**California Code of Regulations**

**TITLE 22. SOCIAL SECURITY**

**DIVISION 9. PREHOSPITAL EMERGENCY MEDICAL SERVICES**

**CHAPTER 7.2. STROKE CRITICAL CARE SYSTEM**

## ARTICLE 1. DEFINITIONS

### § 100270.200. Board-certified

"Board-certified" means a physician who has fulfilled all of the Accreditation Council for Graduate Medical Education (ACGME) requirements in a specialty field, and has been awarded a board diploma by an ACGME approved program.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

### § 100270.201. Board-eligible

"Board-eligible" means a physician has applied to a specialty board and received a ruling that he or she has fulfilled the requirements to take the examination. Board certification must be obtained within five (5) years of the first appointment.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

### § 100270.202. Clinical Stroke Team

"Clinical Stroke Team" means a team of healthcare professionals who provide care for the stroke patient and may include, but is not limited to, neurologists, neurointerventionalists, neurosurgeons, anesthesiologists, emergency medicine physicians, registered nurses, advanced practice nurses, physician assistants, pharmacists, and technologists.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

**§ 100270.203. Continuing Medical Education**

"Continuing Medical Education" or "CME" means education required for the maintenance of a license and refers to the highest level of continuing education approved or recognized by the national and/or state professional organization.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

**§ 100270.204. Emergency Medical Services Authority**

"Emergency Medical Services Authority" or "EMS Authority" means the department in California that is responsible for the coordination and the integration of all state activities concerning Emergency Medical Services (EMS).

Note: Authority cited: Sections 1797.107 and 1797.54, Health and Safety Code. Reference: Sections 1797.100, and 1797.103, Health and Safety Code.

**§ 100270.205. Immediately Available**

"Immediately Available" means:

(a) unencumbered by conflicting duties or responsibilities,

(b) responding without delay upon receiving notification, and

(c) being physically available to the specified area of the hospital when the patient is delivered in accordance with local EMS agency policies and procedures.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

**§ 100270.206. Local Emergency Medical Services Agency**

"Local Emergency Medical Services Agency" or "local EMS agency" means a county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint-powers agency created for the administration of emergency medical services by agreement between counties or cities and which is designated

pursuant to the California Health and Safety Code, Division 2.5, Chapter 4, Section 1797.200.

Note: Authority cited: Sections 1797.94, 1797.107, 1797.176, and 1797.200, Health and Safety Code. Reference: Section1797.94, Health and Safety Code.

**§ 100270.207. Protocol**

"Protocol" means a predetermined, written medical care guideline, which may include standing orders.

Note: Authority cited: Sections 1797.107, 1797.176, 1797.220, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

**§ 100270.208. Stroke**

"Stroke" means a condition of impaired blood flow to a patient's brain resulting in brain dysfunction.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

**§ 100270.209. Stroke Call Roster**

"Stroke Call Roster" means a schedule of licensed health professionals available twenty-four (24) hours a day, seven (7) days a week for the care of stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.220, Health and Safety Code.

**§ 100270.210. Stroke Care**

**"**Stroke Care" means emergency transport, triage, acute intervention and other acute care services for stroke that potentially requires immediate medical or surgical intervention treatment, and may include education, primary prevention, acute intervention, acute and subacute management, prevention of complications, secondary

stroke prevention, and rehabilitative services.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

**§ 100270.211. Stroke Medical Director**

"Stroke Medical Director" means a physician designated by the hospital who is responsible for the stroke service, performance improvement, and patient safety programs related to the Stroke Critical Care System.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

**§ 100270.212. Stroke Program Manager/Coordinator**

"Stroke Program Manager/Coordinator" means a registered nurse or qualified individual designated by the hospital with the responsibility for monitoring and evaluating the care of stroke patients and the coordination of performance improvement and patient safety programs for the stroke center in conjunction with the stroke medical director**.**

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

**§ 100270.213. Stroke Program**

"Stroke Program" means an organizational component of the hospital specializing in the care of stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

**§ 100270.214. Stroke Critical Care System**

**"**Stroke Critical Care System" means a subspecialty care component of the EMS system developed by a local EMS agency. This critical care system links prehospital and hospital care to deliver treatment to stroke patients who potentially require immediate medical or surgical intervention.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

**§ 100270.215. Stroke Team**

"Stroke Team" means the clinical stroke team, support personnel, and administrative staff.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

**§ 100270.216. Telemedicine**

"Telemedicine" means the use of medical information exchanged from one site to another via electronic communications to manage and improve a patient's health status. A neurology specialist will assist the physician in the center in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to the specialist.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176, and 1797.220, Health and Safety Code.

