HELP TEXT FOR LEVEL III STROKE APPLICATION:

General information:

The application was placed on line with only the fill-in portions available for modification. To change from one form field (   ) to another, use the "tab" key on your keyboard, or click on each area. "Check boxes" (☐) can be changed by clicking on them so they are X'ed out (☒). Type as much text as you like in the form field area; however, **the length of visible text that will print out is limited to the size of the box around the text, or the end of that line.** This was done purposely to avoid changing the layout and format of the document. **If you can't see it, it won't print**.

Timely and Sufficient Application:

Excerpts from Stroke Facility Designation Rule 157.133

(f) A timely and sufficient application for a facility seeking initial designation shall include:

(1) the department's current "Complete Application" for the requested level of stroke facility designation, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office;

(2) full payment of the non-refundable $100 designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the office;

(4) a stroke designation survey completed within one year of the date of the receipt of the application by the office; and

(5) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office.

(g) If a healthcare facility seeking initial designation fails to meet the requirements in subsection (f)(1) - (5) of this section, the application shall be denied.

(h) A timely and sufficient application for a stroke facility seeking redesignation shall include:

(1) the department's current "Complete Application" form for the requested level of stroke facility designation, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office one year or greater before the designation expiration date;

(2) full payment of the non-refundable $100 designation fee enclosed with the submitted "Complete Application" form;

(3) any subsequent documents submitted by the date requested by the office; and

(4) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office no less than 60 days prior to the designation expiration date.

(i) If a healthcare facility seeking redesignation fails to meet the requirements outlined in subsection (h)(1) - (4) of this section, the original designation will expire on its expiration date.

Frequently Asked Application Questions:

(1) Question: Parts of the application ask for additional narratives, policies, forms, etc. How do I organize the application so the Texas Department of State Health Services (DSHS) knows which question I'm answering?

(1) Answer: Organize the application in a way that all attachments (narratives, policies, etc.) are easily referenced. Place the entire application questionnaire at the front of the packet and then behind that section, sequentially insert the attachments. Reference each question in the application to the corresponding attachment number.

(2) Question: Should I bind all three copies of the application?

(2) Answer: If you bind your application, only bind the two copies. The original should be paper clipped or rubber banded, without any tabs or dividers. The original application goes into your permanent file at DSHS.

(3) Question: Whom do I call for information or guidance while completing the application?

(3) Answer For technical assistance, call the EMS/Trauma Systems Designation Program (512-834-6700) or email *DSHS.EMS-Trauma@dshs.texas.gov*.

For content or clarification of questions, please call or email us at:

Michael Murray – 512/284-1724
Michael.murray@dshs.state.tx.us

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Application Submission Instructions: (for initial and re-designation)

1. Fill out the "*Complete Application for Support Stroke Facility (Level III) Designation*." Answer all questions completely and enclose attachments as necessary. If a question does not apply to your facility, answer with "n/a" (*not applicable*). This document can be downloaded at:
   www.dshs.state.tx.us/emstraumasystems/formsresources.shtm#stroke

2. Submit the following documents:

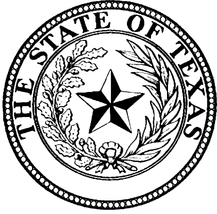
   - three (3) copies of the "*Complete Application for Support Stroke Facility (Level III) Designation"*
   - the application fee of $100.00.
   - a letter from the Regional Advisory Council (RAC) with which the facility is affiliated confirming facility participation in RAC activities.

4. Submit the required documents by US Mail to:

   Texas Department of State Health Services
   Cash receipts branch, MC 2003
   Office of EMS/Trauma Systems Coordination
   P.O. Box 149347
   Austin, Texas 78714-9347

5. For further information relating to the designation process following submission of the application, refer to the "*Process for Support Stroke Facility Designation (Level III) Application*" document at the following OEMS/TS web address:

   www.dshs.state.tx.us/emstraumasystems/formsresources.shtm#stroke



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Office of EMS/Trauma Systems Coordination
P. O. Box 149347
Austin, TX 78714
(512) 834-6700

