# TSE Council

Minutes

**Location:** Oxford Suites, Boise, ID **Date:** 2/10/2015 **Time:** 9 am – 5 pm

## Participants

| | | | |
|---|---|---|---|
| Nicole Noltensmeyer | Bill Spencer | Cheryl Hansen | Erin Shumard |
| Marshall Priest | Casey Meza | Chris Way | Jami Thomas |
| Kate Barnes | Drew Forney | Erin Bennett | Erich Garland |
| Michael McGrane | Jason Steik | Christine Shirazi | Harry Eccard |
| Kevin Kraal | John Mayberry | Nichole Whitener | Sarah Walker |
| John Perl | Wayne Denny | Christian Surjan | |

| Agenda Item | Discussion | Action Required |
|---|---|---|
| **Open Meeting** | Quorum established. (10 of 13 Council members present)<br><br>Motion to approve minutes from 1/13/15 was made by Kevin Kraal, seconded by Bill Spencer, and the vote to approve minutes was unanimous. | Decision |
| **Open Council Seat** | The open TSE Council seat needs to be filled by a chief executive officer or administrator of an Idaho critical access hospital that that either holds or is seeking Idaho trauma, stroke or heart attack designation.<br>There was a recommendation from Christian Surjan to fill the vacant TSE Council seat with Brad Huerta, CEO of Lost Rivers Medical Center in Arco. Brad and Christian had spoken about the responsibilities of council members and Brad was agreeable. Bill Spencer moved to ask the governor to appoint Brad Huerta to the TSE Council, Marshall Priest seconded the motion, and the vote was unanimous in favor. TSE staff will begin the process. | Discussion and Decision |
| **Introduction of New Council Members** | Jason Steik, North Central Regional TSE Committee Chair – ED Manager, St. Joseph Regional Medical Center<br><br>Chris Way, North Regional TSE Committee Chair - Chief, Kootenai County EMS System | Information |

| Agenda Item | Discussion | Action Required |
|---|---|---|
| | Dr. John Mayberry, Southwest Regional TSE Committee Chair – Trauma Surgeon, Saint Alphonsus<br><br>Kevin Kraal, South Central Regional TSE Committee Chair – ED Physician, St. Luke's Magic Valley Medical Center | |
| **STEMI Criteria** | The Council chose to use the criteria from Washington State as a template for creating Idaho's STEMI criteria.<br><br>The Council began by looking through the STEMI Receiving Center (Level I) criteria line by line. The finished draft is attached. The Council then began looking through the STEMI Referring Center (Level II) criteria line by line. The finished draft is attached. The Council had some unanswered questions regarding the Referring (Level II) criteria. Those items are highlighted in yellow. The Council would like to hear feedback from facilities that are currently functioning at or near that level. Please send feedback to **tse@dhw.idaho.gov**<br><br>A motion was made by Jason Steik to share the drafted STEMI criteria with the regional committees. It was seconded by Marshall Priest, and the vote to approve was unanimous.<br><br>The Council discussed using the Get with the Guidelines Action registry. This registry would require data to be submitted from the Receiving Centers only. Chris Way moved to use Action for the STEMI registry. Marshall Priest seconded, and the motion passed unanimously. | Discussion and Decision |
| **Regional Committees Report** | **North Central Region – Jason Steik**<br>They have formed a subcommittee for QI, sent out a survey to hospitals and EMS agencies to identify needs, and have begun working on prehospital instructions for care. Committee members would like guidance from the TSE Council about protected information and a confidentiality form for all members to sign. Jason asked on behalf of the committee if case reviews could be discussed via telephone. The Council felt that it should not be allowed because of the potential for others outside of the Council or Committees to overhear the protected information.<br><br>**South Central Region – Kevin Kraal**<br>They have created committee bylaws, decided on rotating sites for committee meetings, and created a survey of assets for their region. They have also reached out to dispatch centers to get them involved in the regional committee.<br><br>**North Region – Chris Way**<br>They held their first meeting on January 27th and elected officers. Their next meeting is scheduled for February 20th. On the agenda is creating committee bylaws and doing a needs assessment for their region.<br><br>**Southwest Region – John Mayberry**<br>They have held their first meeting and elected officers. Their next meeting is February 19th. | Information |
| **Stroke Criteria** | The Council chose to use the criteria from Washington State as a template for creating Idaho's Stroke criteria. | Discussion and Decision |

