59A-3.2085 F.A.C., Department and Services.

(15) Stroke centers.
(a) Primary Stroke Centers. A hospital program will be designated as a primary stroke center on the basis of that hospital providing to the Agency for Health Care Administration an affidavit on AHCA Form 3130-8009, December 2005, which is incorporated by reference, signed by the Chief Executive Officer of the hospital, attesting that the program has been certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a primary stroke center, or that the program meets the criteria applicable to primary stroke centers as outlined in the Joint Commission on Accreditation of Healthcare Organizations: Disease-Specific Care Certification Manual, 2nd Edition, Oakbrook Terrace, IL; © Joint Commission Resources, 2005. Reprinted with permission. Attestation must also indicate that the program meets requirements outlined in the "Updated Primary Stroke Center Certification Appendix for the Disease-Specific Care Manual," which are incorporated by reference. Copies of these standards are available from the Agency for Health Care Administration Hospital and Outpatient Services Unit, or from the Joint Commission on the Accreditation of Healthcare Organizations at One Renaissance Boulevard, Oak Terrace, IL 60181. Hospitals shall ensure that stroke centers establish specific procedures for screening patients that recognize that numerous conditions, including cardiac disorders, often mimic stroke in children. Stroke centers should ensure that transfer to an appropriate facility for specialized care is provided to children and young adults with known childhood diagnoses.
(b) Comprehensive Stroke Center (CSC). Hospitals shall ensure that stroke centers establish specific procedures for screening patients that recognize that numerous conditions, including cardiac disorders, often mimic stroke in children. Stroke centers should ensure that transfer to an appropriate facility for specialized care is provided to children and young adults with known childhood diagnoses. A hospital's program may be designated as a Comprehensive Stroke Center on the basis of that hospital providing to the Agency for Health Care Administration an affidavit signed by the Chief Executive Officer of the hospital that the program has received initial Primary Stroke Center designation as provided in paragraph 59A-3.2085(15)(a), F.A.C., and that the program meets the following criteria:
1. A comprehensive stroke center shall have health care personnel with clinical expertise in a number of disciplines available.
a. Health care personnel disciplines in a CSC shall include:
(I) A designated comprehensive stroke center medical director;
(II) Neurologists, neurosurgeons, surgeons with expertise performing carotid endartrectomy, diagnostic neuroradiologist(s), and physician(s) with expertise in endovascular neuroInterventional procedures and other pertinent physicians;
(III) Emergency department (ED) physician(s) and nurses trained in the care of stroke patients;
(IV) Nursing staff in the stroke unit with particular neurologic expertise who are trained in the overall care of stroke patients;
(V) Nursing staff in intensive care unit (ICU) with specialized training in care of patients with complex and/or severe neurological/neurosurgical conditions;
(VI) Advanced Practice Nurse(s) with particular expertise in neurological and/or neurosurgical evaluation and treatment, physician(s) with specialized expertise in critical care for patients with severe and/or complex neurological/neurosurgical conditions;
(VII) Physician(s) with specialized expertise in critical care for patients with severe and/or complex neurological/neurosurgical conditions;
(VIII) Physician(s) with expertise in performing and interpreting trans-thoracic echocardiography, transesophageal echocardiography, carotid duplex ultrasound and transcranial Doppler;

(IX) Physician(s) and therapist(s) with training in rehabilitation, including physical, occupational and speech therapy; and
(X) A multidisciplinary team of health care professionals with expertise or experience in stroke, representing clinical or neuropsychology, nutrition services, pharmacy (including a Pharmacy Doctorate (Pharm D) with stroke expertise), case management and social workers.
b. Availability of medical personnel:
(I) Neurosurgical expertise must be available in a CSC on a 24 hours per day, 7 days per week basis and in-house within 2 hours. The attending neurosurgeon(s) at a CSC should have expertise in cerebrovascular surgery.
(II) Neurologist(s) with special expertise in the management of stroke patients should be available 24 hours per day, 7 days per week.
(III) Endovascular/Neurointerventionist(s) should be on active full-time staff. However, when this service is temporarily unavailable, pre-arranged transfer agreements must be in place for the rapid transfer of patients needing these treatments to an appropriate facility.
2. Advanced Diagnostic Capabilities.
a. Magnetic resonance imaging (MRI) and related technologies.
b. Catheter angiography.
c. Coaxial Tomography (CT) angiography.
d. Extracranial ultrasonography.
e. Carotid duplex.
f. Transcranial Doppler.
g. Transthoracic and trans-esophageal echocardiography.
h. Tests of cerebral blood flow and metabolism.
i. Comprehensive hematological and hypercoagulability profile testing.
3. Neurological Surgery and Endovascular Interventions.
a. Angioplasty and stenting of intracranial and extracranial arterial stenosis.
b. Endovascular therapy of acute stroke.
c. Endovascular treatment (coiling) of intracranial aneurysms.
d. Endovascular and surgical repair of arteriovenous malformations (AVM) and arteriovenous fistulae (AVF).
e. Surgical clipping of intracranial aneurysms.
f. Intracranial angioplasty for vasospasm.
g. Surgical resection of AVMs and AVFs.
h. Placement of ventriculostomies and ventriculoperitoneal shunts.
i. Evacuation of intracranial hematomas.
j. Carotid endarterectomy.
k. Decompressive craniectomy.
4. Specialized Infrastructure.
a. Emergency Medical Services (EMS) Link – The CSC collaborates with EMS leadership:
(I) To ensure that EMS assessment and management at the scene includes the use of a stroke triage assessment tool (consistent with the Florida Department of Health sample).
(II) To ensure that EMS assessment/management at the scene is consistent with evidence-based practice.
(III) To facilitate inter-facility transfers.
(IV) To maintain an on-going communication system with EMS providers regarding availability of services.
b. Referral and Triage – A CSC shall maintain:

