SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

STROKE ~~CENTER~~ CRITICAL CARE SYSTEM STANDARDS

PUBLIC COMMENT NOVEMBER 2026

EFFECTIVE DATE: xx/xx/xx ***POLICY REFERENCE NO: 5015*** ***SUPERSEDES: 10/1/22***

1. DEFINITIONS

1.1. Get With The Guidelines-Stroke (GWTG-Stroke): EMS Agency (EMSA) approved data registry for patients meeting a stroke diagnosis.

1.2. Site Visits: On site evaluation of stroke capabilities by EMSA. Typically, by the EMSA Medical Director, EMSA Director, EMSA Stroke Coordinator or EMSA designee.

1.3. Stroke Center: "Stroke Center" means a licensed, certified, General Acute Care Hospital (GACH) that meets the criteria for either an Acute Stroke Ready Hospital (ASRH), a Primary Stroke Center (PSC), a Thrombectomy Capable Stroke Center (TCSC), or a Comprehensive Stroke Center (CSC).

1.4. Stroke Receiving Center: General term of this policy that refers to a stroke center that is designated by EMSA as a facility capable of receiving suspected stroke patients by EMS. This term will apply regardless of certification level of the stroke center.

2. PURPOSE

2.1. ~~Establish the minimum standards for Receiving Hospitals who wish to accept acute stroke patients from approved ALS and BLS providers within the San Francisco EMS System.~~ To establish minimum standards for the development, implementation, designation, and evaluation of Stroke Critical Care Systems as components of California's emergency medical services (EMS) system for stroke receiving centers

2.2. These standards ensure coordinated patient care for the assessment, triage, transport, treatment, and recovery of patients experiencing stroke across the continuum of emergency medical services, from prehospital response through definitive hospital care and rehabilitation.

3. POLICY

3.1. EMSA REQUIREMENTS AND RESPONSIBILITIES

3.1.1. For a state EMS Authority approved stroke critical care system, EMSA shall annually submit a stroke critical care plan update.

3.1.2. EMSA may establish additional requirements in addition to those mandated by statute and state minimum standards.

3.1.3. Collecting and reporting stroke patient care data, establishing and maintaining a QI process, and performing stroke critical care system evaluation

3.1.4. EMSA will develop and implement a stroke critical care system and shall establish a stroke critical care system advisory committee, which shall meet at least twice per year and include participation from public and private EMS provider agencies, 9-1-1-receiving

GACHs, Stroke Receiving Centers within the local EMS system, any regional stroke centers that receive stroke IFTs, and other relevant stakeholders.

3.1.5. The stroke critical care system advisory committee shall advise the EMSA on stroke care policies and protocols and participate in stroke care QI work

3.2. HOSPITAL REQUIREMENTS FOR STROKE RECEIVING CENTER DESIGNATION

3.2.1. A licensed GACH that meets all the requirements of this section may be designated by EMSA as a stroke receiving center

3.2.2. Written agreements with EMSA designating the GACH as:

3.2.2.1. An approved GACH for patients transported by EMS ambulances

3.2.2.2. Stroke Receiving Center designation

3.2.3. Pay all associated fees within thirty (30) days of invoice

3.2.4. Stoke Center Certification by Joint Commission

3.2.5. Letter by Joint Commission with certification date sent to EMSA from the GACH.

3.2.6. Has an understanding of EMSA Policy # 5000 (Destination Policy) § 6.7 (Stroke) for destination decisions by EMS personnel. These policies do not allow "routing" based on Stroke Center certification level.

3.2.7. Has an understanding that in the event the GACH has an Internal Disaster declaration that all 9-1-1 ambulance traffic to the emergency department will be closed resulting in no suspected stroke patients. See EMSA Policy # (5020 Diversion Policy)

3.2.8. Regular participation in the Stroke subcommittee meetings-EMSA Policy # (1010 Advisory Committees)

3.2.9. In collaboration with EMS provider agencies and EMSA, Stroke Receiving Centers shall develop a process for sharing patient outcome information of patients with a diagnosis of a stroke as outlined in § 3.3.2 of this policy.

