SCAI-CAP

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Carotid Artery Stenting Facilities Accreditation
Application and Data Forms

I. FACILITY IDENTIFICATION AND PROGRAM CONTACTS

Name of Hospital:
Hospital FEIN #
Contact Person Name
Contact Person Title
Address (line 1)
Address (line 2)
City/State/Zip Code
Email Address
Telephone Number
Fax Number

Sites/Disciplines within institution that perform Carotid Artery Stenting:

Interventional Cardiology	☐	**Cardiac Catheterization Laboratory**	☐
Interventional Radiology	☐	**Endovascular Suite**	☐
Vascular Surgery	☐	**Radiology Suite**	☐
Neurosurgery	☐	**Operating Room**	☐
Neurology	☐		

CEO (or equivalent):
Name
Title
Address (line 1)
Address (line 2)
City/State/Zip Code
Email Address
Telephone Number
Fax Number

Primary Contact:
If Primary Contact is other, please indicate:
Name
Title
Email Address
phone Number

II. GENERAL HOSPITAL INFORMATION

Accreditation	JCAHO AOA AAAHC Other, please identify accrediting body:
Classification	Please check the box that applies describes your facility. Class I Hospital – General Hospital Class II Hospital – Special Children/Women Hospital Class III Hospital – Special Medical/Psychiatric/Eye/Rehab/ Substance Abuse Hospital Class IV Hospital – Intensive Residential Treatment Facility Outpatient Facility
Description	Public ☐ Not for profit ☐ For profit ☐

III. SPECIFIC HOSPITAL INFORMATION

Volume	Annual volume of Carotid artery procedures performed in the past 2 years	Year _____ Year _____	Volume Carotid Stents_____CEA_____ Volume Carotid Stents_____ CEA_____

Credentialed Physicians

List all Physicians credentialed to perform carotid artery procedures currently at your hospital and the number of primary operator procedures they completed.

Name	**Board Certified (Name of Board and Date)**			
	Year 20_____ 20_____		Year 20_____ 20_____	
			CAS	CEA
Open				
Open				
Open				
Open				
Open				
Open				
Open				
			TOTAL	**TOTAL**

If column totals do not equal hospital's annual volumes (above), explain here:

IV. STANDARD CHECKLIST

Please complete a separate checklist for each site within your facility where carotid artery stenting is performed.

Standard	Present	Name and Model number (where appropriate)
Location(select one) Complete additional forms for each locations: Operating Room ☐ Cardiac Cath lab ☐ Endovascular Suite ☐ Radiology Suite ☐ Other ☐		
High quality digital imaging equipment with the capability of subtraction, magnification road mapping and orthogonal views. Capability of archiving and retrieval of angiographic images		Vendor/Model number
Advanced physiologic monitoring with real time and archived physiologic, hemodynamic and cardiac rhythm monitoring		Vendor/Model number
Support staff capable of interpreting hemodynamic and rhythm information and responding appropriately		Attatch Document/List individuals and qualifications
Emergency management equipment and systems		List equipment/attach document describing protocols
Program for granting carotid stent privileges		Attach document describing credentialing/recredentialing requirments
Program for monitoring the quality of the individual operators		Attach document describing process
Oversight committee empowered to identify the minimum case volume as well as risk-adjusted threshold for complications allowed before suspending privileges or instituting remediation		Attach document/List of Members of review committee
Apply published standard from appropriate specialty society		Attach document describing standards utilized
Data Collection		
Do you participate in a national registry		Yes No
If yes, Which one(s)?		CARE SVS ACR Other
If no		Supply data collection tool being utilized and means for validation
Data Analysis to assess patient safety		
Describe Analysis Protocol		Attach Document

V. Summary of Facility Carotid Stent Experience during Reporting Period

To be available electronically either directly or through one of the established registries of Carotid Artery Stenting

Element	Value
Number of Carotid Stent Procedures	
Number of Medicare Beneficiaries Treated	
Number Male Gender Number Female Gender Number > 80 years of age Number Symptomatic Number enrolled in Category B IDE Trials Number with Distal Protection Used Number with Distal Protection Attempted Number with High Risk Surgical Characteristics Number with Carotid Stenosis ≥ 70%	
Number of Patients with Any Complication	
Number of Patients with Any Stroke	
Number of Patients with Ipsilateral Stroke	
Number of Patients with MI Number of Deaths	

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VI. Individual Data elements on each patient

To be available electronically either directly or through one of the established registries of Carotid Artery Stenting

Element	Format
Medical Record Number	
Date of Procedure	
Date of Birth	MM/DD/YYY
Age	
Gender	Male Female
Medicare Beneficiary	Yes/No
Was patient enrolled in an Category B IDE clinical trial	Yes/no
Were FDA approved devices used	Yes/No
Was embolic protection used	Yes/No
If not	
Was embolic protection attempted	
Symptomatic	Yes/No
If yes:	
TIA	Yes/No
Non-disabling stroke	Yes/No
Modified Rankin score if patient has had prior stroke	
Transient Monocular Blindness	Yes/No
Does the patient meet high surgical risk Criteria	Yes/No
If yes check all criteria that apply:	NYHA Class III/IV Congestive Heart Failure
	LV Ejection Fraction <30%
	CCS Class III/IV angina
	Contralateral carotid occlusion
	Recent MI
	Previous CEA with recurrent stenosis
	Contralateral Laryngeal nerve palsy
	Prior Radiation treatment to the neck
	Age ≥ 80
	Renal Failure
	Severe Pulmonary Disease
	Tracheostomy
	Common Carotid Artery Lesion below the clavicle
	High cervical Internal Carotid Artery Lesion
	Abnormal stress test or need for Coronary Bypass Surgery
Baseline NIH stroke scale	
Degree of Carotid Stenosis (NASCET Technique for measurement) (select one answer)	
50-70%	
≥70%	
≥80%	
Did any complication occur during hospitalization	
If yes	
Stroke	Ipsilateral Contralateral Posterior
MI	Qwave (Y/N)
	Typical rise and rapid fall of CK
	Typical rise and gradual fall of Troponin
	Symptoms of cardiac ischemia
	ST elevation of depression compared to baseline
	PCI or CABG
	Pathologic findings of acute MI
Death	Yes/No Primary Cause of Death
Major Bleed	Transfusion #units
Pressors for >24 hours	
New or worsening renal failure	

V. Follow up Individual Data elements on each patient

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Element		Format
Medical Record Number		
Date of Birth		MM/DD/YYY
Gender		Male Female
Follow-Up Time Point		30 Days 6 Months Other
Complications since Discharge		Yes No
	If Yes	
	Stroke	Yes No
		Ipsilateral Contralateral Posterior
	TIA	Yes No
		Ipsilateral Contralateral Posterior
	MI	Qwave (Y/N)
		Typical rise and rapid fall of CK
		Typical rise and gradual fall of Troponin
		Symptoms of cardiac ischemia
		ST elevation of depression compared to baseline
	Death	Yes/No Primary Cause of Death