

## Supplementary Online Content

Kass-Hout T, Lee J, Tataris K, et al. Prehospital comprehensive stroke center vs primary stroke center triage in patients with suspected large vessel occlusion stroke. *JAMA Neurol*. Published online August 9, 2021. doi:10.1001/jamaneurol.2021.2485

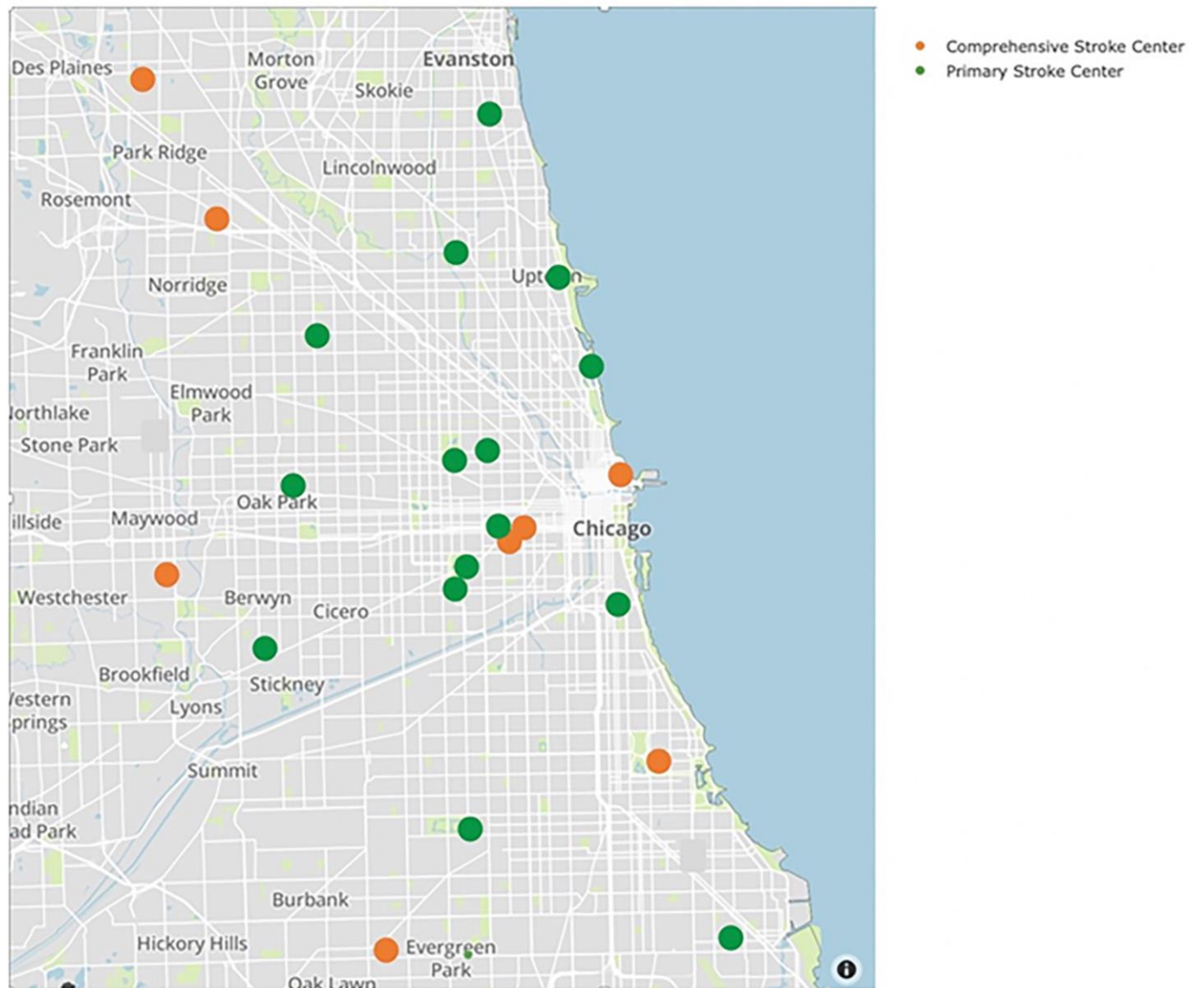
**eFigure 1.** Receiving Hospitals of the Chicago EMS System Showing Primary Stroke Centers and Comprehensive Stroke Centers