| Agenda Item | Discussion | Action Required |
|---|---|---|
| | The Council began by looking through the Comprehensive Stroke Center (Level I) criteria line by line, then the Primary Stroke Center (Level II) criteria, and finally the Acute Stroke Ready Center (Level III). The finished drafts are attached. The Council had some unanswered questions regarding some of the criteria and those items are highlighted in yellow. The Council would like to hear feedback from facilities that are caring for stroke patients in any capacity. Please send feedback to **tse@dhw.idaho.gov** | |
| **Next Meeting Agenda** | Next TSE Council meeting is scheduled for Tuesday, March 10, 2015 at the Oxford Suites in Boise. | |
| **Adjourn** | | |

# STEMI Receiving Center - PCI Capable (Level I)

| Criteria | Supporting Documentation | Met | Resources |
|---|---|---|---|
| **Personnel** | | | |
| 1.1 The center has a cardiac care coordinator. | Job description of cardiac care coordinator. | | |
| 1.2 The center has a defined cardiac care team that responds to cardiac emergencies. | Policy indicating the members of the cardiac care team. | | |
| 1.3 The center has a cardiac care medical director that is board certified in cardiology. | Job description and proof of board certification. | | |
| 1.4 Physicians in the ED 24 hours a day who are board-certified in emergency medicine, or who are board-eligible. Or physicians board certified in a specialty and practicing emergency medicine as their primary practice with special competence in cardiac care. | Most recent 6 months of schedule and proof of board-certification or elegibility. | | |
| 1.5 Interventional cardiologist available on-site within 30 minutes of cardiac care team activation. | Most recent 6 months of records. | | |

| | | | |
|---|---|---|---|
| 1.6 Cardiac catheterization lab staff available within 30 minutes of cardiac care team activation. | Most recent 6 months of records. | | |
| **Training and Education** | | | |
| 2.1 Physicians, mid-level providers, and RNs on the cardiac care team are current in ACLS or equivalent. | Course completion records. | | |
| 2.2 Current ACLS training or equivalent for all ED nurses. | Course completion records. | | |
| 2.3 All RNs complete annual education on signs and symptoms of ACS. | Training / education records. | | |
| 2.4 Interventional cardiologists who perform cardiac caths must have interventional CMEs at least every two years (15 hours per year is recommended). | Training / education records. | | |
| 2.5 The cardiac care medical director must have cardiac CMEs at least every three years (6 hours per year is recommended). | Training / education records. | | |
| 2.6 The cardiac care coordinator must have continuing education in cardiac care at least every three years (6 hours per year is recommended). | Training / education records. | | |
| 2.7 RNs on the Cardiac Care Team complete annual education and/or training in identifying dysrhythmias, symptoms of ACS, and current American Heart Association ACS guidelines. | Training / education records. | | |
| 2.8 The center offers tobacco cessation, nutrition, and other heart-healthy education for its employees and the community. | Schedule of events and classes from the previous 12 month period. | | |
| 2.9 Public education on cardiovascular disease prevention, the signs and symptoms of heart attack, and the importance of learning CPR and calling 911 in cardiac emergencies. | Schedule of events and classes from the previous 12 month period. | | |
| 2.10 Assistance with training and clinical education of EMS in coordination with the EMS Medical Directors, as needed, and if requested, particularly for reading ECG for STEMI patients to enable earlier activation of the team. | Documentation of coordination between center and EMS. | | |
| **Cardiac Services** | | | |
| 3.1 Diagnostic and interventional cardiac catheterization available 24/7. | | | |