Support Stroke Facility (Level III) Designation Application

Date: _____
Hospital Name: _____ Tax ID#: _____
Hospital Owner[1]: _____
Street Address: _____ City, State, Zip: _____
Mailing Address: _____ City, State, Zip: _____
County: _____ Trauma Service Area (TSA):---Choose---

☐ **Initial Designation** ☐ **Initial Designation (Change of Ownership)**

☐ **Re-Designation** **Expiration Date:_____**

DSHS Current License Number:_____ DSHS New License Number (CHOW only):_____

Number of licensed beds (*based on most recent licensing survey*):_____

Amount enclosed: $_____ Make check payable to: "*Texas Department of State Health Services*"

Stroke Nurse Coordinator/Program Manager: _____
Title/position: _____
Phone Number(s): (___) - ___ or (___) - ___
Fax Number(s): (___) - ___ or (___) - ___
Email: ______________________________

Typed name of Stroke Medical Director: _____

Signature of Stroke Medical Director: _____ Date: _______

Stroke Medical Director Email: _____

Typed name of CEO or authorized person: _____ Title: _____

Signature of CEO or authorized person: _____ Date:_______

Phone: (___) - _____ CEO or authorized person Email: _____

[1] Entity legally responsible for the operation of the hospital, whether by lease or ownership.

COMPLETE ALL SECTIONS.

General Information

Provide documentation of the facilities participation in the Regional Advisory Council (RAC). **Attach a letter from the RAC as evidence of your participation.**

Is there specific budgetary support for the Stroke Service? ☐ Yes ☐ No

If "Yes" specify	

Describe the commitment of your administration to stroke care, in detail.

Attach additional sheets if necessary

Pre Hospital

Describe your hospital's participation with the RAC in developing the **Stroke System Plan.** *(DO NOT send your hospital's stroke system plan)*

Stroke Program

Complete Table A

Physician Director: Is there an Identified Stroke Medical Director who:

a) Is actively credentialed by the hospital to provide stroke care ☐Yes ☐No
b) Charged with the overall management of the stroke care provided by the hospital? ☐Yes ☐No
c) Shall have the authority and responsibility of clinical oversight of the stroke program? ☐Yes ☐No
   i. Is there a defined job description? ☐Yes ☐No
   ii. Is there an organizational chart delineating the Stroke Medical Director's role and responsibility? ☐Yes ☐No
   iii. Is the Stroke Medical Director credentialed by the hospital to participate in the stabilization and treatment of stroke patients using specific criteria? ☐Yes ☐No
   iv. Does the Stroke Medical Director participate in the leadership role in the hospital and community? ☐Yes ☐No

Stroke Nurse Coordinator Is there an Identified Stroke Nurse Coordinator who:

a) Is a Registered Nurse? ☐Yes ☐No
b) Has successfully completed and is current in the Advanced Cardiac Life Support? ☐Yes ☐No
c) Has successfully completed 8 hours of stroke continuing education in the last

12 months and has successfully completed the National Institutes of Health Stroke Scales (NIHSS) certification course? ☐Yes ☐No

d) Has the authority and responsibility to monitor the stroke patient care from the Emergency Department (ED) admission through stabilization and transfer to a higher level of care or admission? ☐Yes ☐No

e) Shall have the authority and responsibility of clinical oversight of the stroke program? ☐Yes ☐No

i. Is there a defined job description? ☐Yes ☐No

ii. Is there an organizational chart delineating the Stroke Nurse Coordinator's role and responsibility? ☐Yes ☐No

iii. Does the Stroke Nurse Coordinator have education and training designated for his/her role which provides essential information on the structure, process, organization and administrative responsibilities of a PI program to include stroke outcomes and performance improvement? ☐Yes ☐No

Stroke Response:

Enclose copies of the following policies/protocols:

- Stroke Team Activation Policy
- Roles and Responsibilities of the Stroke Team during stabilization of stroke patient
- Triage Transfer & Admission Criteria Policy of stroke patient
- Protocols for the administration of thrombolytics and other approved stroke treatments
- Stabilization and treatment of stroke patients
- Has the RAC been notified of the facility capabilities for stroke patients? ☐Yes ☐No

Stroke Service Statistical Data:

Stroke Registry:

Total number of <u>ED visits</u> for previous 12 months, including DOA and DIE: ______

Total number of <u>stroke -related</u> ED visits: __________________________
(Each facility will define the ICD 9 Codes that will be counted as stroke related.)

