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**NOTE: The hospital inventory is subject to annual updates.**

### **Instructions for Paul Coverdell National Acute Stroke Program (PCNASP) Hospital Inventory Survey**

#### **Purpose**

The intent of the Paul Coverdell National Acute Stroke Program hospital inventory is to better understand issues associated with acute stroke care. Responses will be used to identify what types of QI interventions work in particular settings, where gaps exist, and how we can better help hospitals with fewer resources. Additionally, this survey will provide vital information to both CDC and State Health Departments about the capacity of hospitals for stroke care. When this survey is submitted to CDC by State Health Departments, it does not contain identifiable hospital information to protect the confidentiality of hospitals. Responses will be aggregated and may be used as additional information to patient-level data collected as part of PCNASP.

#### **Instructions**

All questions should be answered consistently according to the policies or protocols that are currently in place or were established within the last 12 months in the health system. If the recipients administer the survey at the end of every program year, the data will reflect the program year and will better align with the evaluation and performance measure reporting time period.

This survey should be filled out, or at least reviewed, by the stroke coordinator or other designee involved in stroke care. Because of the goals of the inventory, please base your answers on practical availability and use of the procedures and resources. For example, your hospital might have written care protocols that are used in less than 50% of cases. If so, then the answer to questions in **B.2** would be “No”. Alternatively, some procedures employed at your hospital (pre-notification from EMS) might not be formalized, but regularly take place. In this situation, the answer to question **C.2** would be “Always”/ “Sometimes”. For question **G.2**, in reference to “*populations at highest risk for stroke*”, please refer to your state health department’s instructions and definition of this population.

Throughout the survey, circle radio buttons indicate that you should select one best answer; checkboxes indicate that you should select all answers that apply. This hospital inventory survey is completed by hospitals and then transmitted to their respective State Health Department (PCNASP awardee) as an electronic file or paper form, based on the request of your State Health Department.

## A. Hospital Infrastructure

1. Hospital code (as assigned through the PCNASP): \_\_\_\_\_
2. What is your hospital's Rural-Urban Commuting Area (RUCA) code? *To determine this, navigate to the Rural Health Information Hub website (<https://www.ruralhealthinfo.org/am-i-rural>). Enter your hospital's address in the search bar and click "locate". Then click on "Run Report" button in the map. Scroll down to "Rural Urban Commuting Areas (RUCAs) by census tract" to find your hospital's RUCA Code (two digit number, e.g. 1.1, 1.0) and provide this number for the inventory survey.*  
\_\_\_\_\_
3. Current hospital size (number of licensed beds): \_\_\_\_\_
4. Total number of all inpatient discharges (not including observation only, ED patients, ED transfers) in the most recent calendar year: \_\_\_\_\_
5. Total number of acute stroke discharges (primary diagnosis only; see list of ICD-9 and ICD-10 codes in the PCNASP Resource Guide appendix) in the most recent calendar year: \_\_\_\_\_

## B. Acute Stroke Care

1. Does your hospital have a designated acute stroke team? (A stroke team includes at least one physician and one other health care professional such as a nurse or physician extender. The team is available 24 hours per day and can see patients within 15 minutes of being called. The physician can be a neurologist, emergency physician or another specialist, but must have experience and expertise in diagnosing and treating cerebrovascular disease.)
  - Yes
  - No
2. Does your hospital have a written protocol or care pathway in place for each of the following? (select 'yes' for all that apply)
  - a. Emergency care of ischemic strokes (including diagnostic imaging and labs)
    - Yes [[IF YES, GO TO 2ai]]
    - No [[IF NO, GO TO 2b]]
    - i. If yes to (2a), does it include (select all that apply):
      - Initial stabilization
      - Diagnostic imaging
      - Treatment
      - Labs
  - b. Emergency care of subarachnoid hemorrhagic strokes (SAH) (including diagnostic imaging and labs)
    - Yes [[IF YES, GO TO 2bi]]
    - No [[IF NO, GO TO 2bii]]

