



SUBJECT: **STROKE RECEIVING CENTER STANDARDS**

REFERENCE NO. 322

PURPOSE: To establish the standards for 9-1-1 Receiving Hospitals that will be designated to accept acute stroke patients from approved ALS providers within the Los Angeles (LA) County Emergency Medical Services (EMS) System.

AUTHORITY: California Health and Safety Code, Sections 1255, 1256, 1797.220, 1798, 1798.170, 1798.172;
California Code of Regulations, Title 22, Sections 100170

DEFINITIONS:

Primary Stroke Center (PSC): A 9-1-1 receiving hospital that has met all the Primary Stroke Center requirements listed in this policy and has been designated by the LA County EMS Agency as a Primary Stroke Center.

Comprehensive Stroke Center (CSC): A 9-1-1 receiving hospital that has met all the Comprehensive Stroke Center requirements listed in this policy and has been designated by the LA County EMS Agency as a Comprehensive Stroke Center.

Telemedicine: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. General Requirements

A. A Primary Stroke Center shall:

1. Be licensed as a general acute care facility by the California State Department of Public Health.
2. Have a special permit for basic or comprehensive emergency medicine service.
3. Be accredited by any accreditation deemed acceptable by the Centers for Medicare and Medicaid Services (CMS).
4. Be certified as a Stroke Center by an EMS Agency approved certifying body
5. Designate a Stroke Medical Director who shall be responsible for the functions of the Stroke Center. The Stroke Medical Director shall be a physician on the hospital staff, licensed in the State of California and Board Certified in Neurology,


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SUPERSEDES: 01-09-2017

APPROVED:


Director, EMS Agency


Medical Director, EMS Agency



Neurosurgery, Neuroradiology, or Emergency Medicine by the American Board of Medical Specialties.

6. Designate a Stroke Program Manager whose primary responsibility shall be ensuring timely and accurate data submission to the Los Angeles County EMS Agency; and working with the Stroke Medical Director to develop a quality improvement program and ensure stroke receiving center standards are met.
 7. Participate in data collection outlined in this policy.
 8. Implement a quality improvement program for stroke care outlined in this policy.
 9. Affiliate with at least one CSC and establish a written transfer agreement with the affiliated CSC.
 10. Comply with program monitoring conducted by the EMS Agency.
- B. A Comprehensive Stroke Center shall:
1. Meet all the requirements specified in section I.A of this policy.
 2. The Stroke Medical Director shall be Board Certified in Neurology or Neurosurgery by The American Board of Psychiatry and Neurology or The American Board of Neurological Surgery by the American Board of Medical Specialties.
 3. Have a fully executed written agreement (Comprehensive Stroke Services Agreement) with the LA County EMS Agency indicating concurrence of hospital administration and medical staff to meet all Comprehensive Stroke Center requirements.
 4. The Stroke Program Manager shall be dedicated solely to the Comprehensive Stroke Center.
 5. Have the capacity to perform mechanical thrombectomy for the treatment of ischemic stroke 24 hours per day/7 days per week.
 6. Have written transfer agreements with surrounding stroke referral facilities, including PSCs.
 7. Have written transportation agreements with LA County licensed ambulance providers, written agreements shall include provisions to ensure transportation is available 24 hours a day/7 days a week and transport vehicle is available at the stroke referral facility within 60 minutes.
 8. The hospital must provide neurosurgical services or have a written transfer agreement with another comprehensive stroke center that provides neurosurgical services. For hospitals that provide neurosurgical services, a written plan for neurosurgical coverage and a neurosurgical call schedule is readily available to staff.



9. Have dedicated on-call endovascular neurointerventionalist, and neurologist (cannot be concurrently on-call at any other hospital or specialty service (e.g. trauma).
 10. Have tele-medicine capabilities with surrounding PSCs that have an established transfer agreement with the CSC.
- II. Application Process
- A. A 9-1-1 receiving facility seeking designation as a PSC or CSC shall submit a letter of interest to the EMS Agency no later than 60 days prior to the desired date of designation.
- The letter of interest shall include:
1. Documentation verifying that the hospital has been certified as a PSC, thrombectomy-capable stroke center, or CSC by an EMS Agency approved certifying body.
 2. A copy of the findings from the most recent Stroke program review conducted by the approved certifying body.
 3. If hospital is seeking CSC designation, a copy of documents verifying compliance with section I.B. of this policy.
 4. Signature of the Stroke Program Medical Director and the Chief Executive or Chief Operations Officer.
- III. PSC/CSC Designation Process
- A. The EMS Agency will review and verify the submitted documents. If the documents are satisfactory:
1. PSC initial designation will be granted for the same period of the certification by the EMS Agency approved certifying body.
 2. The EMS Agency will initiate execution of a Comprehensive Stroke Services Agreement (if hospital is seeking CSC designation). Upon execution of the Comprehensive Stroke Services Agreement, CSC initial designation will be granted for the same period of the certification by the EMS Agency approved certifying body.
- B. Re-designation will be granted after a satisfactory certification review by the EMS Agency approved certifying body. Representatives from the EMS Agency may attend the certification site review. In the event action items, deficiencies or similar findings are identified, the hospital shall submit a copy of the findings and any action plans for improvement to the EMS Agency.
- IV. The EMS Agency reserves the right to perform a scheduled on-site review or request additional data at any time.
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- V. The PSC/CSC shall immediately provide written notice to the Medical Director of the EMS Agency if unable to adhere to any of the provisions set forth in this policy.
- VI. The PSC/CSC shall provide a 90-day, written notice to the EMS Agency Medical Director of intent to withdraw from the stroke receiving center program.
- VII. The PSC/CSC shall notify the EMS Agency in writing of any change in status of the Medical Director or Stroke Program Manager by submitting a Notification of Personnel Change Form (Reference No. 622.1).
- VIII. Data Collection Requirements
 - A. Ensure adequate data entry personnel, who work collaboratively with Emergency Department (ED) personnel, to assure capture and entry of patients meeting inclusion criteria into the Los Angeles County EMS Agency database on an ongoing basis.
 - 1. Back-up data entry personnel should be identified and trained in the event primary data personnel are unable to meet the data entry requirements.
 - 2. Inclusion criteria:

