

Designation Criteria for Level II Stroke Center

1. Personnel
1.1 The center has a stroke care coordinator. The stroke care coordinator must at least be an RN.
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.
1.3 The center has a defined stroke leadership team. At a minimum, the team consists of a physician and a registered nurse (RN).
1.4 The center has organizational and administrative support.
1.5 The center has clinical personnel trained in diagnosing and treating acute stroke on-site 24/7.
2. Training and Education
2.1 Members of the stroke leadership team have a minimum of 8 hours of annual education on stroke diagnosis and treatment to ensure competence.
2.2 All center staff are educated annually on the signs and symptoms of stroke and the process to activate the stroke team.
2.3 The stroke unit's clinical staff demonstrates 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 must be a specified unit to which most stroke patients are admitted.
3. Stroke Services
3.1 The center has a neurologist or physician experienced in cerebrovascular care available on-site or via telemedicine/telephone within 20 minutes of patient's arrival 24/7 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 performs CT or MRI within 25 minutes of patient's arrival 24/7 with an 80% achievement rate.

3.5 The center has staff on-site or via telemedicine to read and report CT or MRI results within 45 minutes of patient's arrival 24/7 with an 80% achievement rate.
3.6 The center has intracranial and extracranial vascular imaging.
3.7 The center has EKG and chest x-ray capability 24/7.
3.8 The center has laboratory or point-of-care testing 24/7 with results for CBC and coagulation labs in 45 minutes or less from patient arrival with an 80% achievement rate.
3.9 The center has Food and Drug Administration (FDA)-approved IV thrombolytic therapy for stroke available 24/7.
3.10 If the center performs mechanical thrombectomy, it will collect data on the following items:
a. Arrival at interventional hospital to groin puncture.
b. Symptomatic intracranial hemorrhage within 36 hours of the procedure.
c. Mortality within 72 hours of the procedure (all cause).
3.11 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 protocol activation process;
b. initial diagnostic tests;
c. administration of medication; and
d. swallowing assessment prior to oral intake.
3.12 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services including emergency services available 24/7.
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.
3.14 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.
3.15 The center coordinates with Emergency Medical Services (EMS) on stroke care and transport policy and procedures, system activation, training, data collection, and quality improvement.
3.16 The center provides annual public education on stroke-related topics such as prevention, risk factors, signs and symptoms, and the importance of getting treatment right away and calling 911.
3.17 The center provides stroke education to stroke patients and their caregivers.
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 a way to quantify neurological deficits.

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 treatment.

5.2 The center meets the benchmark of door-to-needle time in less than 60 minutes with a 75% 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 (such as documentation and communication), clinical care issues, and transfer decisions must be reviewed by the PI program.

5.7 The stroke program must use current clinical practice guidelines, protocols, and algorithms 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 and updated annually.

5.9 The process of analysis occurs at regular intervals 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 PI program must have audit filters to review and improve patient care.

5.13 The center's PI program must work with receiving and transferring facilities to provide and obtain feedback on all transferred patients.

5.14 If available, the PI program evaluates OR availability and delays.

5.15 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.

5.16 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.

5.17 The PI review is inclusive of all stroke admissions and transfers.

5.18 The center must have a policy to notify dispatch and Emergency Medical Services (EMS) agencies when on divert status.