MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE
APPLICATION FOR STROKE CENTER REVIEW AND DESIGNATION

SECTION A

In accordance with the requirements of the Chapter 190 RSMo and the applicable regulations, this application is hereby submitted for review and designation as a stroke center. Please complete all information applicable to the requested designation level.	Designation Level Requested ☐ I ☐ II ☐ III ☐ IV

Joint Commission Certification
☐ Primary Stroke Center ☐ Comprehensive Stroke Center

HOSPITAL INFORMATION

Name Of Hospital (Name To Appear On Designation Certificate)	Telephone Number	
Address (Street And Number)	City	Zip Code

PROFESSIONAL INFORMATION

Chief Executive Officer	Chairman/President Of Board Of Trustees
Stroke Medical Director	Stroke Program Manager
Medical Director of Emergency Medicine	Medical Director of Intensive Care Unit

RESOURCE INFORMATION

Stroke Caseload	Stroke Team Activations	CT Scan Capability ☐ FULL ☐ PARTIAL ☐ NONE	MRI Capability ☐ FULL ☐ PARTIAL ☐ NONE
Neurosurgical Capability or Transfer Plan	ICU or NICU Beds	Stroke Unit Beds	Stroke Rehab ☐ INPATIENT ☐ OUTPATIENT
Neurologists	Neurosurgeons	Neuro-Interventionalists	Emergency Department (ED) Physicians
Anesthesiologists/ CRNAs & AAs	Angiography Suites	Avg number of patients who received neuro-intervention **(not required for initial review)**	Avg number of patients who received thrombolytics in the past 24 months **(not required for initial review)**

CERTIFICATION

We, the undersigned, hereby certify that the information provided in this application for stroke center review and designation is true and accurate; and give assurance of the intent and ability of the hospital to comply with regulations promulgated under the Chapter 190, RSMo.

We further certify that the hospital will comply with all recommendations for improvement contained in the stroke center site review reports prepared by the Missouri Department of Health and Senior Services.

Date of application____________________

Signed___________________________________
Chairman/President of Board of Trustees, Owner, or one Partner of Partnership

Signed___________________________________
Hospital Chief Executive Officer

Signed___________________________________
Stroke Medical Director

Signed___________________________________
Director of Emergency Medicine

SECTION B

Please attach the following documentation to the application form. **Name of Hospital**:

- ☐ Hospital organizational chart depicting the relationship of the stroke services to other services and defining the organizational structure of the stroke service.
- ☐ Job descriptions and CV for the stroke medical director and stroke coordinator/program manager.
- ☐ A narrative description of the administrative commitment for the stroke center, including how stroke center designation relates to the overall mission of the hospital.
- ☐ A current board resolution supporting the stroke center.
- ☐ A narrative description of the catchment area for the stroke center.
- ☐ A narrative description of the prehospital system including the hospital's participation in medical control, quality assurance, and education of the emergency medicine personnel.
- ☐ Hospital diversion policy.
- ☐ List of the stroke medical director and stroke program coordinator or program manager (core stroke team) indicating the neuro-cerebrovascular related continuing education for each over the past three (3) years. (Do not send continuing education information about the clinical stroke team. This should be available at the time of the review.)
- ☐ Multidisciplinary team policy.
- ☐ List of all neurologists, neurosurgeons, neuro-interventionalists and emergency department physicians and indicate stroke-related CME for each over the past three (3) years.
- ☐ List of physicians and plan for supervised relationship between Level III and higher level stroke center where stroke patients are admitted for care in a Level III center if applicable (this list and plan are only required for Level III centers with a supervised relationship with a Level I or Level II center).
- ☐ Narrative description of the system for notifying/activating stroke team.
- ☐ One-call stroke team activation protocol.
- ☐ Copies of all transfer agreements pertaining to stroke.
- ☐ Policy for consultation for physical medicine and rehabilitation, physical therapy, occupational therapy and speech therapy.
- ☐ Protocols on post-discharge and post-transfer follow-up for stroke patients.
- ☐ A narrative description of the stroke quality improvement (QI) processes utilized by the hospital (Do not send copies of QI minutes or documents. These should be available at the time of review.)
- ☐ Examples of stroke-related educational, outreach, and research projects undertaken by the hospital.
- ☐ Summary of source of stroke information for Table 1 on next page. Table 1 is only required to be filled out by a stroke center which is applying for renewal of its designation prior to a validation review. Table 1 is not required to be filled out by a hospital requesting an initial review and designation.
- ☐ Verification of Primary or Comprehensive Joint Commission certified center (e.g. certificate).

Table 1. Ischemic Stroke Numbers for Past Two (2) Years

Table 1 is only required to be filled out by a stroke center which is applying for renewal of its designation prior to a validation review.

A	B	C	D	E
Indicate year[1] Provide two years of data	**Stroke cases**[2] / **Transfers**[3]	**Stroke cases eligible for NI**[4] / **Received NI**[5]	**Stroke cases eligible for Lytics**[6] / **Received lytics**[7]	**Stroke deaths**[8]
For example: 2011	**53 / 22**	**14 / 8**	**25 / 12**	**2**
Total				
Average/Year				

[1] Include data for the last two (2) years of hospital data. Indicate time frame in months if it is other than January to December.
[2] Include all stroke patients, independent of hospital admission or hospital transfer status. To include walk-ins, transfers, EMS transports, admitted patients, and patients that die. Include all stroke patients that have ICD-9-principal diagnosis code of 433.01, 433.10, 433.11, 433.21, 433.31, 433.81, 433.91, 434.00, 434.01, 434.11, 434.91, 436.00, 430.00 and 431.00
[3] Provide number of all stroke patients transferred to this hospital from another hospital.
[4] Provide number of stroke patients eligible for neuro-intervention (NI).
[5] Provide number of stroke patients that received neuro-intervention (NI).
[6] Provide number of stroke patients that are eligible for thrombolytics.
[7] Provide number of stroke patients that received thrombolytics.
[8] Include all deaths, ED and inpatient, independent of hospital admission or hospital transfer status.