
CNY
RSTAC
REGIONAL STROKE ADVISORY COUNCIL

# Chairman Update:
## AHA/ASA 2021 SSOC Policy Statement Update

**SPECIAL REPORT**

### Recommendations for Regional Stroke Destination Plans in Rural, Suburban, and Urban Communities From the Prehospital Stroke System of Care Consensus Conference

A Consensus Statement From the American Academy of Neurology, American Heart Association/American Stroke Association, American Society of Neuroradiology, National Association of EMS Physicians, National Association of State EMS Officials, Society of NeuroInterventional Surgery, and Society of Vascular and Interventional Neurology: Endorsed by the Neurocritical Care Society

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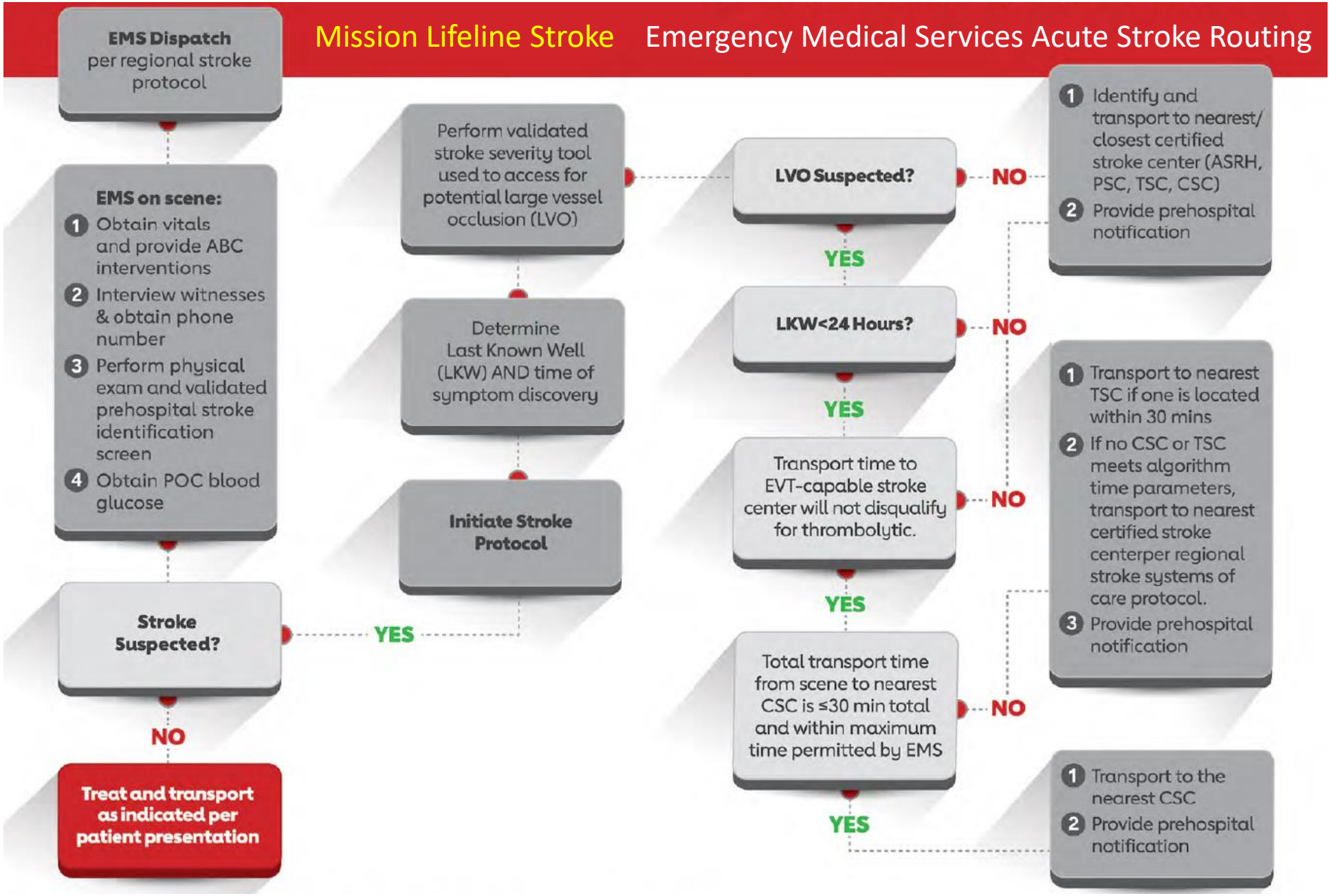
Mission Lifeline Stroke
Emergency Medical Services Acute Stroke Routing
EMS Dispatch per regional stroke protocol
EMS on scene:
1 Obtain vitals and provide ABC interventions
2 Interview witnesses & obtain phone number
3 Perform physical exam and validated prehospital stroke identification screen
4 Obtain POC blood glucose
Stroke Suspected?
NO
Treat and transport as indicated per patient presentation
YES
Initiate Stroke Protocol
Determine Last Known Well (LKW) AND time of symptom discovery
Perform validated stroke severity tool used to access for potential large vessel occlusion (LVO)
LVO Suspected?
NO
1 Identify and transport to nearest/ closest certified stroke center (ASRH, PSC, TSC, CSC)
2 Provide prehospital notification
YES
LKW<24 Hours?
NO
YES
Transport time to EVT-capable stroke center will not disqualify for thrombolytic.
NO
YES
Total transport time from scene to nearest CSC is ≤30 min total and within maximum time permitted by EMS
NO
YES
1 Transport to nearest TSC if one is located within 30 mins
2 If no CSC or TSC meets algorithm time parameters, transport to nearest certified stroke centerper regional stroke systems of care protocol.
3 Provide prehospital notification
1 Transport to the nearest CSC
2 Provide prehospital notification

