

Designation Criteria for Level III Stroke Center

1. Personnel
1.1 The center has a stroke care coordinator (may use a system coordinator).
1.2 The center has a stroke medical director (may use a system 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.
1.3 The center has a defined stroke leadership team. The stroke leadership team is responsible for setting protocol and procedures, for Quality Improvement (QI)/Performance Improvement (PI), and for setting educational requirements.
1.4 The center has organizational and administrative support.
2. Training and Education
2.1 Members of the stroke response team have annual education in stroke diagnosis and treatment to ensure competence.
2.2 The stroke medical director receives at least 4 hours annually of education related to the care of stroke patients.
2.3 All center staff are educated annually on the signs and symptoms of stroke and the process to activate the stroke team.
3. Stroke Services
3.1 The center has a neurologist or physician experienced in cerebrovascular care available 24/7 on-site or via telemedicine/telephone consult within 20 minutes of patient's 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 or telephone to read and report CT results within 45 minutes of patient's arrival 24/7 with an 80% achievement rate.
3.4 The center has EKG and chest x-ray capability 24/7.
3.5 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.
3.6 The center has Food and Drug Administration (FDA)-approved IV thrombolytic therapy 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 protocol 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.
3.8 The center has 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.
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 coordinates with Emergency Medical Services (EMS) on stroke care and transport policy and procedures, system activation, training, data collection, and quality improvement.
3.11 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.
3.12 The center provides stroke education to stroke patients and their caregivers.
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 Door-to-needle time under 60 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 (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 The PI review is inclusive of all stroke admissions and transfers.
5.15 The center must have a policy to notify dispatch and Emergency Medical Services (EMS) agencies when on divert status.