Designation Criteria for Level III Stroke Center

1. Personnel
1.1 The center has a Stroke Program Coordinator (may use a system coordinator). The Stroke Program Coordinator shows evidence of educational preparation and clinical experience caring for stroke patients.
1.2 The center has a Stroke Program Medical Director (may use a system Medical Director). The Medical Director can be an advanced practice provider (APP), a medical doctor (MD), or a Doctor of Osteopathic (DO) and must have sufficient knowledge of cerebrovascular disease to provide administrative leadership, clinical guidance, and input to the program.
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.
2. Training and Education
2.1 The Stroke Program Medical Director has a minimum of 4 hours of annual stroke-related education.
2.2 The Stroke Program Coordinator has a minimum of 4 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 consult within 15 minutes of patient arrival with an 80% achievement rate.
3.2 The center has a CT tech available 24/7.
3.3 The center has staff on-site or via telemedicine to interpret CT results within 45 minutes of patient arrival 24/7 with an 80% achievement rate.
3.4 The center has 12-lead ECG and chest x-ray capability 24/7.

3.5 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.
3.6 The center has IV thrombolytic therapy, as endorse by current evidence-based guidelines, for stroke available 24/7.
3.7 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 (including consultation with a Neurologist or with a Level I or II Stroke Center); and
d. swallowing assessment prior to oral intake.
e. if the center admits stroke patients for inpatient care, must also have written protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include:
i. process that is overseen and operationalized by Stroke Program leadership to ensure appropriateness of admission for inpatient management of non-thrombolytic, and if applicable, thrombolytic-eligible patients;
ii. evaluation and treatment by Physical Therapy, Occupational Therapy, and/or Speech Therapy. Consider as a required reporting to state registry;
iii. 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;
iv. referral to post discharge rehabilitation services if need identified; and
v. clinical staff providing inpatient care for stroke patients have evidence of initial and annual education on the care of stroke patients.
3.8 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.
3.9 The center must have a written transfer protocol with at least one Level I Stroke Center and one Level II Stroke Center. The transfer protocol must include communication with and feedback from the receiving center.
3.10 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.

3.11 The center collaborates with EMS agencies on stroke care.
4. Minimum Requirements
4.1 The stroke program has an organized process, or a designated response team, for rapid evaluation and treatment of inpatients that develop stroke symptoms.
4.2 NIH Stroke Score is used in the Emergency Department (ED) 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 Door-to-needle time equal to or less than 60 minutes with a 50% achievement rate with progression toward a goal of equal to or less than 45 minutes in 50% of cases.
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 facilities to provide and obtain feedback on all transferred patients.
5.13 The PI review is inclusive of all stroke admissions and transfers.
5.14 The center must have a policy to notify dispatch and EMS agencies when on divert status.