AMMENDED MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

STROKE SYSTEM EXECUTIVE COMMITTEE

November 5, 2008 – 10:00 A.M.

MEMBERS PRESENT

David Slattery, M.D., Chairman
Rory Chetelat, EMSTS Manager
Chad Henry, EMT-P, MWA
Christopher Roller, American Heart Assoc.
William Wagnon, MountainView Hospital
Allen Marino, M.D., MAB Chairman
Derek Cox, EMT-P, LVF&R
Scott Selco, M.D., Sunrise Hospital
Anna Smith, R.N., Valley Hospital

MEMBERS ABSENT

Bobbette Bond, Health Services Coalition

SNHD STAFF PRESENT

Mary Ellen Britt, Regional Trauma Coordinator
Trish Beckwith, EMS Field Rep.
Lan Lam, Administrative Assistant
John Hammond, EMS Field Rep.
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

John Higley, EMT-P, MF&R
Jarrod Johnson, M.D., MF&R
Kevin Dickerson, AMR/CSN
Davette Shea, Desert Springs Hospital
James Holtz, RN, Valley Hospital
Ourida Dirtavism St. Rose Siena
Darin Bagg, CSN
Carol Butler, Centennial Hills Hospital
Chief Randy Howell, HFD
Ian Smith, EMT-P, NLVFD
Carol McLeod, Spring Valley Hospital
Chief Bruce Evans, NLVFD
Brian Rogers, EMT-P, HFD
Amy Bochenek, Centennial Hills Hospital
Chief Mike Myers, LVF&R
Mary Ann Dube, St. Rose Siena
Patricia Hatcher, RN, Spring Valley Hospital
Fred Neujahr, RN, Sunrise Hospital
Jackie Levy, University Medical Center
Kathy Silver, UMC
Fab Guillen, NLVFD/CSN
Kim Voss, UMC
Brian Brannman, UMC
Sandy Young, LVF&R
Amelia Hoban, Sunrise Hospital
Tami Vogel, Spring Valley Hospital
Stephen Massa, CSN
Ron Tucker, EMT-P, MWA
Troy Tuke, EMT-P, CCFD

I. CONSENT AGENDA

The Stroke System Executive Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, November 5, 2008. Chairman Slattery called the meeting to order at 10:08 a.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Slattery noted that a quorum was present.

Minutes Stroke System Development Steering Committee Meeting August 6, 2008.

Dr. Slattery asked for a motion to approve the minutes of the August 6, 2008 Stroke System Development Steering Committee meeting. It was noted that Scott Selco, M.D. was in attendance for this meeting and his name needs to be added to the minutes. A motion to accept the minutes with this revision was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

Dr. Slattery opened the meeting by asking all members in attendance to introduce themselves since this was the first executive committee meeting. After introductions, Dr. Slattery thanked everyone for their time and effort in developing a stroke system. He asked that each task force update the committee on the objectives they were given and what was accomplished.

A. Preliminary Progress Report from EMS Quality Assurance/Performance Task Force – Chad Henry/Anna Smith

Objective 2A: Determine the quality measures and measurement tool that will be used for assessing initial and continuous EMS receiving hospital designation

Ms. Smith related that the group has met three times. They felt it was important to establish a standard of expectation prior to moving forward. The group decided that the primary criterion would be certification as a primary stroke center so there is one standard for data to be collected.

Objective 2B: Determine performance and quality measures and measurement tool that will be used to assess prehospital stroke care, decision-making, and protocol compliance

Objective 2B was tabled until after the development of an EMS protocol to enable them to determine which data points need to be collected.

Objective 2C: Determine triggers and process for performing peer review for EMS providers

Ms. Smith stated that there was much discussion about what was important from both an EMS and hospital perspective. Once certain criteria have been established then the data collection points can be shaped to match the criteria outlined in the protocol. Mr. Henry added that it is important to establish a baseline with regard to stroke care in the field. What was decided was to work with the transport agencies in Clark County to evaluate data from 3rd quarter 2008. With the help of Sunrise and Valley Hospitals, they will match pre-hospital transport records where patients have been identified as potential stroke patients or TIA patients with the hospital data and specifically look at scene times, the accuracy of field triage, and also those patients that were brought into the emergency room who were not triaged as potential stroke or TIA patients. At the next meeting they hope to have some of that data to present to this committee for their review. Mr. Henry summed up the discussion by saying they will continue that endeavor with data collection to establish not only a baseline, but also ongoing education.

Objective 2D: Determine process and triggers for performing peer review for stroke receiving hospitals

Ms. Smith commented that certification as a primary stroke center was the trigger to determine what the hospitals are doing.