**ARTICLE 2. LOCAL EMS AGENCY STROKE CRITICAL CARE SYSTEM REQUIREMENTS**

**§ 100270.217. General Requirements and Timeframes**

(a) The local EMS agency may develop and implement a Stroke Critical Care System.

(b) Each local EMS agency implementing a Stroke Critical Care System shall submit to the EMS Authority a Stroke System Plan in accordance with the requirements in section 100270.222.

(c) A new Stroke Critical Care System that starts after the effective date of these regulations shall have the Stroke System Plans approved by the EMS Authority prior to implementation. The authority shall notify the local EMS agency of approval or disapproval of its Stroke System Plan within 30 days from receipt of the Plan. If the EMS Authority disapproves a plan, it shall provide written notification including the reason(s) for the disapproval and the corrective action items required.

(d) The local EMS agency shall provide a corrected plan to the EMS Authority within 60 days of receipt of the disapproval letter.

(e) A local EMS agency that is currently operating a Stroke Critical Care System implemented prior to the effective date of these regulations, shall submit, to the authority, a Stroke System Plan as an addendum to its annual EMS Plan update within 180 days of the effective date of these regulations.

(f) After approval of the plan, the local EMS agency shall submit an update to its Stroke System Plan as part of its annual EMS Plan update, consistent with the requirements in section 100270.218.

Note: Authority cited: Sections 1797.107, 1797.173, 1797.176, 1797.250, and 1798.150, Health and Safety Code. Reference: Sections 1797.105, 1797.176, and 1797.220, Health and Safety Code.

**§ 100270.218. State Stroke System Plan Requirements**

The Stroke System Plan submitted to the EMS Authority shall include, at a minimum, the following components:

(a) the names and titles of the local EMS agency personnel who have a role in the Stroke Critical Care System,

(b) copies of agreements with hospitals for designation of stroke facilities,

(c) description or copy of the local EMS agency's stroke patient identification and destination policies,

(d) description or copy of the method of field communication to the receiving hospital specific to stroke patients,

(e) description or copy of policy that facilitates the inter-facility transfer of stroke patients,

(f) description of the method of data collection from the EMS providers and designated stroke hospitals to the local EMS agency and the EMS Authority,

(g) a copy of all written agreements with neighboring local EMS agencies to provide stroke care,

(h) description of the integration of stroke into existing Quality Improvement QI Committee or description of any stroke specific QI committee, and

(i) description of programs to conduct or promote public education specific to Stroke and Cardiac Care.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1797.220, 1797.250, 1798.150, 1798.170, and 1798.172, Health and Safety Code. Reference: Sections 1797.176, and1797.220, Health and Safety Code.

**§ 100270.219. Stroke System Plan Updates**

The local EMS agency shall submit a Stroke System Plan update as part of its annual EMS plan update. The update shall include, at a minimum, the following:

(a) any changes in the Stroke Critical Care System since submission of the prior annual plan update or the Stroke System Plan addendum,

(b) status of Stroke System Plan goals and objectives,

(c) Stroke Critical Care System performance improvement activities, and

(d) progress on addressing action items and recommendations provided by the EMS Authority within the Stroke System Plan or status report approval letter if applicable.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.250, 1797.254, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1797.222, and 1798.170, Health and Safety Code.

## ARTICLE 3. PREHOSPITAL STROKE CRITICAL CARE SYSTEM REQUIREMENTS

### § 100270.220. EMS Personnel and Early Recognition

(a) The local EMS agency shall ensure that pre-hospital stroke assessment and treatment training is available for pre-hospital emergency medical care personnel as determined by the LEMSA as part of accreditation.

(b) The local EMS agency shall require the use of a validated pre-hospital stroke-screening algorithm for early recognition and assessment.

(c) The local EMS agency's protocols for the use of online medical direction shall be utilized for suspicious or complex findings.