| | | | |
|---|---|---|---|
| 3.2 Laboratory or point-of-care testing available 24/7. | | | |
| 3.3 Fibrinolytic therapy available 24/7. | | | |
| 3.4 Therapeutic hypothermia 24/7 for appropriate post cardiopulmonary arrest with return of spontaneous circulation. Protocol based on current standards. | Copy of policy/protocol. | | |
| 3.5 Cardiac surgery or transfer agreement with cardiac surgery hospital via ground or air to the highest level of care available, preferably critical care. | Transfer agreement, if no cardiac surgery available. | | |
| 3.6 Intensive/critical care unit. | | | |
| 3.7 Protocols for activating the cardiac care team for patients who arrive via EMS and patients who "walk-in". | Copy of policy/protocol. | | |
| 3.8 Protocols for ACS, STEMI, triage for "walk-ins" presenting with symptoms of ACS, fibrinolytic therapy, initiation of hypothermia, and transfer guidelines. | Copy of policy/protocol. | | |
| 3.9 The center should perform a minimum of 36 PCI procedures for STEMI during the most recent rolling 12-month period. | Documentation from previous 12 months. | | |
| 3.10 The center has a written agreement with STEMI Referral center(s) to accept all STEMI referrals. | Copy of all agreements. | | |
| 3.11 Policy for referral to cardiac rehabilitation. | Copy of policy/protocol. | | |
| 3.12 Coordination with local EMS agencies on cardiac care and transport policies and procedures, training, and quality improvement. | Documentation to support the coordination. | | |
| 3.13 A no-divert policy for all patients who meet cardiac care team activation criteria, and a back up plan for situations when the hospital's cardiac care resources are temporarily unavailable. | Copy of policy and back up plan. | | |
| **Performance Measurement and Quality Improvement** | | | |
| 4.1 Participation in Idaho's TSE Registry. It is recommended but not required to participate in the National Cardiovascular Registry's ACTION Registry-Get with the Guidelines. | | | **Idaho TSE Registry:** www.websiteaddresshere lah **Get with the Guidelines:** http://www.heart.org/HE RTORG/HealthcareResear |

| | | | |
|---|---|---|---|
| | | | /GetWithTheGuidelinesHF troke/Get-With-The-Guidelines---HFStroke_UCM_001099_SubHomePage.jsp |
| 4.2 Participation in internal quality improvement activities related to cardiac care. Internal Quality Improvement (QI) means customary QI activities to improve quality of care based on process and outcome data from internal or external cardiac QI programs or registries in which the hospital participates. | Minutes from QI meetings from previous 12 months. | | |
| 4.3 Door-to-balloon time under 90 minutes in 85% of cases. | Data from most recent 12 months. | | |
| 4.4 Participation in Regional TSE Committee activities to allow quality assurance programs to evaluate cardiac care delivery. | | | http://tse.idaho.gov/ |

# STEMI Referring Center - Non-PCI (Level II)

| Criteria | Supporting Documentation | Met | Resources |
|---|---|---|---|
| **Personnel** | | | |
| 1.1 The center has identified an individual responsible for coordination of cardiac care. | Job description of cardiac care coordinator. | | |
| 1.2 The center has a defined cardiac care team that responds to cardiac emergencies. | Policy indicating the members of the cardiac care team. | | |
| 1.3 The center has a physician who oversees cardiac care. | Identified. | | |
| **Training and Education** | | | |
| 2.1 Physicians, mid-level providers, and RNs on the cardiac care team are current in ACLS or equivalent. | Course completion records. | | |
| 2.2 Current ACLS training or equivalent for all ED nurses. | Course completion records. | | |

| | | | |
|---|---|---|---|
| 2.3 All staff complete annual education on signs and symptoms of ACS. | Training / education records. | | |
| 2.4 RNs on the cardiac care team complete annual education and/or training in identifying dysrhythmias, symptoms of ACS, and current American Heart Association ACS guidelines. | Training / education records. | | |
| 2.5 The center offers tobacco cessation, nutrition, and other heart-healthy education for its employees and the community. | Documentation of interventions. | | |
| 2.6 Public education on cardiovascular disease prevention, the signs and symptoms of heart attack, and the importance of learning CPR and calling 911 in cardiac emergencies. | Documentation of interventions. | | |
| 2.7 Assistance with training and clinical education of EMS in coordination with the EMS Medical Directors, as needed, and if requested, particularly for reading ECG for STEMI patients to enable earlier activation of the team. | Documentation of coordination between center and EMS. | | |
| **Cardiac Services** | | | |
| 3.1 Laboratory or point-of-care testing available 24/7. | | | |
| 3.2 Fibrinolytic therapy available 24/7. | | | |
| 3.3 Therapeutic hypothermia 24/7 for appropriate post cardiopulmonary arrest with return of spontaneous circulation. | Copy of policy/protocol. | | |
| 3.4 Resuscitation and stabilization of cardiac patients prior to transfer to higher level of care 24/7. | | | |
| 3.5 Protocols for activating the cardiac care team for patients who arrive via EMS and patients who "walk-in". | Copy of policy/protocol. | | |
| 3.6 Protocols for: ACS, STEMI, triage for "walk-ins" presenting with symptoms of ACS, fibrinolytic therapy, initiation of hypothermia, and transfer guidelines. | Copy of policy/protocol. | | |
| 3.7 Transfer guidelines for rapid transfer of patients requiring a higher level of care. | Copy of transfer guidelines. | | |
| 3.8 Coordination with local EMS agencies on cardiac care and transport policies and procedures, training, and quality improvement. | | | |

