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Effective Date for New Massachusetts Hospital Stroke Services Regulations Draws Near

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Effective January 1, 2026, all Massachusetts emergency departments, including satellite emergency facilities, will be required to provide, at minimum, acute stroke ready services. In August, the Department of Public Health (DPH) issued guidance with additional details to assist hospitals in coming into compliance with this new requirement.

Mandatory acute stroke ready services (105 CMR 130.1402 through 130.1403)

At a minimum, each emergency department (ED) and satellite emergency facility (SEF) must develop and implement written protocols, including but not limited to:

1. The triage and treatment of patients with symptoms of acute stroke, including systems in place to promptly perform initial diagnostic tests, such as brain computed tomography (CT) or magnetic resonance imaging (MRI), laboratory (e.g., routine serum chemistry, hematology, coagulation studies), electrocardiograms, and/or chest x-rays, as necessary.

2. Communicating effectively with Emergency Medical Service (EMS) personnel in the pre-hospital setting during transportation of a patient with symptoms of acute stroke.

3. A specific, well-organized system for promptly notifying and activating the acute stroke team to evaluate patients presenting with symptoms of acute stroke.

Additionally, each ED and SEF that provides acute stroke ready services but does not have a primary stroke service or endovascular stroke service

designation must have **a coordinating stroke care agreement** with a hospital with this designation within their service area. The coordinating stroke care agreement may include the provision of telestroke services and must include transfer and communication protocols.

Designation of primary stroke service or endovascular capable stroke service (105 CMR130.1404 through 1405)

EDs may additionally seek designation as a primary stroke service or endovascular capable stroke service, which requires certification from a nationally recognized accrediting body. After initial designation by DPH, hospitals must maintain a current letter of certification from their accrediting body and re-apply for the primary stroke service or endovascular capable stroke service designation with each renewal of their DPH hospital license.

Time targets (105 CMR 130.1403(A))

The guidance also provides a chart specifying and delineating the appropriate stroke service time targets for patient care for each type of service. Time targets include door to provider (≤ 10 minutes), door to CT (≤ 25 minutes), and door to IV thrombolytic (at least 85% of patients in ≤ 60 minutes, at least 75% of patients in ≤ 45 minutes).

Quality improvement and reporting to DPH (105 CMR 130.1406)

In addition to implementing and maintaining an effective, data-driven quality assessment and performance improvement program for the hospital's stroke service, the guidance also provides DPH's expectations for reporting stroke data. Each hospital must submit its stroke data within two months of a patient's discharge. For example, patients discharged from May 1 to May 31 must be reported to DPH by July 31. Patients with a final diagnosis of ischemic stroke, transient ischemic attack (TIA), subarachnoid hemorrhage, intracerebral hemorrhage, and stroke not otherwise specified must be included with some exclusions, such as patients under 18.

Continuing education of healthcare professionals (105 CMR 130.1407)

Hospitals must provide ED and EMS system personnel at least **one hour per year** of education that addresses acute stroke prevention, diagnosis, and treatment needs of physicians, nurses, allied health professionals, and EMS personnel. Education can be provided in the manner most appropriate for the audience, including speakers, audio, or video conferences (live or recorded, by the hospital or purchased from the National Institute of Health Stroke Scale); certification/recertification training; and simulation lab training. All training activities must be properly documented to be compliant with the requirement.

Community education (105 CMR 130.1408)

Hospitals must provide ongoing community education on stroke prevention, recognition of stroke symptoms, and the treatment of stroke. Acceptable methods include newsletters, newspapers, radio or television segments, printed materials at community health fairs, and speaker forums/series. Hospitals must be able to demonstrate compliance with the community education requirements by maintaining logs of distribution for flyers or brochures, attendance sheets, copies of educational materials, and documentation of dates, presenters, and summaries of live events.

Attestation due September 30, 2025

Ahead of the regulation's effective date, each ED and SEF must report to DPH regarding (1) its readiness as an acute stroke ready service, or (2) provide an update on its progress toward certification for stroke care through a nationally recognized accreditation entity, **no later than September 30, 2025**.

EDs and SEFs should review their current protocols, identify any gaps with the new regulations, and update their policies and written protocols to ensure compliance with the upcoming regulations. Any changes to your hospital or SEF's systems must be communicated to all staff and impacted teams in advance of such changes.

Contact us

For questions about the stroke care regulations or to discuss how these changes may impact you, contact Crystal Bloom, Rebecca Rodman, Kasey Ciolfi, another member of our Massachusetts-based Healthcare team, or your local Husch Blackwell attorney.