(d) The prehospital treatment policies for stroke-specific basic life support (BLS), advanced life support (ALS), and limited advanced life support (LALS) shall be developed according to scope of practice and local accreditation.

(e) Prehospital findings of suspected stroke patient, as defined by the local EMS agency, will be communicated to the Stroke Center of Care facility in advance of arrival, according to the local EMS agency's Stroke System Plan.

Note: Authority cited: Sections 1797.92, 1797.103, 1797.107, 1797.176, 1797.189(a)(2), 1797.206, 1797.214, and 1798.150, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1798.150, and 1798.170, Health and Safety Code.

## ARTICLE 4. HOSPITAL STROKE CARE REQUIREMENTS

Any stroke center designated by the local EMS agency prior to implementation of these regulations shall continue to operate. Upon re-designation, by the local EMS agency at the next regular interval, stroke centers shall be re-evaluated to meet the criteria established in these regulations.

### § 100270.221. Primary Stroke Centers

Hospitals to be designated by the local EMS agency as a Primary Stroke Center shall meet the following minimum criteria to provide care for stroke patients in the emergency department and those patients that are admitted:

(a) adequate staff, equipment, and training to perform rapid evaluation, triage and treatment for the stroke patient in the emergency department;

(b) standardized stroke care pathway;

(c) twenty-four (24) hours a day, seven (7) days a week stroke diagnosis and treatment capacity; and

(d) a quality improvement system, including data collection.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.220, 1798.150, 1798.167, and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, 1798.150, and 1798.170, Health and Safety Code.

**§ 100270.222. Evaluation of Primary Stroke Centers**

The local EMS agency is to ensure evaluation of the Primary Stroke Center occurs as part of their Stroke Critical Care System including assessment of the following:

(a) The hospital shall be committed to supporting the Stroke Critical Care System.

(b) An acute stroke team, available to see in person or via telemedicine, a patient identified as a potential acute stroke patient within 15 minutes following the patient's arrival at the hospital's emergency department or within 15 minutes following a diagnosis of a patient's potential acute stroke.

(c) Written policies and procedures for stroke services that are reviewed at least every two (2) years, revised more frequently as needed, and implemented. These policies and procedures shall include written protocols and standardized orders for emergency care of stroke patients.

(d) Data-driven, continuous quality improvement including collection and monitoring of standardized performance measures.

(e) Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, such that imaging shall be performed within twenty-five (25) minutes following order entry. Such studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their

training in an ACGME-approved radiology, neurology, or neurosurgery training program within twenty (20) minutes of study completion.

(1) Neuro-imaging services shall, at a minimum, include computerized tomography (CT) scanning or magnetic resonance imaging (MRI), as well as interpretation of the imaging.

(2) In the event that tele-radiology is used in image interpretation, all staffing and staff qualification requirements contained in this subchapter shall remain in effect and shall be documented by the hospital.

(3) For the purpose of this subsection, a qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

(4) For the purpose of this subsection, a qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(5) For the purpose of this subsection, a qualified neurosurgeon shall be board-certified by the American Board of Neurological Surgery.

(f) Laboratory services capability that is available twenty-four (24) hours a day, seven (7) days a week, such that services may be performed within forty-five (45) minutes following order entry.

(g) Neurosurgical services that are available, including operating room availability, either directly or under agreement with a comprehensive or another primary stroke center, within two (2) hours following admission of acute stroke patients to the primary stroke center.

(h) Acute care rehabilitation services.

(i) Transfer arrangements with one or more higher level of care centers when clinically warranted.

(j) There shall be a physician director of a primary stroke center, who may also serve as a physician member of a stroke team, who is board-certified in neurology or neurosurgery.

(k) At a minimum, an acute care stroke team shall consist of:

(1) a neurologist, neurosurgeon, interventional neuroradiologist, or emergency physician who is board-certified or board-eligible in neurology, neurosurgery,

endovascular neurosurgical radiology, with experience and expertise dealing with cerebral vascular disease; and

(2) a registered nurse, physician assistant or nurse practitioner who has demonstrated competency, as determined by the physician director described in (k)(1) above, in caring for acute stroke patients.