| Performance Measurement and Quality Improvement | | | |
|---|---|---|---|
| 4.1 Participation in Idaho's TSE Registry. It is recommended but not required to participate in the National Cardiovascular Registry's ACTION Registry-Get with the Guidelines. | | | **Idaho TSE Registry:** www.websiteaddresshere lah **Get with the Guidelines:** http://www.heart.org/HE RTORG/HealthcareResear /GetWithTheGuidelinesHF troke/Get-With-The-Guidelines--- HFStroke_UCM_001099_S bHomePage.jsp |
| 4.2 Participation in internal quality improvement activities related to cardiac care. Internal Quality Improvement (QI) means customary QI activities to improve quality of care based on process and outcome data from internal or external cardiac QI programs or registries in which the hospital participates. | Minutes from QI meetings from previous 12 months. | | |
| 4.3 Participation in Regional TSE Committee activities to allow quality assurance programs to evaluate cardiac care delivery. | | | http://tse.idaho.gov/ |

# Comprehensive Stroke Center (Level I)

| Criteria | Supporting Documentation | Met | Resources |
|---|---|---|---|
| **Personnel** | | | |
| 1.1 The center has a stroke care coordinator. | Job description of stroke care coordinator. | | |

| | | | |
|---|---|---|---|
| 1.2 The center has a stroke program medical director. The director must be a neurologist. | Job description of stroke medical director. | | |
| 1.3 The center has an acute stroke team, as designated by the stroke center medical director, available 24/7 within 15 minutes. Acute stroke team means the team of physicians and nurses who respond within 15 minutes to assess and treat acute stroke. | Policy indicating the members of the stroke team. | | |
| 1.4 The center has a neurologist available 24/7 that is on-site within 20 minutes of stroke team activation, or that is available via telemedicine within 20 minutes of stroke team activation and on-site within 45 minutes if needed. | | | |
| 1.5 The center has a board-certified vascular neurologist; or ABPN-certified neurologist who has completed 12 months of formal training in vascular neurology, or who devotes a minimum of 25% of practice time to vascular neurology. | | | |
| 1.6 The center has a vascular surgeon. | | | |
| 1.7 The center has interventional/endovascular physicians. | | | |
| 1.8 The center has critical care medicine or neurocritical care physicians. | | | |
| 1.9 The center has physical medicine and rehabilitation physicians. | | | |
| 1.10 The center has a neurosurgeon available 24/7 that is on-site within 30 minutes of notification of patient's arrival. | | | |
| 1.11 The center has organizational/administrative support. | | | |
| 1.12 Clinical ED personnel trained in diagnosing and treating acute stroke are available 24/7. | Training records. | | |
| **Training and Education** | | | |
| 2.1 Members of the stroke team have a minimum of 8 hours of annual education on stroke diagnosis and treatment to ensure competence. | Training / education records. | | |

| | | | |
|---|---|---|---|
| 2.2 The stroke medical director has a minimum of 4 hours of annual education related to the care of patients with cardiovascular disease. | Training / education records. | | |
| 2.3 Practitioners working on the stroke unit demonstrate evidence of initial and ongoing training in the care of acute stroke patients. | Training / education records. | | |
| 2.4 All staff have education on the signs and symptoms of stroke and the process to activate the stroke team. | Training / education records. | | |
| 2.5 The center provides stroke-related education for ED personnel involved in stroke diagnosis and treatment to ensure competence, as determined appropriate by the stroke medical director. | Training / education records. | | |
| **Stroke Services** | | | |
| 3.1 The center has neuroradiology. | | | |
| 3.2 The center has diagnostic radiology. | | | |
| 3.3 The center has physical therapy. | | | |
| 3.4 The center has occupational therapy. | | | |
| 3.5 The center has speech therapy. | | | |
| 3.6 The center has staff stroke nurses. | | | |
| 3.7 The center has an intensive care unit that is available 24/7. | | | |
| 3.8 The center has a CT tech available 24/7. | Copy of scheduling matrix. | | |
| 3.9 The center has staff on-site or via telemedicine to read and report CT/MRI within 45 minutes of patient arrival 24/7. 85% achievement rate. | Copy of policy/protocol. | | |
| 3.10 The center performs CT or MRI within 25 minutes of patient arrival 24/7. 85% achievement rate. | | | |
| 3.11 The center has MRI with diffusion. | | | |
| 3.12 The center has MR angiography/MR venography. | | | |
| 3.13 The center has CT angiography. | | | |

