Arkansas Department of Health

4815 West Markham Street ● Little Rock, Arkansas 72205-3867 ● Telephone (501) 661-2000
Governor Sarah Huckabee Sanders
Renee Mallory, RN, BSN, Interim Secretary of Health
Jennifer Dillaha, MD, Director

Arkansas Stroke Ready Hospital (ArSRH) Re-Designation Application: 2022

PURPOSE

Any facility requesting re-designation as an Arkansas Stroke Ready Hospital (ArSRH) must submit the attached Re-Designation Application to the Arkansas Department of Health (ADH) every three (3) years. Hospitals may choose to seek higher levels of stroke designation such as Primary Stroke Center (PSC) or Comprehensive Stroke Center (CSC) offered by The Joint Commission (TJC).

Of note, the initial designation as an ArSRH by the ADH is a testament of the hospital's capacity and capability to provide the recommended stroke care based on the designation. Re-designation as an ArSRH demonstrates the quality and performance measures for optimal stroke care in addition to demonstrating capacity and capability.

Section A. ARKANSAS STROKE READY HOSPITAL RE-DESIGNATION GUIDELINES

The process to apply for and receive re-designation as an ArSRH is to be submitted as follows:

1. Application is to be submitted between sixty (60) and ninety (90) days prior to the expiration date of ArSRH designation.
2. Hospital representative completes Sections B, C, D, E (if necessary), and F of this application. If any of the required measures fall below the specified ADH benchmark, a Corrective Action Plan (CAP) addressing each deficient measure must be submitted to ADH staff along with the completed re-designation application via email. The CAP is a step-by-step plan that explains how performance is to be improved (NOTE: please use the CAP template provided in Section E). A CAP is needed only if any of the required measures do not meet or fall below the ADH benchmark. A CAP is not required for any of the reporting measures.
3. Hospitals are expected to have measurable improvement, reaching the target benchmarks within 6 months of the CAP being submitted and approved. If the target(s) are not reached, the hospital's designation may be impacted. It is critical to work with the Registry Staff if Quality Improvement (QI) assistance is needed.
4. Email completed application to Joanne.Labelle@arkansas.gov
5. The ADH re-designation team will review the application.
   a. The number of required measures that fall below the ADH benchmark will determine the re-designation process.
      i. If no required measures fall below the ADH benchmark, the re-designation application will be approved.
      ii. If one or two required measures fall below the ADH benchmark, the hospital needs to submit CAPs for each deficient measure and the re-designation application will be approved after review of CAPs.

      iii.   If three or more required measures fall below the ADH benchmark, the hospital needs to submit CAPs for each deficient measure and a timeline to address them. The hospital needs to submit at least three (3) months of new data into the Arkansas Stroke Registry (post-date of CAP) and then the ADH will re-evaluate at that time.

b.   Upon approval, ADH issues a letter to the hospital extending the license term as an ArSRH for an additional three (3) years. Furthermore, ADH provides certificate of designation providing proof of the ArSRH term extension.

c.   If the hospital is required to re-submit a new application for re-designation due to three or more required measures having failed to meet the ADH benchmark, the ADH team decides if re-designation is appropriate upon receipt of the new application.

      i.   If approved, an official letter of designation and certificate of designation is provided to the hospital.

      ii.   If any data continues to fall short of the specified benchmark and the application is not approved, the ADH team informs hospital staff and indicates the path forward for re-designation at that point.

Additional information:

- On a quarterly basis (at minimum), the ArSRH creates Get With the Guidelines (GWTG) – Stroke measure reports as part of stroke care quality improvement meetings conducted with hospital staff and local EMS to evaluate performance. These measures include the following data points part of the ADH program review process: stroke band ID; EMS Pre-notification; NIHSS performed by hospital staff; Door-to-CT time <= 25 minutes; Door-In-Door-Out times at first hospital prior to transfer to acute therapy; Time to intravenous (IV) thrombolytic therapy – 60 minutes; IV-thrombolytic: arrive by 2 hours, treat by 3 hours; IV-thrombolytic: arrive by 3.5 hour, treat by 4.5 hour; Early Antithrombotics; VTE prophylaxis; Antithrombotics; Anticoag for A fib/A flutter; Smoking cessation; Statin at discharge; Dysphagia screen; Stroke education; Rehab considered; CDC/COV Defect-free score. The hospital creates the most recent quarter of data available for each of these measures using GWTG-Stroke and has this report this report ready for ADH staff to review as part of the annual stroke performance program review process.
- The ArSRH re-designation review process does not require an on-site visit, however, the ADH reserves the right to perform site visits as needed.
- A hospital that is not designated by ADH cannot represent itself as an ArSRH.
- There are two categories of data points to be recorded within Section D of the application for re-designation: "Required" and "Reported." While both categories are necessary for the hospital to disclose as part of this re-designation process, only the required measures are being evaluated to determine eligibility for re-designation. Reported measures may become required in the future.
- Any Designated Stroke Center is required to notify the ADH if other Stroke Level of Certifications are denied or suspended/revoked.
- Any ArSRH that fails to submit a Re-Designation application every 3 years risks suspension/revocation of its designation. A 3-month grace period is given to hospitals to submit

their application. However, if the application is not submitted during the 3-month grace period, the hospital may be required to receive designation through the original designation process.