3.2.10. The EMSA Medical Director may establish requirements for designation as a stroke receiving center in addition to those required under this section.

3.3. Data Collection and Reporting Requirements;

3.3.1. Stroke Receiving Centers shall submit stroke data to EMSA quarterly for the purposes of continuous quality improvement, training to enhance the level of care, and for required state data reporting

3.3.2. **All** patients with a final/discharge diagnosis of a stroke meet the required entry into GWTG-Stroke and that no sampling will be permitted. This includes:

3.3.2.1. Cerebral Infarction

3.3.2.2. Intracerebral Hemorrhage (non-traumatic)

3.3.2.3. Ischemic Stroke

3.3.2.4. Stroke

3.3.2.5. Subarachnoid Hemorrhage (non-traumatic)

3.3.2.6. Transient Ischemic Attack (TIA)

- For ICD-10 codes see Appendix A
- For state EMS Authority elements see Appendix B

3.3.3. Stroke patient care data elements shall be collected and submitted to the Emergency Medical Services Authority, through EMSA via GWTG-Stroke on a quarterly basis and within ninety (90) days of patient discharge. Data entry deadlines are as follows:

3.3.3.1. Quarter 1 due by the last day of quarter 2 (June 30)

3.3.3.2. Quarter 2 due by the last day of quarter 3 (September 30)

3.3.3.3. Quarter 3 due by the last day of quarter 4 (December 31)

3.3.3.4. Quarter 4 due by the last day of quarter 1 of the following year (March 31)

3.3.4. The EMSA Medical Director may establish additional data entry requirements.

4. INITIAL AND MAINTENANCE OF STROKE RECEIVING CENTER DESIGNATION SITE VISITS

4.1. Site visits will be conducted by EMSA prior to initial and to maintain a Stroke Receiving Center designation, no less than 1 time every 2 years, or by the direction of the EMSA Medical Director.

4.2. Site Visits will be coordinated with the EMSA Stroke coordinator and Stroke Program Manager or facility designee no less than thirty (30) days prior to evaluation

4.3. The EMSA Stroke coordinator shall provide the site evaluation tool kit at the time of scheduling with the Stroke Program Manager or facility designee.

4.4. Based on the certification level by Joint Commission, EMSA shall refer to Title 22 Division 9, Chapter 6, Article 4, Subarticle 2 when conducting evaluation site visits.

4.5. Stroke receiving centers must be in compliance with § 3.2 of this policy prior to or to maintain a Stroke Receiving Center designation.

4.6. Any findings during the site visit will be provided in writing to the Stroke Receiving Center within thirty (30) days of the evaluation.

4.7. If applicable the Stroke Receiving Center will have ninety (90) days from the written findings to correct.

4.7.1. The facility may continue to operate as a Stroke Receiving Center during this period, unless determined by the EMSA Medical Director that there exists an immediate threat to public health and safety.

5. AUTHORITY

5.1. California Health and Safety Code, Division 2.5 § ~~Sections~~ 1797.270 , 1797.202,1797.206, 1797.227, 1797.252, 1798, and 1798.150

5.2. California Code of Regulations, Title 22, Chapter 6, Article 4 ~~Sections 100270.223~~

5.3. Joint Commission

5.4. San Francisco Business and Tax Regulations Code SEC. 249.8 (e)(1-2)

5.5. American Heart Association-Get With the Guidelines-Stroke

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APPENDIX A: ICD-10 CODES THAT REQUIRE GWTG-STROKE DATA ENTRY

Code	Short Description
I60.00 - I60.9	Non-traumatic subarachnoid hemorrhage
I61.0 - I61.9	Non-traumatic intracerebral hemorrhage
I63.00 - I63.9	Cerebral Infarction (occlusion and stenosis of cerebral and precerebral arteries, resulting in cerebral infarction)
G45.0 - G45.2	TIA and related syndromes
G45.8 - G45.9	TIA and related syndromes
O99.411 - O99.43	Diseases of the circulatory system complicating pregnancy, childbirth and puerperium