| | | | |
|---|---|---|---|
| 3.14 The center has digital cerebral angiography. | | | |
| 3.15 The center has transcranial doppler. | | | |
| 3.16 The center has transesophageal echo. | | | |
| 3.17 The center has carotid artery duplex ultrasound imaging. | | | |
| 3.18 The center has EKG and chest x-ray capability 24/7. | | | |
| 3.19 The center has laboratory or point-of-care testing 24/7 with results in 45 minutes or less. | | | |
| 3.20 The center has IV thrombolytic therapy available 24/7. | | | |
| 3.21 The center has IA recanalization capability. | | | |
| 3.22 The center can perform carotid endarterectomy. | | | |
| 3.23 The center can provide treatment of intracranial aneurysm. | | | |
| 3.24 The center can provide placement of intracranial pressure transducer. | | | |
| 3.25 The center can provide placement of ventriculostomy. | | | |
| 3.26 The center can perform hematoma removal/draining. | | | |
| 3.27 The center can perform endovascular treatment of intracranial aneurysms/arterial venous malformations. | | | |
| 3.28 The center can perform endovascular treatment of vasospasm. | | | |
| 3.29 The center can perform stenting/angioplasty of extracranial vessels or referral mechanism/protocol. | | | |
| 3.30 The center can perform stenting/angioplasty of intracranial vessels or referral mechanism/protocol. | | | |
| 3.31 The stroke unit has practitioners that demonstrate evidence of initial and ongoing training in the care of acute stroke patients. Stroke units may be defined and implemented in a variety of ways. The stroke unit does not have to be a specific enclosed area, but it will be a specified unit to which most stroke patients are admitted. | | | Refer to the *2014 Guidelines for the Early Management of Patients With Acute Ischemic Stroke* for further guidance on stroke units. http://stroke.ahajournals.org/content/44/3/870 |

| | | | |
|---|---|---|---|
| 3.32 The center has operating room coverage 24/7 and is ready within 1 hour of notification. 85% achievement rate. | | | |
| 3.33 The center has interventional services coverage 24/7, on-site within 30 minutes of notification. 85% achievement rate. | | | |
| 3.34 The center has a stroke clinic. | | | |
| 3.35 The center must have written stroke protocols/order sets/procedures/algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include: | Copy of policies/protocols. | | |
| a. Stroke team activation process; | | | |
| b. Initial diagnostic tests; | | | |
| c. Administration of medication; and | | | |
| d. Swallowing assessment prior to oral intake. | | | |
| 3.36 The center has an adequate number of qualified pharmacy personnel to ensure effective medication management services, including emergency services. | | | |
| 3.37 The center has transfer protocols or guidelines specific to stroke patients, although there should be no reason to transfer stroke patients from a Comprehensive Stroke Center (Level I) other than disasters, equipment failure, severe staffing shortage, etc. | Copy of policy/protocol. | | |
| 3.38 The center coordinates with EMS on stroke care and transport policy and procedures, system activation, training, data collection and quality improvement. | Documentation to support the coordination. | | |
| 3.39 The center provides public education annually on stroke-related topics such as prevention, risk factors, signs and symptoms, and the importance of getting treatment right away and calling 911. | Schedule of events and classes from the previous 12 month period. | | |
| 3.40 The center provides stroke education to stroke patients and their caregivers. | Copy of educational materials. | | |
| **Minimum Requirements** | | | |
| 4.1 The center cares for 20 or more SAH patients per year. | | | |

| | | | |
|---|---|---|---|
| 4.2 The center performs 10 or more clippings or coilings per year for aneurysm. | | | |
| 4.3 Each neurosurgeon participates in 10 or more surgical intervention cases per year. | | | |
| **Performance Measurement and Quality Improvement** | | | |
| 5.1 The center participates in the Idaho TSE Registry. | | | **Idaho TSE Registry:** www.websiteaddresshere.blah |
| 5.2 The center has internal quality improvement activities related to stroke care. Internal Quality Improvement (QI) means customary QI activities to improve quality of care based on process and outcome data from internal or external stroke QI programs or registries in which the hospital participates. | Minutes from QI meetings from previous 12 months. | | |
| 5.3 The center measures performance on at least two relevant patient care benchmarks each year. | Data from most recent 12 months. | | |
| 5.4 The center participates in Regional TSE Committee activities to allow quality assurance programs to evaluate stroke care delivery. | | | http://tse.idaho.gov/ |

