

**ARTICLE 6. ~~REPEALED~~ STROKE CARE**

**R9-25-601. ~~Repealed~~ Definitions**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article, unless otherwise specified:

1. “Council” means the emergency medical services council established under A.R.S. § 36-2203.
2. “Local EMS coordinating system” means the same as in A.R.S. § 36-2210.
3. “National stroke care standards” means criteria for the assessment and treatment of stroke that are consistent with guidelines established by the American Stroke Association.
4. “National stroke center certification organization” means an entity:
  - a. Such as:
    - i. The Joint Commission;
    - ii. The Healthcare Facilities Accreditation Program; or
    - iii. Det Norske Veritas Healthcare, Inc.;
  - b. That assesses the compliance of a hospital with national stroke care standards; and
  - c. That documents hospitals that meet national stroke care standards.
5. “Primary stroke center” means a hospital that meets national stroke care standards, as determined by a national stroke center certification organization.
6. “Stroke patient” means an individual who has signs or symptoms of a stroke and is receiving assessment or treatment for a stroke.

**R9-25-602. ~~Repealed~~ Emergency Stroke Care Protocols**

- A. The council shall:
  1. Establish emergency stroke care protocols, and
  2. Support the adoption of emergency stroke care protocols by emergency medical services providers through local EMS coordinating systems.
- B. The council shall ensure that emergency stroke care protocols:
  1. Are developed and implemented in coordination with:
    - a. Local EMS coordinating systems,
    - b. National organizations that focus on heart disease and stroke,
    - c. Emergency medical service providers, and
    - d. Health care providers;

2. Include procedures for the pre-hospital assessment and treatment of stroke patients;
  3. Provide for transport of stroke patients to the most appropriate emergency receiving facility, consistent with A.R.S. § 36-2205(E), taking into account the:
    - a. Needs of a stroke patient;
    - b. Availability of resources in urban areas, suburban areas, rural areas, and wilderness areas;
    - c. Capability of an emergency receiving facility to practice telemedicine, as defined in A.R.S. § 36-3601, with specialists in stroke care;
    - d. Location of emergency receiving facilities that:
      - i. Are primary stroke centers; and
      - ii. Participate in quality improvement activities, including the submission of data on stroke care provided by the emergency receiving facility that may be compiled on a statewide basis;
    - e. Capability of an emergency receiving facility that is not a primary stroke center to stabilize a stroke patient before initiating a transfer to a primary stroke center;
    - f. Capability of an emergency receiving facility that is not a primary stroke center to stabilize and admit a stroke patient; and
    - g. Distance and duration of transport;
  4. Are consistent with national stroke care standards; and
  5. Are based on data on stroke care from:
    - a. National organizations that focus on heart disease and stroke,
    - b. U.S. Department of Transportation, National Highway Traffic Safety Administration; and
    - c. Statewide data on stroke care, as available.
- C.** The council shall review and update, as necessary, the emergency stroke care protocols in subsection (A) at least once every three years.