RI Stroke System Development Through Policy:

The Stroke Prevention and Treatment Act of 2009 (RIGL 23-78.1)

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Purpose

The current fragmented approach to stroke care in Rhode Island provides inadequate linkages and coordination among the fundamental components of the stroke system. Policy change at the state level may help reduce the devastating effects of stroke by creating a coordinated system to improve patient care.

Objective

To secure passage of legislation that establishes an inclusive and coordinated stroke system of care in Rhode Island.

Legislation

2009 -- H 5798 SUBSTITUTE A AS AMENDED

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2009

AN ACT

RELATING TO HEALTH AND SAFETY -- STROKE PREVENTION ACT OF 2009

Introduced By: Representatives Naughton, McNamara, Winson, and Ist Rice

Date Introduced: February 26, 2009

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

SECTION 1. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby amended by adding thereto the following chapter:

CHAPTER 78.1

STROKE PREVENTION AND TREATMENT ACT OF 2009

23-78.1-1. Short title. -- This chapter shall be known and may be cited as the "Stroke Prevention and Treatment Act of 2009."

23-78.1-2. Legislative findings. -- It is hereby found and declared as follows:

(1) The most disabilities, frequent, and payment of stroke can save the lives of stroke victims and in some cases can reverse neurological damage such as paralysis and speech impairments, leaving stroke victims with few or no neurological deficits.

(2) Despite significant advances in diagnosis, treatment and prevention, stroke is the 4th leading cause of death and a leading cause of disability; an estimated seven hundred and thousand (700,000) new and recurrent stroke occur each year in this country; and with the aging of the population, the number of persons who have strokes is projected to increase.

(3) This year in Rhode Island, more than three thousand (3,000) people will risk various catastrophic incidents and more than one hundred (800) Rhode Islanders will die from stroke-related complications. This tragic loss of life and variable course in general during hospitals for the care of new those hundred twelve million dollars ($112,000,000) in medical expenses, care, and lost productivity.

(4) Although new treatments are available to improve the clinical outcomes of the cause acute care hospitals must lack the necessary staff and equipment to optimally treat eligible stroke patients, including the provision of national, safe and effective assessment care for patients.

(5) An effective system to support stroke survival is needed in our communities in order to treat stroke patients in a timely manner and to improve the overall treatment of stroke systems in order to increase survival and decrease the disabilities associated with stroke. There is a health need for acute care hospitals in this area to establish primary stroke centers to ensure rapid tissue diagnostic evaluation and treatment of patients suffering an acute stroke.

(6) Primary stroke centers should be established for the treatment of acute stroke. No stroke center should be established in an acute care care hospitals as possible. There are would evaluate, stabilize and provide assessment and in certain cases to patients with acute stroke and

(7) That it is in the best interest of the residents of this state to establish a proper facilities development of stroke treatment capabilities throughout the state. This program provides specific patient care and support services ensure that stroke centers meet/exceed to set ensure that stroke patients receive safe and effective care. It is also in the best interest people of this state to modify the state's emergency medical response system to ensure that stroke victims now be rapidly identified and transported to and treated in facilities that possesses programs for providing timely and effective treatment for stroke victims.

(8) For the purposes of non-hospital trauma and tissue classification, an "acute stroke defined as new non-recurrent focal neurological deficit determined to be less than six (6) days have not been noticed.

23-78.1-3. Designation of Rhode Island primary stroke centers. -- (a) The director of the department of health shall establish a process to recognize primary stroke centers in Rhode Island. A hospital shall be designated as a "Rhode Island primary stroke center" if it has met a certificate of distinction for primary stroke center issued by the joint commission or accreditation of healthcare organizations (joint commission).

(b) The department of health shall recognize as many hospitals as Rhode Island primary stroke centers as qualify and are awarded certification by the joint commission or other nationally recognized certification body if a formal process is developed in the future.

(c) The director of the department of health may suspend or revoke a hospital's designation as a Rhode Island primary stroke center, after notice and hearing, if the director or health determines that the hospital is not in compliance with the requirements of this chapter.

23-78.1-4. Acute care hospitals. -- (a) All acute care hospitals shall maintain readiness to treat stroke patients. This shall include:

(1) Adherence with American Heart Association/American Stroke Association guidelines;

(2) Establishment of written care protocols for the treatment of ischemic and hemorrhagic stroke patients, including transfer of acute stroke patients to a primary stroke center as appropriate and medically indicated;

(3) Participation in Get With The Guidelines-Stroke to collect nationally recognized stroke outcomes and ensure continuous quality improvement;

(4) Participation in the Rhode Island Stroke Task Force and the Stroke Coordinators Network to provide oversight for the stroke system of care and to share best practices.

23-78.1-5. Emergency medical services providers; triage and transportation of stroke patients. -- (a) The department of health, division of EMS and the ambulance service advisory board shall adopt and distribute a nationally recognized evidence-based assessment tool for stroke. The division of EMS shall post this stroke assessment tool on its website and provide a copy of the assessment tool to each licensed emergency medical services provider no later than January 1, 2010. Each licensed emergency medical services provider must use the stroke triage assessment tool provided by the department of health, division of EMS.

(b) The department of health, division of EMS and the ambulance service advisory board shall establish pre-hospital care protocols related to the assessment, treatment, and transport of stroke patients by licensed emergency medical services providers in this state. Such protocols must include plans for the triage and transport of acute stroke patients to the closest primary stroke center as appropriate and within a specified timeframe of onset of symptoms.