# Primary Stroke Center (Level II)

| Criteria | Supporting Documentation | Met | Resources |
|---|---|---|---|
| **Personnel** | | | |
| 1.1 The center has a stroke care coordinator. | Job description of stroke care coordinator. | | |

| | | | |
|---|---|---|---|
| 1.2 The center has a stroke medical director. The medical director must be a physician; a neurologist or neurosurgeon is preferred but not required. The director may oversee more than one center's stroke program within the same hospital system or corporate structure as long as the director is involved in program decision-making at each hospital. | Job description of stroke medical director. | | |
| 1.3 The center has a defined stroke team. At a minimum, the team consists of a physician and an RN. | Policy indicating the members of the stroke team. | | |
| 1.4 Clinical ED personnel trained in diagnosing and treating acute stroke are available 24/7. | Training records and schedule matrix. | | |
| **Training and Education** | | | |
| 2.1 Members of the stroke team have a minimum of 8 hours of annual education on stroke diagnosis and treatment to ensure competence. | Training / education records. | | |
| 2.2 The stroke medical director has a minimum of 4 hours of annual education related to the care of patients with cardiovascular disease. | Training / education records. | | |
| 2.3 Practitioners working on the stroke unit demonstrate evidence of initial and ongoing training in the care of acute stroke patients. | Copy of education opportunities and records. | | |
| 2.4 All staff have education and training on the process used to activate the stroke team. | Training / education records. | | |
| **Stroke Services** | | | |
| 3.1 The center has a CT tech available 24/7. | Copy of scheduling matrix. | | |
| 3.2 The center has a neurologist or physician experienced in cerebrovascular care available on-site or via telemedicine within 20 minutes of patient's arrival 24/7. | Copy of policy/protocol. | | |
| 3.3 The center has staff on-site or via telemedicine to read and report CT/MRI within 45 minutes of patient's arrival 24/7. 85% achievement rate. | Copy of policy/protocol. | | |

| | | | |
|---|---|---|---|
| 3.4 The center performs CT or MRI within 25 minutes of patient's arrival 24/7. 85% achievement rate. | | | |
| 3.5 The center has EKG and chest x-ray capability 24/7. | | | |
| 3.6 The center has laboratory or point-of-care testing 24/7 with results in 45 minutes or less. 85% achievement rate. | | | |
| 3.7 The center has IV thrombolytic therapy available 24/7. | | | |
| 3.8 The center has carotid artery duplex imaging (recommended). | | | |
| 3.9 The center has intracranial and extracranial vascular imaging (recommended). | | | |
| 3.10 The center must have written stroke protocols/order sets/procedures/algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include: | Copy of policies/protocols. | | |
| a. Stroke team activation process; | | | |
| b. Initial diagnostic tests; | | | |
| c. Administration of medication; and | | | |
| d. Swallowing assessment prior to oral intake. | | | |
| 3.11 The center has: | | | |
| a. ICU (recommended); | | | |
| b. Physical therapy; | | | |
| c. Occupational therapy; and | | | |
| d. Speech therapy. | | | |
| 3.12 The center has an adequate number of qualified pharmacy personnel to ensure effective medication management services, including emergency services. | | | |
| 3.13 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 t-PA treatment window, etc. | Copy of policy/protocol. | | |

