

DRAFT
Texas Stroke Center Plan

Three levels of stroke centers will be designated:

Comprehensive Stroke Center (CSC)

Primary Stroke Center (PSC)

Secondary or Supporting Stroke Center (SSC)

Comprehensive Stroke Center

The Comprehensive Stroke Center will meet all of the requirements specified in the Consensus Statement of Stroke on Comprehensive Stroke Centers. (Recommendations for comprehensive stroke centers: a consensus statement from the Brain Attack Coalition. Stroke. 2005; 36(7):1597-616_) The CSC will submit a detailed plan to the state of Texas detailing their plan for meeting these CSC requirements. The CSC will provide annual submission of continued compliance with these requirements.

Compliance will not be routinely certified but an audit or certification or request for additional information may be required if evidence of non-compliance with the requirements is made available to the state. The cost of certification will be the expense of the submitting CSC or if evidence was falsely submitted may be the expense of the reporting entity.

Additional requirements include:

- Identify and submit any agreements with Secondary Stroke Centers
- SSC Agreements must be incorporated into the EMS Plan

JCAHO Stroke certification is not a requirement to become a Texas CSC. (This alleviates specific JCAHO information gathering requirement and the cost of obtaining and maintaining JCAHO certification). A Texas CSC may identify themselves as a “Texas Approved Comprehensive Stroke Center” but may not identify themselves as a JCAHO Certified center unless certification is received through the JCAHO certifying body. The word “Texas approved” or “Texas certified” or any implicit advertising suggesting state approved capability should not be used in conjunction with any advertising of stroke center capability unless an application has been submitted and approval has been granted through the DSHS of Texas.

Primary Stroke Center

The 12 requirements for a Primary Stroke Center outlined in the Brain Attack Coalition will form the basis for identification as a PSC. The PSC will be able to deliver stroke treatment capability which includes the administration of tPA 24/7.

These criteria are as follows:

- 24 hour Stroke Team
- Written Care Protocols
- EMS Agreement
- Trained ED Personnel
- Dedicated Stroke Unit
- Neurosurgical Services
- Stroke Center Director (Physician)
- Neuroimaging services available 24 hours a day
- Lab services available 24 hours a day
- Quality improvement plan
- Annual Stroke CE requirement
- Public Education program

Additional requirements include:

- Identify and submit any agreements with Secondary Stroke Centers
- SSC Agreements must be incorporated into the EMS Plan

JCAHO Stroke certification is not a requirement to become a Texas PSC. (This alleviates specific JCAHO information gathering requirement and the cost of obtaining and maintaining JCAHO certification). A Texas PSC may identify themselves as a "Texas Approved Primary Stroke Center" but may not identify themselves as a JCAHO Certified center unless certification is received through the JCAHO certifying body.

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Secondary or Supporting Stroke Center (SSC)

A secondary or supporting stroke center may not meet all of the requirements of a Primary Stroke Center (PSC) to deliver acute stroke treatment capability 24/7 but must meet all of the following requirements and submit a plan that encompasses the following:

- Identifies the PSC(s) or CSC(s) that will accept their stroke patients for items they fail to meet and submits a copy of the agreement(s) between the two hospitals.
- Develop written treatment protocols which include transport or communication criteria with the accepting PSC or CSC
- Develop an EMS agreement that clearly specifies transport protocols to the SSC and clearly identifies how “red light” or “off” times and “green light “ or “on” times are identified and specifies the alternate transport agreements.
- Trains ED personnel
- Designates a Stroke Director (this individual may be an ER Physician)
- Use the NIHSS administered by personnel holding current certification to evaluate an acute stroke patient if no on-site Neurologist is available.
- Designate and specify availability of Neurosurgery services.
- If neurosurgical services are not available the transport protocol must identify access through the accepting PSC,CSC and a transport plan with access to neurosurgical services within 90 minutes of the identified need.

Comments: The thought in this initial proposal is to provide a framework that will allow most people access to acute stroke treatment with a coordinated transport protocol in a defined but inclusive approach that will allow telemedicine and “drip and ship” and other combined approaches to be employed. In order to address one concern raised by Dr. Grotta about SSC designations within a larger metroplex being utilized when a PSC or CSC is available, I would propose that all EMS Transport protocols have a statement similar to this:

Acute stroke patients will be transported to the nearest CSC, PSC, or SSC (“time is brain”.) If a PSC or CSC is within 10 minutes of the nearest center of an SSC, the stroke patient will be directed to the PSC or CSC since more comprehensive care will be available at that center.

Also, as I think about “time is brain”, I think that the stroke transport plan should reach outside RAC’s and have an agreement with neighboring RAC’s if the nearest PSC or CSC is in another RAC territory.