Note: Authority cited: Sections 1797.102, 1797.103, 1797.107, 1797.176, 1797.204 1797.220, 1797.250, 1797.254, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.104, 1797.176, and 1797.204, 1797.220, 1797.222, 1798.170, Health and Safety Code.

**§ 100270.223. Comprehensive Stroke Centers**

Hospitals designated as Comprehensive Stroke Centers by the local EMS agency shall have the following minimum criteria in addition to the requirements for being Primary Stroke Centers explained in this chapter.

(a) Neuro-endovascular diagnostic and therapeutic procedures available twenty-four (24) hours a day, seven (7) days a week.

(b) Advanced imaging, including but not limited to, computed tomography (CT), angiography, magnetic resonance imaging (MRI), and diffusion-weighted magnetic resonance imaging, available twenty-four (24) hours a day, seven (7) days a week.

(c) Intensive care unit (ICU) beds with licensed independent practitioners with the expertise and experience to provide neuro-critical care twenty-four (24) hours a day, seven (7) days a week.

(d) Written policies and procedures for comprehensive stroke services that are reviewed at least every two (2) years, revised as needed, and implemented.

(e) Data-driven, QI including collection and monitoring of standardized comprehensive stroke center performance measures.

(f) Satisfy the following staff qualifications:

(1) a neurosurgical team capable of assessing and treating complex stroke and stroke-like syndromes,

(2) a neuroradiologist with current Certificate of Added Qualifications in neuroradiology on staff;

(3) a physician with neuro-interventional angiographic training and skills on staff as deemed by the hospital's credentialing process,

(4) a physician with current Certificate of Added Qualifications in vascular neurology on staff.

(5) a qualified neuroradiologist, board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology; and

(6) a qualified vascular neurologist, board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(g) In the event that tele-radiology is used, all staffing and staff qualification requirements contained in § 100270.223. (f) shall remain in effect and shall be documented by the hospital.

(h) Provide comprehensive rehabilitation services either on-site or by written transfer agreement with another health care facility licensed to provide such services.

(i) Written transfer agreements with primary stroke centers in region to accept transfer of patients with complex strokes when clinically warranted.

(j) Comprehensive Stroke Center shall at a minimum, provide guidance and continuing medical education to hospitals designated as Primary Stroke Centers with which they have transfer agreements.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.204, 1797.220, and1797.222, Health and Safety Code.

**§ 100270.224. Acute Stroke Ready Hospitals (Satellite Stroke Centers)**

Acute Stroke Ready Hospitals (Satellite Stroke Centers) are able to provide the minimum level of care for stroke patients in the emergency department, which are paired with one or more hospitals with higher level of services. In these hospitals, the necessary emergency department neurological expertise may be provided in person or through telemedicine.

The local EMS agency is responsible for evaluation of Acute Stroke Ready Hospitals as part of their Stroke Critical Care System, which includes assessment of the following structural components:

(a) An acute stroke team available to see in person or via telemedicine a patient identified as a potential acute stroke patient within thirty (30) minutes following the patient's arrival at the hospital's emergency department.

(b) Written policies and procedures for emergency department stroke services that are reviewed, revised as needed, and implemented at least every three (3) years.

(c) Emergency department policies and procedures shall include written protocols and standardized orders for emergency care of stroke patients.

(d) Data-driven, QI including collection and monitoring of standardized performance measures.

(e) Neuro-imaging services capability that is available twenty-four (24) hours a day, seven (7) days a week, such that imaging shall be performed within sixty (60) minutes following order entry. Such studies shall be reviewed by a physician with appropriate expertise, such as a board-certified radiologist, board-certified neurologist, a board-certified neurosurgeon, or residents who interpret such studies as part of their training in an ACGME-approved radiology, neurology, or neurosurgery training program, within forty-five (45) minutes of patient arrival at the emergency department.

(1) Neuro-imaging services shall, at a minimum, include computerized tomography (CT) scanning or magnetic resonance imaging (MRI), as well as interpretation of the imaging.

(2) In the event that tele-radiology is used in image interpretation, all staffing and staff qualification requirements contained in this subchapter shall remain in effect and shall be documented by the hospital.

(3) For the purpose of this subsection, a qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

(4) For the purpose of this subsection, a qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(5) For the purpose of this subsection, a qualified neurosurgeon shall be board-certified by the American Board of Neurological Surgery.