| | | | |
|---|---|---|---|
| 3.14 The center has a written transfer agreement with at least one Comprehensive Stroke Center. The transfer agreement must include communication and feedback from the receiving center. | Copy of agreements. | | |
| 3.15 The center coordinates with EMS on stroke care and transport policy and procedures, system activation, training, data collection and quality improvement. | Documentation to support the coordination. | | |
| 3.16 The center provides public education annually on stroke-related topics such as prevention, risk factors, signs and symptoms, and the importance of getting treatment right away and calling 911. | Schedule of events and classes from the previous 12 month period. | | |
| 3.17 The center provides stroke education to stroke patients and their caregivers. | Copy of educational materials. | | |
| **Performance Measurement and Quality Improvement** | | | |
| 4.1 The center participates in the Idaho TSE Registry. | | | |
| 4.2 The center has internal Quality Improvement activities related to stroke care. Internal quality improvement (QI) means customary QI activities to improve quality of care based on process and outcome data from internal or external stroke QI programs or registries in which the hospital participates. | Minutes from QI meetings from previous 6 months. | | |
| 4.3 The center meets the benchmark of door-to-needle time in under 60 minutes. 85% achievement rate. | Data from most recent 6 months. | | |
| 4.4 The center participates in Regional TSE Committee activities to allow quality assurance programs to evaluate stroke care delivery. | | | |

# Acute Stroke Ready Center (Level III)

| Criteria | Supporting Documentation | Met | Resources |
|---|---|---|---|
| **Personnel** | | | |
| 1.1 The center has a stroke care coordinator. | Job description of stroke care coordinator. | | |
| 1.2 The center has a stroke medical director. The medical director does not need to be board-certified in neurology or neurosurgery, but must have sufficient knowledge of cerebrovascular disease to provide administrative leadership, clinical guidance, and input to the program. | Job description of stroke medical director. | | |
| 1.3 The center has a defined stroke team. At a minimum, the team consists of a physician, or advance practice nurse/physician's assistant (with consultation from a Level I or Level II Stroke Center) and an RN. | Policy indicating the members of the stroke team. | | |
| **Training and Education** | | | |
| 2.1 Members of the stroke team have a minimum of 4 hours of annual education in stroke diagnosis and treatment to ensure competence. | Training / education records. | | |
| 2.2 The stroke medical director receives at least 4 hours annually of education related to the care of patients with stroke. | Training / education records. | | |
| 2.3 All staff have education and training on the process used to activate the stroke team. | Training / education records. | | |
| **Stroke Services** | | | |
| 3.1 The center has a CT tech available 24/7. | | | |
| 3.2 The center has a neurologist or physician experienced in cerebrovascular care available 24/7 on-site or via telemedicine within 20 minutes of patient's arrival. | Copy of policy/protocol. | | |

| | | | |
|---|---|---|---|
| 3.3 The center has staff on-site or via telemedicine to read and report CT/MRI within 45 minutes of patient's arrival 24/7. 85% acheivement rate. | Copy of policy/protocol. | | |
| 3.4 CT or MRI performance within 25 minutes of patient's arrival 24/7. 85% achievement rate. | | | |
| 3.5 EKG and chest x-ray are available 24/7. | | | |
| 3.6 FDA approved for stroke IV thrombolytic therapy is available 24/7. | | | |
| 3.7 Written stroke protocols/order sets/procedures/algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include: | Copy of policy/protocol. | | |
| a. Stroke team activation process; | | | |
| b. Initial diagnostic tests; | | | |
| c. Administration of medication (including consultation with a Level I or II Stroke Center); and | | | |
| d. Swallowing assessment prior to oral intake. | | | |
| 3.8 Transfer protocols that include criteria specific to transferring stroke patients including hemorrhagic stroke patients, stroke patients outside of the IV t-PA treatment window, etc. | Copy of policy/protocol. | | |
| 3.9 A written transfer agreement with at least one Level I Stroke Center and one Level II Stroke Center. The transfer agreement must include communication and feedback from the receiving center. | Copy of agreements. | | |
| 3.10 Laboratory or point-of-care testing 24/7. | | | |
| 3.11 Coordination with EMS on stroke care and transport policy and procedures, system activation, training, data collection and quality improvement. | Documentation to support the coordination. | | |
| 3.12 The center provides public education annually on stroke-related topics such as prevention, risk factors, signs and symptoms, and the importance of getting treatment right away and calling 911. | Provide materials. | | |

| | | | |
|---|---|---|---|
| 3.13 The center provides stroke education to stroke patients and their caregivers. | Copy of educational materials. | | |
| **Performance Measurement and Quality Improvement** | | | |
| 4.1 Participation in Idaho's TSE Registry. | | | |
| 4.2 Door-to-needle time under 60 minutes. 85% achievement rate. | Data from most recent 12 months. | | |
| 4.3 Participation in Regional TSE Committee activities to allow quality assurance programs to evaluate stroke care delivery. | | | |