(I) An acute stroke team available 24 hours per day, 7 days per week, including: ED physician(s), nurses for ED patients, neurologist, neurospecialist RNs, radiologist with additional staffing/technology including: 24 hours per day, 7 days per week CT availability, STAT lab testing/pharmacy and registration.
(II) A system for facilitating inter-facility transfers.
(III) Defined access telephone numbers in a system for accepting appropriate transfer.
c. Inpatient Units – These specialized units should have a subspecialty Medical Director with particular expertise in stroke (intensivist, pulmonologist, neurologist, neurosurgeon or neuro-intensivist) who demonstrates ongoing professional growth by obtaining at least 6 CME credits in cerebrovascular care annually.
(I) ICU with medical and nursing personnel who have special training, skills and knowledge in the management of patients with all forms of neurological/neurosurgical conditions that require intensive care.
(II) Acute Stroke Unit with medical and nursing personnel who have training, skills and knowledge sufficient to care for patients with neurological conditions, particularly acute stroke patients, and who are appropriately trained in neurological assessment and management.
d. Rehabilitation and Post Stroke Continuum of Care –
(I) A CSC shall provide inpatient post-stroke rehabilitation.
(II) A CSC shall utilize healthcare professionals who can assess and treat cognitive, behavioral, and emotional changes related to stroke (i.e., clinical psychologists or clinical neuropsychologists).
(III) A CSC shall ensure discharge planning that is appropriate to the level of post-acute care required.
(IV) A CSC shall ensure continuing arrangements post-discharge for rehabilitation needs and medical management.
(V) A CSC shall ensure that patients meeting acute care rehabilitation admission criteria are transferred to a CARF/JCAHO accredited acute rehabilitation facility.
e. Education –
(I) The CSC shall fulfill the educational needs of its medical and paramedical professionals by offering ongoing professional education for all disciplines.
(II) The CSC shall provide education to the public as well as to inpatients and families on risk factor reduction/management, primary and secondary prevention of stroke, the warning signs and symptoms of stroke, and the medical management and rehabilitation for stroke patients.
(III) The CSC shall supplement community resources for stroke and stroke support groups.
f. Professional standards for nursing – The CSC shall provide a career development track to develop neuroscience nursing, particularly in the area of cerebrovascular disease.
(I) ICU and neuroscience/stroke unit nursing staff will be familiar with stroke specific neurological assessment tools such as the National Institute for Health (NIH) Stroke Scale.
(II) ICU nursing staff must be trained to assess neurologic function and be trained to provide all aspects of neuro critical care.
(III) Nurses in the ICU caring for stroke patients, and nurses in neuroscience units must obtain at least 8 hours of continuing education credits (4 hours continuing education in the formalized CEU credits and 4 hours of continuing education related to their specialty that can be verified through documentation of participation).
g. Research – A CSC shall have the professional and administrative infrastructure necessary to conduct clinical trials and should have participated in stroke clinical trials within the last year and actively participate in ongoing clinical stroke trials.
5. Quality Improvement and Clinical Outcomes Measurement.
a. The purpose of a quality improvement program is analysis of data, correction of errors, systems improvements, and ongoing improvement in patient care and delivery of services.

b. A multidisciplinary institutional Quality Improvement Committee should meet on a regular basis to monitor quality benchmarks and review clinical complications.
c. Specific benchmarks, outcomes, and indicators should be defined, monitored, and reviewed on a regular basis for quality assurance purposes. Outcomes for procedures such as carotid endarterectomy, carotid stenting, IVtPA, endovascular/interventional stroke therapy, intracerebral aneurysm coiling, and intracerebral aneurysm clipping should be monitored.
d. A database and/or registry should be established that allows for tracking of parameters such as length of stay, treatments received, discharge destination and status, incidence of complications (such as aspiration pneumonia, urinary tract infection, deep venous thrombosis), and discharge medications and comparing to institutions across the United States.
e. A CSC shall participate in a national and/or state registry (or registries) for acute stroke therapy clinical outcomes, including IVtPA and endovascular/interventional stroke therapy.

Specific Authority 395.1055, 395.3038, 395.401, 408.036 FS. Law Implemented 395.001, 395.1055, 395.1065, 395.3038, 395.401, 408.036, 957.05 FS. History–New 4-17-97, Amended 3-29-98, 8-23-99, 3-23-06.