- An ArSRH's Designation may be denied/suspended for, but not limited to, any one of the following reasons:
    - Failure to comply with applicable sections withing the ArSRH's guidelines.
    - Failure to provide care consistent with the facility's capability and capacity.
    - Willful preparation or filing of false stroke reports, records, or data.
    - Fraud or deceit in obtaining or attempting to obtain designation status.
    - Failure to submit stroke data to the Arkansas Stroke Registry as described in the Arkansas Stroke Registry guidelines.
    - Failure to have appropriate staff and/or equipment required for an ArSRH as described in the ArSRH guidelines.
    - Unauthorized disclosure of stroke medical or other confidential information.

Section B. LEVEL OF DESIGNATION

Designation Level	None	ArSRH	PSC	CSC	Other (please describe)
Current Level:	☐	☐	☐	☐	
Applying For:	☐	☐	☐	☐	

Does your hospital participate in either the UAMS Institute for Digital Health & Innovation Stroke Program or Mercy Telestroke Program?

Yes ☐   No ☐

If "No," specify the name of the participating Telestroke program: _____

Section C. FACILITY IDENTIFYING INFORMATION

Facility Name			
Stroke Coordinator(s) Name			
Mailing Address for Stroke Program Coordinator			Telephone Number(s)
City	State	Zip	County
Email		Fax	

Section D. RE-DESIGNATION DATA METRICS

Directions: Obtain the hospital data metrics from the Stroke Registry's GWTG-Stroke Database. Run a report on the most recent 12 months of accurate data. Because there is an allowable 3-month delay for data entry, the most accurate data can be calculated by counting back 3 months from the month of the application submission. For example, if the month of the re-designation application submission is in April 2022, your report will be: 2/28/2021-01/31/2022. You may choose to use more recent data if you are certain that the data entry is complete.

Indicate "yes" or "no" as a response to "CAP provided," "Feedback to EMS," and "Community Education." The "Feedback to EMS" and "Community Education" measures are not tracked in the database. If you have questions, please contact Joanne LaBelle @ Joanne.Labelle@arkansas.gov

Hospital Name: _____

Date of Initial Designation: _____

Time Period Reported (most recent 12 months): _____

Num.	Den.	Rate (%)	Required Stroke Performance Measures	ADH Benchmark	CAP Provided
			1. Pre-notification - % of cases of advanced notification by EMS for suspected stroke patients transported by EMS from scene.	75%	
			2. Stroke Band ID - % of stroke patients from whom a stroke band identification number was recorded in the Stroke Registry.	75%	
			3. Door to CT Time <= 25 min - % of patients who received brain imaging within 25 minutes of arrival, filtered by 24-hours from last known well (LKW).	75%	
			4. Time to Intravenous Thrombolytic Therapy <= 60 min - % of acute ischemic stroke patients receiving therapy during the hospital stay who have a time from hospital arrival to initiation of thrombolytic therapy administration within 60 minutes or less.	75%	
			5. IV Thrombolytic Therapy: Arrive by 2, Treat by 3 Hours - % of acute ischemic stroke patients who arrive at the hospital within 2 hours of time LKW and for whom IV thrombolytic was initiated at the hospital within 3 hours of time LKW.	75%	
			6. IV Thrombolytic Therapy: Arrive by 3.5, Treat by 4.5 Hours - % of acute ischemic stroke patients who arrive at the hospital within 3.5 hours of LKW time and for whom IV	75%	

Num	Den	Rate (%)		ADH Benchmark	CAP Provided (optional)
			thrombolytic was initiated at the hospital within 4.5 hours of time LKW.		
			7. Feedback to EMS – Does the hospital provide feedback to local EMS on stroke patient final diagnosis and outcome? If yes, indicate frequency, i.e., weekly, monthly, etc. and how it is provided (spreadsheet, in-person, phone call, etc.).	At least quarterly	
			8. Community Education – Does the hospital currently perform community outreach events specific to increase stroke awareness and/or usage of 911 when stroke is suspected? If yes, indicate the frequency.	At least monthly	
Num	Den	Rate (%)	Reported Stroke Performance Measures	ADH Benchmark	CAP Provided (optional)
			1. NIHSS Reported - % of ischemic stroke and stroke not otherwise specified patients with a score reported for NIHSS.	75%	
			2. Door to CT Time <= 25 min - % of patients who received brain imaging within 25 minutes of arrival.	75%	
			3. Door-In-Door-Out Times at first hospital prior to transfer to acute therapy - % of confirmed stroke patients for whom <= 90 minutes was spent in the ED prior to transfer to a higher-level stroke center, e.g., PSC, CSC, etc. for time-critical therapy.	75%	
			4. Dysphagia Screen - % of stroke patients undergoing screening for dysphagia with an evidence-based bedside testing protocol approved by the hospital before being given any food, fluids, or medications by mouth.	75%	