(c) By June 1 of each year, the department of health, division of emergency medical services (EMS), shall send the list of primary stroke centers to each licensed emergency medical services agency in this state and shall post a list of primary stroke centers on the division of EMS website. For the purposes of this chapter, the division of EMS may include primary stroke centers in Massachusetts and Connecticut that are certified by the joint commission, or any otherwise designated by that state's department of public health or meeting the criteria for primary stroke centers as established by the Texas stroke institute.

(d) Each emergency medical services provider must comply with all sections of this chapter by June 1, 2010.

23-78.1-6. Continuous improvement of quality of care for individuals with stroke. -- (a) The department of health shall establish and implement a plan for achieving continuous quality improvement in the realm of care provided under the statewide system for stroke response and treatment. In implementing this plan, the department of health shall undertake the following activities:

(1) Develop measurable and provide assistance for sharing information and data among health care providers on ways to improve the quality of care;

(2) Facilitate the communication and analysis of health information and data among the health care professionals providing care for individuals with stroke;

(3) Promote the application of evidence-based treatment guidelines regarding the transitioning of patients to community-based follow-up care in hospital orientated, discussion, offline and multivariate clinic settings for ensuring care after hospital discharge following acute treatment for a stroke;

(4) Ensure primary stroke center hospitals and emergency medical service agencies to report data concerned with nationally recognized guidelines on the treatment of individuals with confirmed stroke within the statewide system for stroke response and treatment;

(5) Ensuring data generated by the statewide system on stroke response and treatment and

(6) The department of health shall maintain a statewide stroke database that compiles information and statistics on stroke care that aligns with the stroke consensus metrics developed and approved by the American Heart Association/American Stroke Association, Centers for Disease Control and Prevention and The Joint Commission. The department of health shall utilize Get With The Guidelines-Stroke as the stroke registry data platform or another nationally recognized data platform with confidentiality standards no less secure. To avoid unnecessary duplication, the department of health shall coordinate with national volunteer health organizations involved in stroke quality improvement to avoid duplication and redundancy.

(b) Except to the extent necessary to address continuity of care issues, health care information shall not be provided in a format that contains individually identifiable information about a patient. The sharing of health care information containing individually identifiable information about patients shall be limited to that information necessary to address continuity of care issues, and shall otherwise be released in accordance with chapter 37-3 of title 5 and subject to the confidentiality provisions required by that chapter and by other relevant state and federal law.

(c) Annual reports. On June 1 after enactment of this chapter and annually thereafter, the department of health and the Rhode Island stroke task force shall report to the general assembly on statewide systems toward improved care quality of care and patient outcomes under the statewide system for stroke response and treatment.

SECTION 2. This act shall take effect upon passage.

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Conclusion

The Stroke Prevention and Treatment Act of 2009 aims to address existing deficiencies and vastly improve the components of the stroke system of care in Rhode Island. Future data analysis will determine if the new law increases adherence to evidence-based guidelines and improves patient outcomes in the state.

Design

In Fall 2008, the Rhode Island Stroke Task Force determined that legislation would be needed to move its recommendations forward. The American Stroke Association, Department of Health, Stroke Task Force and legislative champions worked together to craft and promote the Stroke Prevention and Treatment Act of 2009. The legislation – based on AHA/ASA science and guidelines – reflected years of collaboration around the table with this core group of partners.

Stroke Prevention and Treatment Act Timeline

January 2006 Stroke Task Force convenes for first meeting under leadership of Doug DeOrchis, MD

June 2004 House and Senate pass legislation (H. 8192Aaa, S. 2905A) establishing RI Stroke Task Force

January-April 2008 Stroke Task Force members draft report and recommendations

January 2006 - December 2007 Stroke Task Force reviews national policy guidance, scientific statements and data. Conducts survey of hospitals and analyzes findings.

June 2008 Report endorsed by Department of Health and submitted to General Assembly

April 2008 Task Force completes report to General Assembly

November 2008 STF and ASA representatives meet with senior leadership at Department of Health to discuss next steps toward improving the stroke system of care in RI

September 2008 Department of Health appoints new Stroke Task Force (STF) chairman Peter Panagos, MD, to oversee implementation of recommendations

January 2009 STF convenes under Dr. Peter Panagos' leadership and elects to pursue legislation during 2009 Legislative Session

December 2008 STF and ASA submit Petition for Rulemaking to Department of Health for Primary Stroke Center designation. Petition not accepted for current rulemaking period and held for further review

February 26, 2009 Stroke Prevention and Treatment Act of 2009 (H. 5798Aaa, S. 752A) introduced in House and Senate

February 2009 Legislation drafted and sponsors recruited in House and Senate. Copy of draft legislation shared with Hospital Association of RI for review.

March 25, 2009 Hearing before the House Health, Education and Welfare Committee

February 2009-July 2009 ASA activates You're the Cure grassroots network to contact legislators and Governor to build support for the Stroke Prevention and Treatment Act of 2009

April 30, 2009—House Health, Education and Welfare Committee recommends passage

May 4-June 24, 2009 STF and ASA work with Hospital Association to achieve a consensus on final bill text and provisions

May 26, 2009 House passes bill

May 27, 2009 Hearing before the Senate Health and Human Services Committee

June 23, 2009 STF, ASA and Rep. Naughton host roundtable discussion at State House to discuss strategy for Senate passage

June 24, 2009 Senate Health and Human Services Committee recommends passage

June 25, 2009 Senate passes bill

July 8, 2009 Legislation transmitted to Governor's Office

July 9, 2009 Stroke Prevention and Treatment Act of 2009 signed into law by Governor Donald Carcieri