EMS Primary Stroke Center Designation

I. PURPOSE

This policy defines the designation process and criteria for EMS Stroke Receiving Center in Contra Costa County. EMS Stroke Receiving Centers are facilities that have been designated by the Contra Costa County EMS Agency (LEMSA) as appropriate care centers for patients with suspected stroke. The EMS Stroke Receiving Centers work collaboratively with emergency medical services (EMS) system partners to establish and support an optimal system of stroke care in the community.

II. APPLICATION PROCESS

To apply for designation as an EMS Stroke Receiving Center in Contra Costa County, the hospital shall:

A. Submit a designation application to the LEMSA.
B. Submit applicable designation fees to support stroke system of care activities.
C. Meet EMS Stroke Receiving Center designation criteria and contractual requirements.

III. WRITTEN AGREEMENT

All EMS Stroke Receiving Centers must enter into a written agreement with the LEMSA prior to designation. The written agreement details the specific obligations of all parties responsible for the management of stroke patient care within the LEMSA.

IV. PSC DESIGNATION CRITERIA

Designation criteria for an EMS Stroke Receiving Center in Contra Costa County shall require documentation of the following:

A. The hospital is a 9-1-1 receiving hospital, licensed in the State of California.
B. A written commitment to fully participate in the Contra Costa County EMS Quality Improvement (QI) and data collection program.
C. Participation in California Stroke Registry (CSR).
D. Participate in Get With The Guidelines- Stroke (GWTG-Stroke) Program
E. Internal policies and procedures to assure reliable use of ReddiNet to communicate CT diversion in compliance with EMS Policy 5002 (Hospital CT / STEMI - Cardiac Cath Lab And Internal Disaster Diversion).
F. Hospitals designated by the local EMS agency as an EMS Stroke Receiving Center shall meet all the following minimum criteria:
   1. Adequate staff, equipment, and training to perform rapid evaluation, triage, and treatment for the stroke patient in the emergency department.
   2. Standardized stroke care protocol/order set.
   3. Stroke diagnosis and treatment capacity twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year.
   4. Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.
   5. Continuing education in stroke care provided for staff physicians, staff nurses, staff allied health personnel, and EMS personnel.
   6. Public education on stroke and illness prevention.

7. A clinical stroke team, available to see in person or via telehealth, a patient identified as a potential acute stroke patient within 15 minutes following the patient's arrival at the hospital's emergency department or within 15 minutes following a diagnosis of a patient's potential acute stroke.
8. At a minimum, a clinical stroke team shall consist of:
   i. A neurologist, neurosurgeon, interventional neuro-radiologist, or emergency physician who is board certified or board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, or other board-certified physician with sufficient experience and expertise in managing patients with acute cerebral vascular disease as determined by the hospital credentials committee.
   ii. A registered nurse, physician assistant or nurse practitioner capable of caring for acute stroke patients that has been designated by the hospital who may serve as a stroke program manager.
9. Written policies and procedures for stroke services which shall include written protocols and standardized orders for the emergency care of stroke patients. These policies and procedures shall be reviewed at least every three (3) years, revised as needed, and implemented.
10. Data-driven, continuous quality improvement process including collection and monitoring of standardized performance measures.
11. Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year, such that imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.
12. CT scanning or equivalent neuro-imaging shall be initiated within twenty-five (25) minutes following emergency department arrival.
13. Other imaging shall be available within a clinically appropriate timeframe and shall, at a minimum, include:
   i. MRI.
   ii. CTA and / or Magnetic resonance angiography (MRA).
   iii. TEE or TTE.
14. Interpretation of the imaging.
15. If teleradiology is used in image interpretation, all staffing and staff qualification requirements contained in this section shall remain in effect and shall be documented by the hospital.
16. Neuro-imaging studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in ACGME-approved radiology, neurology, or neurosurgery training program within forty-five (45) minutes of emergency department arrival.
   i. For the purpose of this subsection, a qualified radiologist shall be board certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

ii. For the purpose of this subsection, a qualified neurologist shall be board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
iii. For the purpose of this subsection, a qualified neurosurgeon shall be board certified by the American Board of Neurological Surgery.

17. Laboratory services capability that is available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days per year, such that services may be performed within forty-five (45) minutes following emergency department arrival.
18. Neurosurgical services shall be available, including operating room availability, either directly or under an agreement with a thrombectomy-capable, comprehensive or other stroke center with neurosurgical services, within two (2) hours following the arrival of acute stroke patients to the primary stroke center.
19. Acute care rehabilitation services.
20. Transfer arrangements with one or more higher level of care centers when clinically warranted or for neurosurgical emergencies.
21. There shall be a stroke medical director of a primary stroke center, who may also serve as a physician member of a stroke team, who is board-certified in neurology or neurosurgery or another board-certified physician with sufficient experience and expertise dealing with cerebral vascular disease as determined by the hospital credentials committee.

G. Additional requirements may be stipulated by the local EMS agency medical director.

V. DESIGNATION PROCESS AND TERM

A. Initial EMS Stroke Receiving Center designation will be awarded to a hospital following satisfactory review of all evidence to show compliance with this policy and upon completion of an informational site survey conducted by the Contra Costa EMS Stroke Receiving Center designation review team.
B. The PSC designation term shall be not more than three (3) years, as specified in the written agreement between the EMS Stroke Receiving Center and the County.

VI. RENEWAL PROCESS AND TERM

A. EMS Stroke Receiving Centers who maintain compliance with PSC designation criteria will be eligible for automatic renewal of designation.
B. Renewal requires maintaining a written agreement and submission of annual designation fees.

VII. OUT-OF-COUNTY DESIGNATION

A. EMS Stroke Receiving Centers that are located out-of-the county qualify for recognition as designated EMS Stroke Receiving Centers within Contra Costa County under the following conditions:
   1. Certified by The Joint Commission as a Primary Stroke Center or equivalent accrediting organization as approved by the LEMSA.
   2. Designated by their county's LEMSA as an EMS Stroke Receiving Center.

3. If the Hospital is located in a county that does not have a stroke system, the hospital must enter into a written agreement to be qualified for EMS Stroke Receiving Center designation in the Contra Costa Stroke System.

VIII. LOSS OF DESIGNATION

The inability to meet and maintain PSC designation as defined in this policy and the written agreement is criteria for loss of designation.

IX. LIST OF DESIGNATED PRIMARY STROKE CENTERS

Contra Costa County Stroke Centers	Out-of-County Stroke Centers
John Muir Medical Center – Concord	Summit Medical Center - Oakland
John Muir Medical Center – Walnut Creek	Kaiser Permanente Medical Center – Oakland
Kaiser Permanente Medical Center – Antioch	Kaiser Permanente Medical Center – Vallejo
Kaiser Permanente Medical Center – Richmond	Sutter Medical Center - Solano
Kaiser Permanente Medical Center – Walnut Creek	Marin General - Greenbrae
San Ramon Regional Medical Center – San Ramon	Kaiser Permanente Medical Center – San Rafael
	Valley Care – Pleasanton