**eFigure 2.** EMS Policy and Protocol

**eTable.** Inclusion of Patients With Missing Mode of Arrival in Primary Analysis Using Interrupted Time Series to Evaluate the Association of Policy Implementation With Endovascular Therapy Rate and Thrombolysis Rate Before and After Implementation

This supplementary material has been provided by the authors to give readers additional information about their work.

**eFigure 1. Receiving Hospitals of the Chicago EMS System Showing Primary Stroke Centers and Comprehensive Stroke Centers**

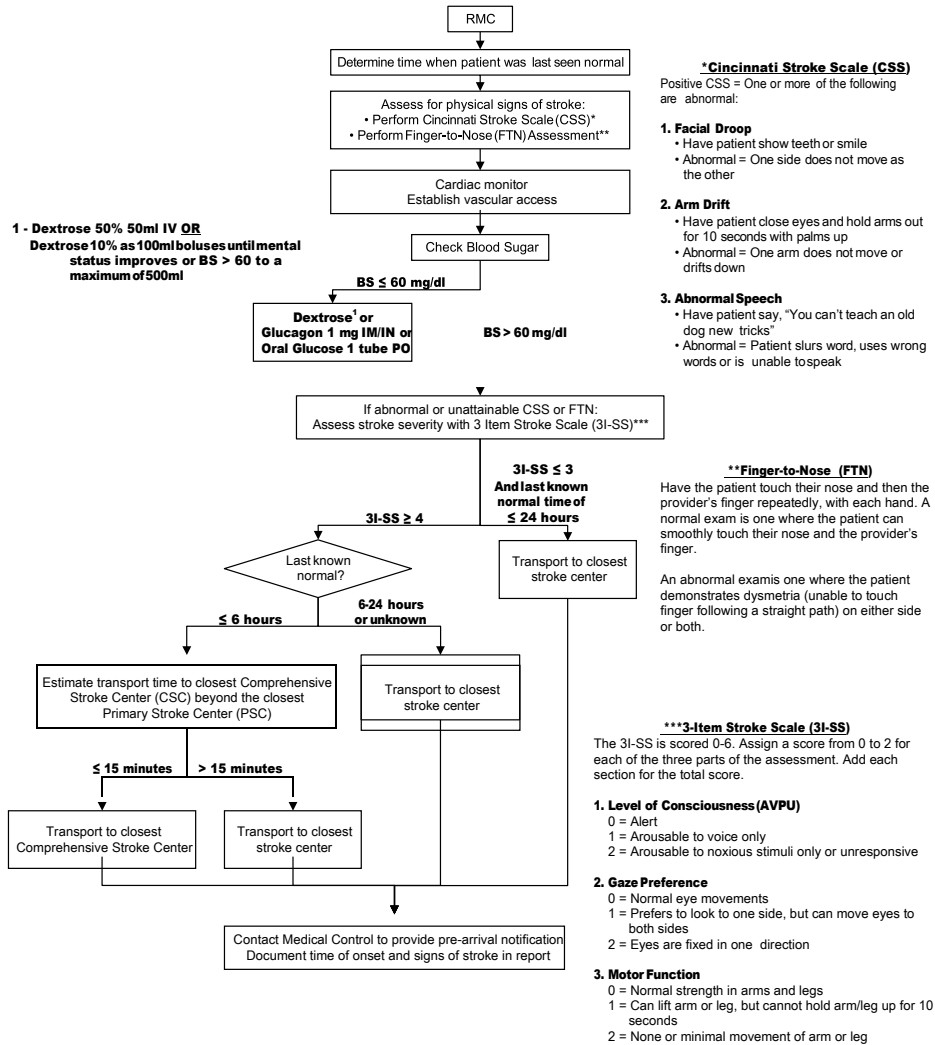


eFigure 2. EMS Policy and Protocol



<b>REGION 11 CHICAGO EMS SYSTEM PROTOCOL</b>	Title: Stroke - ALS
	Section: Cardiovascular
	Approved: EMS Medical Directors Consortium
	Effective: November 28, 2018