# 4 Levels of Stroke Care Facility

| Characteristics | ASRH | PSC | TSC | CSC |
|---|---|---|---|---|
| Location | Typically rural | Often urban/sub-urban | Often urban/sub-urban | Typically urban |
| Stroke team accessible/available 24/7 | Yes | Yes | Yes | Yes |
| Noncontrast CT available 24/7 | Yes | Yes | Yes | Yes |
| Advanced imaging available 24/7 (eg, CTA/CTP/MRI/MRA/MRP) | No | Possibly | Yes | Yes |
| Intravenous thrombolysis capable 24/7 | Yes | Yes | Yes | Yes |
| Thrombectomy capable 24/7 | No | Possibly | Yes | Yes |
| Diagnose stroke etiology and manage poststroke complications | Unlikely | Yes, routine | Yes, complex | Yes, complex |
| Admit hemorrhagic stroke | No | Possibly | Possibly | Yes |
| Clip/coil ruptured intracranial aneurysms | No | Unlikely | Possibly | Yes |
| Dedicated stroke unit | No | Yes | Yes | Yes |
| Neurocritical care unit and expertise | No | Possibly | Possibly* | Yes |
| Clinical stroke research performed | Unlikely | Possibly | Possibly | Yes |

# Important policy statement recommendations

| Recommendations | Central New York Region |
|---|---|
| Region-specific Stroke System of Care (SSOC) should be developed by all local stakeholders | Yes – via RSTAC |
| Stroke advisory committees should be created | Yes – via RSTAC |
| Destination Plans | |
| Public Education | Yes – via RSTAC |
| 911-Stroke Screening for potential stroke patients with EMS dispatch priority | |
| Integration of regional EMS into the SSOC | Yes – via RSTAC |
| Coordinated interfacility transport | |

# Specific recommendations for RURAL SSOC

- Ensure local availability of thrombolysis 24/7 for patients within 4.5hr LKW
- Ensure efficient transport of suspected LVO to CSC/TSC
- Direct transport of suspected LVO
  - To ASRH/PSC if no CSC/TSC within 60 min of ground transport
  - To TSC if within 60 min (and no CSC)
  - To CSC if within 60 min (and additional transport time beyond nearest TSC does not exceed 30 min)
- EMS destionation plans should prioritize rural hospitals with formal collaboration agreement (e.g. telestroke) with regional CSC (or TSC)