100159.03 Primary Stroke Centers

(a)

Hospitals designated by the local EMS agency as a primary stroke center shall meet all the following minimum criteria: (1) Adequate staff, equipment, and training to perform rapid evaluation, triage, and treatment for the stroke patient in the emergency department. (2) Standardized stroke care protocol/order set. (3) Stroke diagnosis and treatment capacity twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year. (4) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures. (5) Continuing education in stroke care provided for staff physicians, staff nurses, staff allied health personnel, and EMS personnel. (6) Public education on stroke and illness prevention. (7) A clinical stroke team, available to see in person or via telehealth, a patient identified as a potential acute stroke patient within 15 minutes following the patient's arrival at the hospital's emergency department or within 15 minutes following a diagnosis of a patient's potential acute stroke. (A) At a minimum, a clinical stroke team shall consist of:(i) A neurologist, neurosurgeon, interventional neuro-radiologist, or emergency physician who is board certified or board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, or other board-certified physician with sufficient experience and expertise in managing patients with acute cerebral vascular disease as determined by the hospital credentials

committee. (ii) A registered nurse, physician assistant or nurse practitioner capable of caring for acute stroke patients that has been designated by the hospital who may serve as a stroke program manager. (8) Written policies and procedures for stroke services which shall include written protocols and standardized orders for the emergency care of stroke patients. These policies and procedures shall be reviewed at least every three (3) years, revised as needed, and implemented. (9) Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures. (10) Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year, such that imaging shall be initiated within twenty-five (25) minutes following emergency department arrival. (11) CT scanning or equivalent neuro-imaging shall be initiated within twenty-five (25) minutes following emergency department arrival. (12) Other imaging shall be available within a clinically appropriate timeframe and shall, at a minimum, include:(A) MRI. (B) CTA and / or Magnetic resonance angiography (MRA). (C) TEE or TTE. (13) Interpretation of the imaging. (A) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital. (B) Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty-five (45) minutes of emergency department arrival. (i) For the purpose of this subsection, a qualified radiologist shall be board certified by the American Board of Radiology or the American Osteopathic Board of Radiology. (ii) For the purpose of this subsection, a

qualified neurologist shall be board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. (iii) For the purpose of this subsection, a qualified neurosurgeon shall be board certified by the American Board of Neurological Surgery. (14) Laboratory services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, such that services may be performed within forty-five (45) minutes following emergency department arrival. (15) Neurosurgical services shall be available, including operating room availability, either directly or under an agreement with a thrombectomy-capable, comprehensive or other stroke center with neurosurgical services, within two (2) hours following the arrival of acute stroke patients to the primary stroke center. (16) Acute care rehabilitation services. (17) Transfer arrangements with one or more higher level of care centers when clinically warranted or for neurosurgical emergencies. (18) There shall be a stroke medical director of a primary stroke center, who may also serve as a physician member of a stroke team, who is board-certified in neurology or neurosurgery or another board-certified physician with sufficient experience and expertise dealing with cerebral vascular disease as determined by the hospital credentials committee.

(1)

Adequate staff, equipment, and training to perform rapid evaluation, triage, and treatment for the stroke patient in the emergency department.

(2)

Standardized stroke care protocol/order set.

(3)

Stroke diagnosis and treatment capacity twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.

(4)

Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.

(5)

Continuing education in stroke care provided for staff physicians, staff nurses, staff allied health personnel, and EMS personnel.

(6)

Public education on stroke and illness prevention.

(7)

A clinical stroke team, available to see in person or via telehealth, a patient identified as a potential acute stroke patient within 15 minutes following the patient's arrival at the hospital's emergency department or within 15 minutes following a diagnosis of a patient's potential acute stroke. (A) At a minimum, a clinical stroke team shall consist of:(i) A neurologist, neurosurgeon, interventional neuro-radiologist, or emergency physician who is board certified or board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, or other board-certified physician with sufficient experience and expertise in managing patients with acute cerebral vascular disease as determined by the hospital credentials committee. (ii) A registered nurse, physician assistant or nurse practitioner capable of caring for acute stroke patients that has been designated by the hospital who may serve as a stroke program manager.

(A)

At a minimum, a clinical stroke team shall consist of:(i) A neurologist, neurosurgeon, interventional neuro-radiologist, or emergency physician who is board certified or board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, or other board-certified physician with sufficient experience and expertise in managing patients with acute cerebral vascular disease as determined by the hospital credentials committee. (ii) A

registered nurse, physician assistant or nurse practitioner capable of caring for acute stroke patients that has been designated by the hospital who may serve as a stroke program manager.

(i)

A neurologist, neurosurgeon, interventional neuro-radiologist, or emergency physician who is board certified or board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, or other board-certified physician with sufficient experience and expertise in managing patients with acute cerebral vascular disease as determined by the hospital credentials committee.

(ii)

A registered nurse, physician assistant or nurse practitioner capable of caring for acute stroke patients that has been designated by the hospital who may serve as a stroke program manager.

(8)

Written policies and procedures for stroke services which shall include written protocols and standardized orders for the emergency care of stroke patients. These policies and procedures shall be reviewed at least every three (3) years, revised as needed, and implemented.

(9)

Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.

(10)

Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year, such that imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.

(11)

CT scanning or equivalent neuro-imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.

(12)

Other imaging shall be available within a clinically appropriate timeframe and shall, at a minimum, include:(A) MRI. (B) CTA and / or Magnetic resonance angiography (MRA). (C) TEE or TTE.

(A)

MRI.

(B)

CTA and / or Magnetic resonance angiography (MRA).

(C)

TEE or TTE.

(13)

Interpretation of the imaging. (A) If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital. (B) Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty-five (45) minutes of emergency department arrival. (i) For the purpose of this subsection, a qualified radiologist shall be board certified by the American Board of Radiology or the American Osteopathic Board of Radiology. (ii) For the purpose of this subsection, a qualified neurologist shall be board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. (iii) For the purpose of this subsection, a qualified neurosurgeon shall be board certified by the American Board of Neurological Surgery.

(A)

If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital.

(B)

Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty-five (45) minutes of emergency department arrival. (i) For the purpose of this subsection, a qualified radiologist shall be board certified by the American Board of Radiology or the American Osteopathic Board of Radiology. (ii) For the purpose of this subsection, a qualified neurologist shall be board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. (iii) For the purpose of this subsection, a qualified neurosurgeon shall be board certified by the American Board of Neurological Surgery.

(i)

For the purpose of this subsection, a qualified radiologist shall be board certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

(ii)

For the purpose of this subsection, a qualified neurologist shall be board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(iii)

For the purpose of this subsection, a qualified neurosurgeon shall be board certified by the American Board of Neurological Surgery.

(14)

Laboratory services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, such that services may

be performed within forty-five (45) minutes following emergency department arrival.

(15)

Neurosurgical services shall be available, including operating room availability, either directly or under an agreement with a thrombectomy-capable, comprehensive or other stroke center with neurosurgical services, within two (2) hours following the arrival of acute stroke patients to the primary stroke center.

(16)

Acute care rehabilitation services.

(17)

Transfer arrangements with one or more higher level of care centers when clinically warranted or for neurosurgical emergencies.

(18)

There shall be a stroke medical director of a primary stroke center, who may also serve as a physician member of a stroke team, who is board-certified in neurology or neurosurgery or another board-certified physician with sufficient experience and expertise dealing with cerebral vascular disease as determined by the hospital credentials committee.

(b)

Additional requirements may be stipulated by the local EMS agency medical director.