nursing care and attention
6	Dead

TOTAL (0–6): _____

References
Rankin J. “Cerebral vascular accidents in patients over the age of 60.”

Additional Resources

Building the Case for a Primary Stroke Center

http://www.stroke.org/stroke-resources/resource-library/building-case-primary-stroke-center

Joint Commission

http://www.jointcommission.org/certification/primary_stroke_centers.aspx

Recommendations From the American Stroke Association's Task Force on the Development of Stroke Systems

http://www.virginiastrokesystems.org/assets/files/1/files/pdf/recommendationsfortheestablishmentofstrokesystemsofcare.pdf

Minnesota Stroke System Hospital Designation Tool Kit

http://www.health.state.mn.us/divs/healthimprovement/content/documents/MinnesotaStrokeSystemToolkit140920.pdf