**STROKE – ALS**





**REGION 11  
CHICAGO EMS SYSTEM  
POLICY**

Title: Transport of Patients with Suspected Acute Stroke

Section: Transportation

Approved: EMS Medical Directors Consortium

Effective: November 28, 2018

**TRANSPORT OF PATIENTS WITH  
SUSPECTED ACUTE STROKE**

I. Patients with stroke symptoms  $\leq 24$  hours in duration or of unknown time of last known normal shall be assessed using the Cincinnati Stroke Scale (CSS – Facial Droop, Arm Drift, Abnormal Speech). Screening for additional stroke syndromes shall be performed using the Finger-to-Nose (FTN) test. A severe stroke screen using the 3 Item Stroke Scale (3I-SS) shall subsequently be performed on all patients with an abnormal CSS (one or more abnormal CSS elements) or abnormal FTN test.

II. Patients with a negative or unobtainable CSS, FTN or 3I-SS may be transported to a Primary Stroke Center (PSC) or Comprehensive Stroke Center (CSC) if acute stroke is suspected by the Base Station or Paramedics.

ECRNs should seek consultation with an ECP for any situation in which there is a question as to the best receiving hospital for a patient with possible stroke symptoms.

III. Patients who have a 3I-SS score of  $\geq 4$  and have a known last normal time of  $\leq 6$  hours should be transported to the closest CSC. Only if the closest CSC is  $>15$  minutes travel time beyond the closest PSC, the patient should be transported to the closest PSC.

Patients who have a 3I-SS score of  $\geq 4$  and have a known last normal time of 6-24 hours or have an unknown last known normal time should be transported to the closest stroke center (PSC or CSC).

Patients who have a 3I-SS score of  $<4$  and have a known last normal time of  $<24$  hours or have an unknown last known normal time should be transported to the closest stroke center (PSC or CSC).

IV. In the event the closest appropriate stroke center is on ALS bypass, the "T + 5 minute" rule should be followed, i.e. if the transport time to the next closest stroke center is greater than an additional 5 minutes, the patient should be transported to the closest appropriate stroke center (PSC or CSC) on ALS bypass (see Notification and Monitoring of Hospital Resource Limitation(s)/Ambulance Bypass policy, Section VI.)

Patients with suspected acute stroke should not be transported to a stroke center which has notified Region 11 Base Stations regarding a temporary lack of CT scanners; they should instead be transported to the next closest appropriate stroke center.

Patients with suspected acute stroke can be diverted to the closest comprehensive emergency department if the patient is deemed too unstable for the longer transport to a stroke center (e.g. inability to oxygenate or ventilate the patient).

arm or leg

**eTable. Inclusion of Patients With Missing Mode of Arrival in Primary Analysis Using Interrupted Time-Series to Evaluate the Association of Policy Implementation With Endovascular Therapy Rate and Thrombolysis Rate Before and After Implementation**

	<b>Parameter Estimate</b>	<b>Standard Error</b>	<b><i>P</i>-value</b>
<b>Endovascular Therapy Rate (%)</b>			
b0, baseline (Dec 2017)	3.98	2.29	0.12
b1, Pre-implementation trend	0.18	0.41	0.67
b2, Level change immediately post-implementation	7.42	3.08	0.03
b3, Post-implementation trend	0.10	0.57	0.87
<b>Intravenous Thrombolysis Rate (%)</b>			
b0, baseline (Dec 2017)	39.89	8.42	<0.001
b1, Pre-implementation trend	-0.07	1.49	0.96
b2, Level change immediately post-implementation	2.30	10.90	0.84
b3, Post-implementation trend	-0.47	2.13	0.83