(f) Laboratory services at a minimum, including blood testing, electrocardiography and x-ray services capability, available twenty-four (24) hours a day, seven (7) days a week and able to perform within sixty (60) minutes following order entry.

(g) Neurosurgical services that are available, including operating room availability, either directly or under agreement with a Primary or Comprehensive Stroke Center, within three (3) hours following admission of acute stroke patients to the Satellite Stroke Center.

(h) Transfer arrangements with one or more primary or comprehensive stroke center(s) that facilitate transfer of patients with strokes to the stroke center(s) for care when clinically warranted.

(i) There shall be a director of the Satellite Stroke Center, who may also serve as a member of a stroke team, who is a physician or advanced practice nurse who maintains at least six (6) hours per year of educational time in cerebrovascular disease;

(j) Acute care stroke team for Satellite Stroke Center at a minimum shall consist of a nurse and a physician with training and expertise in acute stroke care.

(k) Additional requirements may be included at the discretion of the local EMS agency medical director.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.204, 1797.220, and1797.222, Health and Safety Code.

**§ 100270.225. EMS Receiving Hospitals (Non-designated for Stroke Critical Care Services)**

Hospitals that are not designated shall do the following at minimum, in cooperation with Stroke Receiving Centers and the local EMS agency in their jurisdictions:

(a) Participate in the local EMS agency's QI system, including data submission as determined by the local EMS agency medical director;

(b) Participate in the inter-facility transfer agreements to ensure access to the Stroke Critical Care System for potential stroke patient.

Note: Authority cited: Sections 1797.88, 1797.103, 1797.107, 1797.176, 1797.220, 1798.100, 1798.150, and 1798.172, Health and Safety Code. Reference: Sections 1797.176, 1797.220, and1798.150, 1798.170, Health and Safety Code.

## ARTICLE 5. DATA MANAGEMENT, QUALITY IMPROVEMENT AND EVALUATION

### § 100270.226. Data Management

(a) The local EMS agency shall implement a standardized data collection and reporting process for Stroke Critical Care Systems.

(1) The system shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency.

(2) The prehospital and hospital stroke patient care elements selected by the local EMS agency shall be compliant with the most current version of the California EMS Information Systems (CEMSIS) data base, the National EMS Information System (NEMSIS) and national standards published by the U.S. Centers for Disease Control and Prevention, Paul Coverdell National Acute Stroke Program Resource Guide, dated October 24, 2016.

(3) Stroke data shall be integrated into the local EMS agency and the EMS Authority data management system through data submission on no less than a quarterly basis.

(4) All hospitals that receive stroke patients shall participate in the local EMS agency data collection process in accordance with local EMS agency policies and procedures.

Note: Authority cited: Sections. 1797.102, 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1797.227, 1798.150, and 1798.172. Health and Safety Code. Reference: Section 1797.220, 1797.222, 1797.204.

### § 100270.227. Quality Improvement Process

Each Stroke Critical Care System shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. This process shall include, at a minimum:

(a) a detailed audit of all stroke-related deaths, major complications, and transfers;

(b) a multidisciplinary stroke QI Committee including both pre-hospital and hospital members;

(c) participation in the stroke data management system;

(d) compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected stroke cases.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, and 1798.150, Health and Safety Code. Reference: Sections 1797.176, 1797.204, 1797.220, and 1798.150, Health and Safety Code.

**§ 100270.228. Stroke Critical Care System Evaluation**

(a) The local EMS agency is responsible for on-going performance evaluation of the local or regional Stroke Critical Care System.

(b) The local EMS agency shall be responsible for the development of a quality improvement process pursuant to Section 100270.227.

(c) The local EMS agency shall be responsible for ensuring that designated Stroke Centers and other hospitals that treat stroke patients participate in the quality improvement process contained in Section 100270.227, as well as prehospital providers involved in the Stroke Critical Care System.

Note: Authority cited: Sections 1797.102, 1797.103, 1797.107, 1797.176, 1797.204, 1797.220, 1797.250, 1797.254, 1798.150, and 1798.172. Health and Safety Code. Reference: Section 1797.104, 1797.176, 1797.204, 1797.220, 1797.222, 1798.170 Health and Safety Code.