- i. If yes to (2b), does it include (*select all that apply*):
- Initial stabilization
  - Diagnostic imaging
  - Treatment
  - Labs
- ii. Does your hospital admit most subarachnoid hemorrhagic (SAH) stroke patients?
- We typically transfer SAH patients
  - We typically admit these patients
  - We admit or transfer depending on staff availability or other factors (please describe): \_\_\_\_\_
- c. Emergency care of intracerebral hemorrhagic (ICH) strokes (including diagnostic imaging and labs)
- Yes *[[IF YES, GO TO 2ci]]*
  - No *[[IF NO, GO TO 2cii]]*
- i. If yes to (2c), does it include (*select all that apply*):
- Initial stabilization
  - Diagnostic imaging
  - Treatment
  - Labs
- ii. Does your hospital admit most intracerebral hemorrhagic (ICH) stroke patients?
- We typically transfer ICH patients
  - We typically admit these patients
  - We admit or transfer depending on staff availability or other factors (please describe): \_\_\_\_\_
- d. IV tPA (alteplase)
- Yes
  - No
- e. Endovascular therapy
- Yes
  - No
- f. Admission orders
- Yes
  - No
3. Does your hospital have a neuro- intensive care unit?
- Yes *[[IF YES, GO TO 3a]]*
  - No *[[IF NO, GO TO 4]]*

a. If yes to (3), does your hospital have a neurointensivist to manage care for stroke patients?

Yes

No

4. Does your hospital have neurosurgical services on-staff?

Yes *[[IF YES, GO TO 4a]]*

No *[[IF NO, GO TO 5]]*

a. If yes to (4), does your hospital have neurosurgical services available 24/7 (may be on-site or at a remote location)?

Always *[[IF ALWAYS, GO TO 5]]*

Sometimes *[[IF SOMETIMES, GO TO 5]]*

Rarely

Never *[[IF NEVER, GO TO 4b]]*

b. If never to (4a), does your hospital have neurosurgical services available within 2 hours of patient arrival (may be on-site or at a remote location)?

Always

Sometimes

Rarely

Never

5. Does your hospital provide neurointerventional treatment/mechanical thrombectomy?

Yes

No

### **C. Emergency Medical Services (EMS) Integration**

1. Is there a written plan for receiving patients with suspected stroke via EMS (*This should include how the ED receives a call in advance of arrival and may include other information on assigning high priority code to ensure rapid evaluation and transport.*)?

Yes

No

2. How often does pre-notification by EMS regarding a suspected stroke case lead to activation of the stroke team?

Always

Sometimes

Rarely

Never

No pre-notification

3. How often does pre-notification lead to activation of written stroke care protocols (e.g. notification to pharmacy, “clearing” of CT scanner)?
  - Always
  - Sometimes
  - Rarely
  - Never
  - No pre-notification
  
4. Does your hospital have written protocols for stroke patients transferred to and from your hospital?
  - Yes
  - No
  
5. How often does your hospital upload any EMS data (electronically or manually) into stroke patient’s eHR?
  - Always
  - Sometimes
  - Rarely
  - Never
  
6. Do you have a formal process for data feedback to EMS agencies?
  - Yes *[[IF YES, GO TO 6a]]*
  - No *[[IF No, GO TO 7]]*
  
  - a. How often does your hospital provide feedback to EMS agencies?
    - Always
    - Sometimes
    - Rarely
    - Never

**D. Community Clinical Linkages**

1. How often do you utilize a transition of care summary with stroke patients during discharge? (*The National Transitions of Care Coalition (NTOCC) defines a transition of care summary as a method of communication between sending and receiving providers and patient/family/caregivers. Use of a transition of care summary has been proven to reduce readmission rates and decrease medical errors.*)
  - Always
  - Sometimes
  - Rarely
  - Never
  
2. Has your hospital implemented a system for tracking referrals provided to stroke patients to support their post hospital transition of care?
  - Yes, fully implemented
  - Yes, partially implemented
  - No referral tracking system

3. How often does your hospital utilize an inventory of community resources to make referrals for post-stroke needs, including resources that can meet patients' medical, social, and functional needs?
- Always
  - Sometimes
  - Rarely
  - Never
  - Do not have a community resources inventory
4. Has your hospital established partnerships with any of the following? Please count any that your hospital participates in or provides resources to as a partnership (provide an estimated number next to each):
- \_\_\_\_ State or local stroke coalition
  - \_\_\_\_ State or local stroke initiatives
  - \_\_\_\_ State or local professional organizations
  - \_\_\_\_ National stroke initiatives or organizations
  - \_\_\_\_ Other (open text – provide number in parenthesis (example: hospital association (2), stroke nurses association (2))
5. Does your hospital have a Collaborative Practice Agreement (CPA) in place that includes community health workers (CHWs)?
- Yes *[[IF YES, GO TO 5a]]*
  - No *[[IF No, GO TO 6]]*
- a. If yes to (5), specific to CHWs, does the CPA include a CHW scope of practice?
- Yes *[[IF YES, GO TO 5b]]*
  - No *[[IF No, GO TO 6]]*
- b. Does the CPA ensure that CHW scope of practice maintains CHWs' connections to the community?
- Yes
  - No
6. How often does your hospital utilize community health workers to refer stroke survivors to resources that can meet their medical, social, and functional needs post-discharge?
- Always
  - Sometimes
  - Rarely
  - Never
  - Do not utilize community health workers