Disposition from ED:

Disposition	
ED to ICU*	
ED to Floor	
Other **	
Deaths	

Stroke Transfers:

Number of Stroke Transfers	**Air**	**Ground**	**Total**
In			
Out			

*indicate if specific stroke unit or if **other – define.
*____

TOTAL	0

**______________________________________

Do you have written agreements for transfer of Stroke Patients out of your facility for acute management? (*Have agreements available on-site for examination.*) ☐ Yes ☐ No

Do you have Transfer Protocols? (*Have protocols available on-site for examination.*) ☐Yes ☐No

List receiving hospitals, their level of Stroke Designation and distance from your facility.

Hospital	Stroke Designation Level	Distance (*in miles*)

Hospital Facilities

Nursing Services:

Nursing staff certifications/competencies:

(Include 100% of nurses providing initial stabilization care for stroke patients)

Total Staff*	Percent Compliance	Explain here if needed
Percent with ACLS		
competency *or* certification for: NIHH		
Percent with dysphasia screening		
Percent with Thrombolytic therapy		

Emergency Department:
Enclose a copy of your current ED Stroke Flow sheet? (if no specific flow sheet for stroke patient, provide the flow sheet used for admission of stroke patient to the ED)

Describe how pre-hospital personnel communicate with your Emergency Department.
Attach additional sheets if necessary
What is the average lead time from EMS communication with the ED to their arrival?

By ground?	
By air?	

Radiology

Does the facility have CT capability? ☐Yes ☐No
Is there a 24-hour CT technician available in-hospital? ☐Yes ☐No
If no, is there a performance improvement program which reviews the timeliness of the CT tech response? ☐Yes ☐No
Does the facility have the capability to have the CT report read within 45 minutes of patient arrival? ☐Yes ☐No

Clinical Laboratory:

Is there a 24-hour lab technician available in-hospital?
☐ Yes ☐ No
If "No", is there a performance improvement program which reviews timeliness of lab tech (30 min) response?
☐ Yes ☐ No

Does your facility have:

Bedside Glucose ☐Yes ☐No

Standard Analysis of blood ☐Yes ☐No

Standard Analysis of urine ☐Yes ☐No

Standard Analysis of body fluids ☐Yes ☐No

Micro-sampling ☐Yes ☐No

Blood Type and CM ☐Yes ☐No

Coagulation Studies ☐Yes ☐No

Blood ph gases and ph determination ☐Yes ☐No

Stroke Performance Improvement (PI) Program

Initial designation: Does the facility have 6 months of audits for all qualifying stroke patients with evidence of loop closure? ☐Yes ☐No

Does the Stroke PI program include the following:

- how issues are identified and tracked ☐Yes ☐No
- personnel responsible for supervision of both system and peer review issues ☐Yes ☐No

- list all members of any Stroke Committees ☐Yes ☐No
- provide the frequency of the Stroke Committee meetings ☐Yes ☐No
- describe the Physician Director's involvement and oversight of the PI program ☐Yes ☐No

Enclose blank copies of all PI forms used to track "loop closure". Include your audit filters and all referral forms. *(Have PI reports available on-site for examination.)*

Describe any changes or improvements made as a result of your Stroke PI process *(i.e. new policies, improved documentation, peer review, lengths of stay, etc.)*

Do not send any performance improvement minutes or patient specific information! Have the minutes available on-site at the time of your survey.

Stroke Bypass/Divert:

Does the facility have a diversion policy? ☐Yes ☐No

Are times and reasons for diversions documented and reviewed by the Stroke PI program?* ☐Yes ☐No

Has your facility gone on Stroke Bypass/Divert during the previous year? ☐Yes ☐ No

If "Yes", complete **Table H** - "Stroke Bypass/Divert Occurrences" *(located at end of the application).*

*The criterion is under PI – have the process documented in the diversion policy or the PI program.