All patients who initially are identified in the prehospital setting by EMS or transported by EMS and identified in the ED as meeting one or more of the following:

 - a. Met Prehospital Care Policy Reference No. 1251, Treatment Protocol: Stroke/Acute Neurological Deficits.
 - b. Final hospital (if admitted) or ED (if not admitted) diagnosis is ischemic stroke, transient ischemia attack, intracerebral hemorrhage, intraventricular hemorrhage, or subarachnoid hemorrhage.
 - c. Transported to a PSC or CSC for stroke care either primarily by 9-1-1 or interfacility transport.
 - d. Transfer to the CSC for stroke care and arrived at the transferring facility by 911 transport within 24 hours.
 - B. Data Fields
 - 1. The stroke data dictionary identifies the current data fields with associated data definitions to be collected and entered. The Stroke Center shall enter all required data elements as defined in the current LA County EMS *Stroke Center Data Dictionary*.
 - 2. Data fields are subject to change.
 - 3. Data should be reviewed at least monthly for accuracy and blanks.
 - C. Data Submission Requirements:
 - 1. Stroke patient data shall be entered concurrently into the stroke database with all patients entered within 60 days following discharge.



2. A monthly tally of newly diagnosed stroke patients is to be submitted to the EMS Agency by end of the month for the previous month (For example: January tally is due February 28th).
- D. The Stroke Center must maintain a minimum 90% compliance for:
1. Capture of patients meeting the criteria for data entry
 2. Data field completion
 3. Data field accuracy
 4. Timely data entry
 5. Timely tally submission
- XI. Quality Improvement
- A. Stroke Program must include a comprehensive-multidisciplinary QI Meeting:
1. Meeting participation should include the Stroke Program Medical and Clinical Directors, prehospital care providers, stroke care coordinators, Stroke/provider educators, neurologists, ED physicians and ED personnel, as well as other healthcare specialties including neurointerventionalists, or endovascular neurosurgery when applicable.
 2. Meetings to be held quarterly, at a minimum.
 3. Meeting minutes and roster must be maintained for each meeting and available for review.
 4. Stroke Centers that are also a Base Hospital are encouraged to provide periodic Stroke Base Hospital education with the collaboration of the Stroke Clinical Director.
- B. Pertinent aspects of care should be tracked and trended with the identification of areas requiring improvement and the action(s) necessary to improve care.
- C. The Stroke QI program shall have a method for identifying, tracking, documenting and addressing non-indicator issues and unusual occurrences.
- XII. Stroke Diversion
- A. Stroke Centers are responsible for updating Reddi-Net diversion status for Computerized Tomography (CT) scanner to ensure the most current information is available for patient destination decisions.
- B. The Stroke Center must incorporate into policy, administrative and/or Stroke Medical Director's decision to request diversion; to include the name and title of the authorizing party required to complete the diversion request.
- C. Stroke Diversion may be requested when:
1. The Stroke Center is on internal disaster.



2. The Stroke Center is unable to provide essential diagnostic procedures due to lack of a functioning CT scanner. If it is anticipated that the CT scanner will be not functional for greater than 24 hours then the Stroke Center must notify the EMS Agency Stroke Program Manager directly as to the nature of the failure or equipment issue and the estimated time of the diversion.
- D. ED saturation is not an appropriate rationale to request stroke diversion.

CROSS REFERENCE:

Prehospital Care Policy Manual:

- Reference No. 322.1 Stroke Database Application Form
- Reference No. 502, Patient Destination
- Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
- Reference No. 521, Stroke Patient Destination
- Reference No. 622.1 Notification of Personnel Change Form
- Reference No. 650 Stroke Data Dictionary
- Reference No. 1251, Treatment Protocol: Stroke/Acute Neurological Deficits