Designation Criteria for Level II Stroke Center

1. Personnel
1.1 The center has a Stroke Program Coordinator that is at minimum an RN.
1.2 The center has a Stroke Program Medical Director that must be a physician; a Neurologist or Neurosurgeon preferably but not required.
1.3 The Stroke Program Coordinator and Stroke Program Medical Director are responsible for program design, education, protocols, Performance Improvement (PI), program development, outreach, etc.
1.4 The center has organizational and administrative support.
1.5 The center has clinical Emergency Department (ED) personnel trained in diagnosing and treating acute stroke on-site 24/7.
2. Training and Education
2.1 The Stroke Program Medical Director has a minimum of 8 hours of annual stroke-related education.
2.2 The Stroke Program Coordinator has a minimum of 8 hours of annual education on stroke diagnosis and treatment.
2.3 All center staff are educated annually on the signs and symptoms of stroke and the process to activate emergency systems.
2.4 The Emergency Department (ED) and Stroke Unit's clinical staff demonstrate evidence of initial and annual training in the care of acute stroke patients.
2.5 The center provides annual public education on stroke-related topics such as disease prevention, risk factors, signs and symptoms, and 911 activation.
2.6 The center provides stroke education to stroke patients and their caregivers.
2.7 The center offers disease prevention for its employees at least annually.
3. Stroke Services
3.1 The center has a Neurologist or physician experienced in cerebrovascular care available 24/7 on-site or via telemedicine within 20 minutes of patient arrival with an 80% achievement rate.
3.2 The center has:
a. an Intensive Care Unit (ICU);
b. Physical Therapy;
c. Occupational Therapy; and
d. Speech Therapy.
3.3 The center has a CT tech on-site 24/7.

3.4 The center initiates CT or MRI within 20 minutes of patient arrival 24/7 with an 80% achievement rate.
3.5 The center has staff on-site or via telemedicine to interpret CT or MRI results within 45 minutes of patient arrival 24/7 with an 80% achievement rate.
3.6 The center has intracranial and extracranial vascular imaging.
3.7 The center has transesophageal and transthoracic echo.
3.8 The center has carotid artery duplex ultrasound imaging or other non-invasive vessel imaging.
3.9 The center has 12-lead ECG and chest x-ray capability 24/7.
3.10 The center has laboratory or point-of-care testing 24/7 with:
a. blood glucose results that are obtained and documented prior to initiation of thrombolytics;
b. results for CBC and coagulation labs are available in a median of 45 minutes or less from patient arrival; and
c. testing results do not delay initiation of thrombolytics.
3.11 The center has IV thrombolytic therapy, as endorse by current evidence-based guidelines, for stroke available 24/7.
3.12 Centers offering services beyond those required for their level of designation must have a written plan for provision and monitoring of those services consistent with the highest level of standards requiring that service.
3.13 The center has post discharge stroke services.
3.14 The center must have written stroke protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include:
a. stroke team activation process;
b. initial diagnostic tests;
c. administration of medication;
d. swallowing assessment prior to oral intake;
e. evaluation and treatment by Physical Therapy, Occupational Therapy, and/or Speech Therapy. Consider as a required reporting to state registry;
f. discharge order set, protocol, or process that includes consideration for antithrombotic therapy, statin therapy, or anticoagulants as needed for patients with atrial fibrillation (AFib) and toward patient education on secondary prevention and risk factors; and
g. referral to post discharge rehabilitation services if need identified.
3.15 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services including emergency services available 24/7.
3.16 The center has transfer protocols or guidelines that include criteria specific to transferring stroke patients including hemorrhagic stroke patients, stroke patients outside of the IV thrombolytic/endovascular treatment window, patients at high risk for decompensation, malignant edema or death, etc.

3.17 The center must have a written transfer protocol with at least one Level I Stroke Center. The transfer protocol must include communication with and feedback from the receiving center.
3.18 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.
3.19 The center collaborates with EMS agencies on stroke care.
3.20 The center has a process for initiation of palliative care and/or comfort care.
4. Minimum Requirements
4.1 The stroke program identifies clinical practice guidelines that are used to facilitate evidence-based clinical care.
4.2 The stroke program has an organized process, or a designated response team, for rapid evaluation and treatment of inpatients that develop stroke symptoms.
4.3 The stroke program will collect data on door-in-door-out times for patients transferred for endovascular therapy and hemorrhagic strokes.
4.4 NIH Stroke Score is used in the Emergency Department (ED) and the inpatient setting as the primary neurologic assessment tool.
5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge.
5.2 The center meets the benchmark of door-to-needle time of less than 45 minutes with a 50% achievement rate.
5.3 The center participates in their Regional TSE Committee.
5.4 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.5 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.
5.6 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.
5.7 The center must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.8 All process and outcome measures must be documented in a written PI plan.
5.9 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.10 The process demonstrates problem resolution (loop closure).
5.11 The center is able to identify the stroke patient population for review.
5.12 The center's PI program must work with receiving and transferring facilities to provide and obtain feedback on all transferred patients.

5.13 If available, the PI program evaluates OR availability and delays.
5.14 If available, delays in Surgeon/Interventionalist response time must be monitored and reviewed for cause of delay and opportunities for improvement. Corrective actions must be documented.
5.15 Transfers within 24 hours to a higher level of care must be reviewed to determine the rationale for transfer, adverse outcomes, and opportunities for improvement.
5.16 The PI review is inclusive of all stroke admissions and transfers.
5.17 The center must have a policy to notify dispatch and EMS agencies when on divert status.