Additional Entry Criteria: Unique to GWTG® - Stroke

Code	Short Description
G97.31 - G97.32	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a procedure
G97.51 - G97.52	Post-procedural hemorrhage and hematoma of a nervous system organ or structure following a procedure
I97.810 - I97.821	Intraoperative and postoperative cerebrovascular infarction

APPENDIX B: CALIFORNIA STATE EMS AUTHORITY ELEMENTS FOR DATA REPORTING

		Element ID
Identifiers	EMS Run Number	emsrunseq
	EMS Intervention Service Name	emsagencylist:ems_agency_name
	Facility ID	FACILITY_DISPLAY_ID
Patient	Date of Birth	dob
	Age	age
	Patient Gender Identity	patgenid
	Patient Race	race
ED Arrival	Emergency Department Acute Care Admission Date	arrdt
Treatment	Thrombolytic Used	thromboused
	IV TPA or Other Thrombolytic Initiated At This Facility	ivtpaordereddt
	IV TPA or Other Thrombolytic At Outside Facility	ivtpaoutside
	Mechanical Endovascular Reperfusion ICA	mer_ica
	Mechanical Endovascular Reperfusion MCA	mer_mca
Discharge	ICD-10 Diagnosis	I10dschstkdx

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SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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STROKE CENTER STANDARDS

I. PURPOSE

Establish the minimum standards for Receiving Hospitals who wish to accept acute stroke patients from approved ALS and BLS providers within the San Francisco EMS System.

II. POLICY

A. Stroke Centers shall be Receiving Hospitals as defined by San Francisco (SF) Emergency Medical Services (EMS) Agency Policy and will comply with all Federal, State, and local laws as well as all EMS Agency Policies.
   1. Joint Commission accredited Stroke Centers (Primary, Thrombectomy-Capable or Comprehensive) are considered to have met the specialty equipment and personnel requirements of this policy. Hospitals approved under this provision will have transfer agreements with other Receiving Hospitals for stroke patients.

B. Stroke Centers shall provide a Stroke Advisory Committee Member and Alternate Member and participate in committee meeting per Policy 1010 – EMS Advisory Committees.

C. Stroke Centers shall maintain a current Memorandum of Understanding with the EMS Agency.

D. Application process
   1. A Receiving Hospital that wishes to become a Stroke Center must submit a request in writing no later than 60 days prior to the desired date of designation as a Stroke Center by the EMS Agency.
   2. The request must include the date of achievement of a Joint Commission accreditation as a Stroke Center and the name and contact information for the Stroke Center Program Manager.
   3. The request must be signed by the Program Manager and the hospital Chief Executive or Chief Operations Officer.
   4. Currently designated Stroke Centers must maintain their MOU's with the EMS Agency.

E. Approval
   1. New Stroke Centers will be approved after satisfactory review of application documentation and a sire survey, when deemed necessary, by the EMS Agency Medical Director or his/her designee.

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2. ~~The Stroke Center will be re-approved after satisfactory San Francisco EMS Agency review every three (3) years.~~
3. ~~The Stroke Center Program Manager shall notify the EMS Agency of subsequent changes in their status.~~

~~III. AUTHORITY~~

A. ~~California Health and Safety Code, Sections 1255, 1255.5, 1256, 1797.220, 1797.222, 1798, 1798.150, 1798.163, 1799.202 et seq.~~
B. ~~California Code of Regulations, Title 22, Sections 100270.223-100270.227~~
C. ~~Joint Committee on the Accreditation of Hospitals and Health Care Organizations (Joint Commission) Primary Stroke Center~~