Educational Activities / Outreach Programs

Are Stroke education programs provided for your physicians, nurses, staff and pre-hospital personnel available? ☐Yes ☐ No
(During survey, provide documentation to include staff roster/attendance for the programs)

Are Stroke orientation processes and skills evaluation for nurses in the emergency department

available? ☐Yes ☐ No
(During survey, provide documentation to include staff roster/attendance for the programs)

Is there hospital funding for physician, nursing or EMS Stroke education? ☐ Yes ☐ No
If "yes", describe.

Attach additional sheets if needed

Is there documentation of public Stroke education programs, including Regional Advisory Council (RAC) involvement AND how the effectiveness of these programs is evaluated? ☐ Yes ☐ No
(During the survey, provide documentation)

____
Signature (Stroke Coordinator)

______________________________ ______________________________
Date

APPLICATION ATTACHMENT CHECKLIST

General Information

- ☐ Designation Application Fee
- ☐ RAC Letter of Participation

StrokeProgram

- ☐ Complete Table A – Stroke Medical Director/Stroke Nurse Coordinator
- ☐ Stroke Team Activation Policy
- ☐ Roles and Responsibilities of the Stroke Team
- ☐ Stroke Resuscitation Protocol
- ☐ Stroke Triage Transfer & Admission Criteria Policy
- ☐ "Table of contents" copy from Stroke Manual

Hospital Facilities

- ☐ Table B – Education of Nursing Personnel
- ☐ Table C – Education of Emergency Department (ED) Medical Personnel
- ☐ Stroke Flow Sheet (ED)
- ☐ Pediatric Stroke Resuscitation Protocol
- ☐ Table D – Stroke Bypass/Divert Occurrences

Performance Improvement

- ☐ Narrative – Stroke PI Program
- ☐ Stroke PI Forms (*audit, "loop closure" tracking*)

TABLE A

Stroke Program

1. Physician Director, Emergency Department – ENCLOSE Curriculum Vitae

   Name:_____

   Board Certification: _____

   ACLS Course completion date: _____

   Organizational chart with Stroke Program/Stroke Medical Director? ☐Yes☐ No

   Credentialed to participate in the stabilization and treatment of stroke patients? ☐Yes☐ No

   Documentation of participation in the Stroke performance improvement program?☐Yes☐ No

   Number of Stroke CME hours in last 12 months:_____

2. Stroke Nurse Coordinator - ENCLOSE Curriculum Vitae

   Name: _____ RN Degree:_______

   ACLS Course completion date: _____

   Completed HIHSS certification course? ☐Yes☐ No

   Organizational chart with Stroke Program/Stroke Nurse Coordinator? ☐Yes☐ No

   Other specialty certification(s): _____

   Eight hours of stroke CE hours in last 12 months? ☐Yes☐ No

Table B

EDUCATION/CERTIFICATION OF NURSING PERSONNEL

Complete the chart; include only nursing personnel who cover the Emergency Department.

NAME	LICENSURE (RN/LVN)		COURSE COMPLETION DATES				NUMBER OF *STROKE* CE HOURS IN LAST 12 MONTHS
	RN	LVN	ACLS	NIHSS (competency or certification)	Dysphagia screening	Thrombolytic therapy administration	
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Table C

EDUCATION/CERTIFICATION OF MEDICAL PERSONNEL

Complete the chart; include only physicians and **physician assistants**? who cover the Emergency Department.

Name	**Residency**		**Board Certified**		**ACLS**		**Number of Stroke CME hours in last 3 years-hours**	**Frequency of shifts/call per month**	
	Where	When Completed	Type (abbr.)	Year	Check if Instructor	Expiration (mm/yy)		**Freq**	**# calls**
					☐				
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TABLE D
STROKEBYPASS/DIVERT OCCURRENCES

Date of Occurrence	Time on Bypass	Time Off Bypass	Reason for Bypass

Total number of occurrences of bypass during reporting period? _____ # of occurrences

Total number of hours on diversion during reporting period? ______# of hours