Section E. CORRECTIVE ACTION PLAN (CAP) TEMPLATE – ArSRH RE-DESIGNATION

Date of Re-Designation Application:		Hospital:		Stroke Coordinator/ ED Director Contact Information	

Pre-Notification

No.	Finding/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

Stroke Band ID Recording

No.	Findings/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

Section E. CORRECTIVE ACTION PLAN (CAP) TEMPLATE – ArSRH RE-DESIGNATION (con't)

Door to CT Time <= 25 minutes, withing 24 hours of last known well

No.	Findings/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

Time to Intravenous Thrombolytic Therapy – 60 minutes

No.	Findings/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

IV-Thrombolytic: Arrive by 2 Hours, Treat by 3 Hours

No.	Findings/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

Section E. CORRECTIVE ACTION PLAN (CAP) TEMPLATE – ArSRH RE-DESIGNATION (con't)

IV-Thrombolytic: Arrive by 3.5 Hours, Treat by 4.5 Hours					
No.	Findings/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

Feedback to EMS					
No.	Findings/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

Community Education					
No.	Findings/Specific Areas to be Improved	Proposed Corrective Action to be Taken to Improve Performance	Improvement Timeframe (2 weeks – 3 months)	Documentation of Improvement	Action Corrected (Y/N)

Your signature indicates that you have received a copy of this Corrective Action Plan and that you understand and contributed to its contents

Hospital Stroke Coordinator/ED Director Signature   Date

Section F. ArSRH RE-DESIGNATION QUESTIONNAIRE

Instructions: For the ADH to better understand the acute care provided to stroke patients in the Emergency Department (ED) at your facility, please answer the following questions. In addition, in the section "Support Requested," please indicate the information/educational topics needed. Provide any additional information in the comments section at the end of the questionnaire.

STRUCTURE

Hospital Structure for Stroke: Answer "Yes" or "No" as it applies to your organization.

Availability: My Hospital	YES	NO
1. Participates in the Arkansas Stroke Registry	☐	☐
2. Has a designated stroke coordinator/facilitator	☐	☐
3. Utilizes stroke ID bands	☐	☐
4. Documents stroke ID bands	☐	☐
5. Staffs the Emergency Department (ED) with an RN 24/7	☐	☐
6. Staffs the ED with a physician 24/7	☐	☐
7. If an ED physician is not available, are provisions made for immediate patient care?	☐	☐
8. Is an RN authorized to initiate the stroke protocol?	☐	☐
9. Provides 24/7 neurology services, either in-house or through tele-stroke/tele-neurology	☐	☐
10. Provides 24/7 capability for:	☐	☐
a. CT / MRI	☐	☐
b. CT / MRI interpretation within 45 minutes of patient arrival	☐	☐
c. Laboratory staffed	☐	☐
d. Administration of IV-thrombolytics	☐	☐
e. IV-thrombolytics are stocked in the hospital	☐	☐
11. Process for stroke activation	☐	☐

To better understand the acute care in the hospital, indicate the processes used in your organization.

1. If your hospital receives a stroke pre-notification by EMS regarding a suspected stroke case, prior to patient arrival, how often does it lead to stroke activation or other type of preparation by hospital staff?
   - (a.) Always
   - (b.) Sometimes
   - (c.) Rarely
   - (d.) Never

2. How often does your hospital use tele-neurology?
   - (a.) Only when in-house neurology is not available
   - (b.) With all stroke cases because we do not have in-house neurology
   - (c.) Never, we have 24/7 in-house neurology coverage

   If yes, specify your tele-stroke/tele-neurology vendor: _____

3. Which statement most closely represents the process of when and how IV-thrombolytics are ordered for acute stroke patients in your ED?
   - (a.) Ordered by ED physician after an examination, without a neurology consultation
   - (b.) Ordered by ED physician after a physical examination by an in-house neurologist
   - (c.) Ordered by ED physician after a telephone consultation with a neurologist
   - (d.) Ordered by ED physician after telephone consultation with tele-neurology
   - (e.) Other (please specify): _____

4. Data reports are created for analysis:
   - (a.) Daily
   - (b.) Weekly
   - (c.) Monthly
   - (d.) Quarterly
   - (e.) Semi-annually
   - (f.) Annually
   - (g.) Reports are not run

SUPPORT REQUESTED

1. Stroke data:
   - (a.) Entering data
   - (b.) Correcting data entered
   - (c.) Running reports
   - (d.) Using the database to drill-down into the data
   - (e.) Reading reports
   - (f.) Creating a list of patients entered and results
   - (g.) Other (please specify): _____

2. Quality Improvement (QI):
   - (a.) Selecting a QI target
   - (b.) Planning improvement
   - (c.) Corrective action planning
   - (d.) Other (please specify): _____

Additional Comments:

This Section for the Arkansas Department of Health Only

Full Designation		Provisional Designation		Denial/Incomplete Application	

Chief Medical Officer (Acting)

State Chronic Disease Director

Section Chief, Stroke and STEMI

Branch Chief for EMS/Trauma, Stroke, STEMI

Medical Director of EMS and Trauma

State Stroke Nurse Coordinator

Chief Epidemiologist/Evaluator

Section Chief, EMS

Quality Improvement Contractor