#### **E. Certification and Education**

1. Does your hospital have a residency or fellowship programs (neurology or other/residency fellowship)?
- Yes
  - No

2. Is your hospital currently certified as a Joint Commission Acute Stroke Ready Hospital (JC ASRH), Joint Commission Primary Stroke Center (JC PSC), Joint Commission Comprehensive Stroke Center (JC CSC), Joint Commission thrombectomy capable stroke center (TSC) or other similar organization such as Det Norske Veritas (DNV) or Healthcare Facilities Accreditation Program (HFAP)?
  - Yes
  - No
  
3. Does your hospital receive stroke consultation services from another hospital via telemedicine?
  - Yes; only when in-house neurology is not available *[[IF YES, GO TO 4a]]*
  - Yes; because we do not have in-house neurology *[[IF YES, GO TO 4a]]*
  - No; we have 24/7 in-house neurology coverage *[[IF NO, GO TO 5]]*
  
4. Does your hospital provide stroke consultation services to other hospitals via telemedicine?
  - Yes, we provide telestroke consultation services and can receive patients that we have provided consultations on *[[IF YES, GO TO 5A]]*
  - Yes, we provide telestroke consultation services but cannot receive patients in any cases *[[IF YES, GO TO 5A]]*
  - No, we do not provide telestroke consultation services *[[IF NO, GO TO 6]]*

#### **F. Data Abstraction**

1. What process is used for case identification? *(select one best answer)*
  - Prospective only
  - Retrospective only
  - Combination
  
2. Does your hospital contribute data to a state health information exchange (HIE)?
  - Yes
  - No

#### **G. Data-Driven Quality Improvement**

1. Does your hospital use the EHR system and standardized clinical quality measures to track differences between populations at highest risk for stroke events compared to all stroke patients for any of the following?
  - Stroke risk factors
  - Acute stroke care
  - Referrals for post-stroke care
  
2. During the past 12 months, did your hospital conduct data-driven quality improvement initiatives (e.g. the Plan-Do-Study-Act model, small tests of change, lean, six-sigma) related to stroke care to address any of the following (select all that apply)?
  - Use of Multidisciplinary Teams for Care Management
  - Electronic Health Record (EHR) and Patient Tracking Systems
  - Self-Management and Care Management
  - Clinical Guidelines

- Clinical Decision Support and Protocols
- Patient Education
- Other (please specify): \_\_\_\_\_
- Did not do any data-driven quality improvement in the past 12 months

3. Did your hospital's data-driven quality improvement initiatives lead to a change in hospital stroke policies or systems?

Yes, please describe.

\_\_\_\_\_

No

Not applicable

4. Did your hospital's data-driven quality improvement initiatives lead to an improvement in a performance measure of care (e.g. door-to-needle time, proportion of eligible patients receiving IV tPA)?

Yes, please describe the improvement(s) and the measure(s).

\_\_\_\_\_

No

Not applicable

#### H. Hospital Retention

1. What reasons or incentives are most important in your hospital's decision to participate in (if new) or continue to participate in the Coverdell Stroke Registry? (*select the three most important reasons*)

- Opportunities for professional development/learning (conference calls, journal articles, etc)
- Opportunities for networking/information sharing with other hospitals
- Desire/Need to enhance the quality of stroke care we provide
- Financial incentive / opportunity to compete for additional funds
- Allows/facilitates my hospital becoming/maintaining Stroke Center designation
- Access to and/or training on the GWTG tool
- Request/interest from upper management/administration
- Opportunity to benchmark my hospital against others in the state
- Hospital recognition
- Other: \_\_\_\_\_

#### I. Contact Information

(This information is not forwarded beyond the State Health Department staff, is not entered into any database, and will only be used to contact you if we have questions about your inventory.)

Name: \_\_\_\_\_

Position / Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

What is the best way to reach you?

Phone

Email

If by phone, when are the best days and times to reach you?

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