Objective 2E: Working with the Southern Nevada Health District's Office of EMS & Trauma System to provide a proposed budget to the Executive Committee for stroke system data collection, clerical and statistical support, and quality assurance and oversight activities

This item was tabled.

Dr. Slattery agreed that there needs to be protocol compliance but felt that they still need to look at the big picture to determine outcome measures for a stroke system by determining what triggers a bad outcome for a stroke patient both from a prehospital and hospital standpoint. He added that he would be happy to attend the next task force meeting to help facilitate that discussion.

Mr. Wagnon asked about the process of maintaining peer review and the appropriate sharing of data. Mr. Chetelat stated that the Health District has peer review protection that is applied generically to any peer review quality assurance done in a committee formed under the District Board of Health. Dr. Slattery stated that the peer review process is the stimulus to look at the triggers for EMS and the facilities to review the stroke system under a protected environment.

B. Preliminary Progress Report from Stroke System Hospital Task Force – Will Wagnon

Objective 3A: Invite all hospitals in Southern Nevada to participate in the assessment process

Mr. Wagnon reported that a meeting notice was sent out to all the facilities. He noted that they met prior to this meeting, and that there was representation from a majority of the facilities.

Objective 3B: Assess each of the hospitals in Southern Nevada regarding their readiness for stroke care management

Mr. Wagnon stated that assessment forms were sent out to all the facilities to complete and send back to Amy Hoban with a due date of November 7th. He thanked Ms. Hoban for sending those assessments out and asked all facilities who haven't done so yet to please complete and submit them so that this objective can be completed and be reported on at the next meeting with a proposed timeline.

Objective 3C: Make recommendations to the Executive Committee regarding criteria of the above listed hospital resources, facility commitment, and any additional requirements determined by the task force to be eligible for designation as a Stroke Receiving Hospital for the EMS System in Southern Nevada

Mr. Wagnon reported that there was considerable discussion regarding the eligibility for designation as a stroke receiving hospital. The consensus was unanimous to use The Joint Commission certification as the minimum standard.

Objective 3D: Design process for keeping information obtained from 3B current for continuous system decision-making

Mr. Wagnon noted that by using The Joint Commission certification as the bar to participate, a lot of prescribed quality assurance will occur in that process. He felt that they need more dialog with the QA task force.

Mr. Wagnon stated that the question came up whether NRS legislation is needed to mandate destination protocols. Mr. Chetelat stated that the Health District has been given the authority to make those decisions at the local level for Clark County. If there was legislation in place by introducing a stroke bill it might make it easier to avoid roadblocks. Mr. Wagnon stated his preference would be to avoid the legislative route.

Mr. Roller questioned whether objective 2E would fall under a statewide stroke registry or is this something needed specifically for Southern Nevada in terms of data collection. Mr. Chetelat felt that there would be two levels; to establish a stroke registry, and for the Health District to run the ongoing system which would include QA and review of the registry. Mr. Wagnon questioned the redundancy of participating in the formal process to maintain certification and the QA process with the Health District. Dr. Slattery stated that the vision of the Health Districts involvement is more of a system approach, reporting QA measures in a closed fashion and not getting involved in certifying hospitals. Dr. Selco felt that the process for the QA at the local level as it concerns this committee is totally separate than the impetus for a state stroke registry as envisioned by the ASA.

C. Preliminary Progress Report from Stroke System EMS Protocol and Education Development Task Force – Derek Cox

Mr. Cox reported that his group met on August 26th. He noted that the representation was good. They reviewed the objectives and decided to split up into two separate workgroups. One workgroup assessed

the dispatch portion of the objectives and the other assessed the objectives for educational needs and stroke treatment protocols.

Objective 1A: Assess current dispatch center(s) management of stroke

- *Current protocol*
- *Educational deficiencies*
- *Pre-arrival instructions*
- *Outcome measurements*

Mr. Cox stated that Steve Herrin from the Fire Alarm Office coordinated the dispatch workgroup which met on September 26th and their first discussion was the ProQA protocol. ProQA is an Emergency Medical Dispatcher (EMD) computer software package based on the Medical Priority Dispatch System (MPDS) protocols utilizing expert system logic and quality assurance data collection. The dispatch determinant code for stroke is Card 28. When a 911 caller calls in and says that they are having symptoms of a stroke, the dispatcher refers to Card 28. There was some discussion about Card 28 actually being an alpha response, which is a non lights & sirens response in the system. Mr. Cox then explained the response time differences between an Alpha call and a Charlie or Delta call that do respond with lights & sirens. The workgroup made a recommendation to strike that dispatch use any type of non lights & sirens response (Alpha) for a possible stroke. Mr. Cox stated that an EMD is a nationally recognized certification that must attend continuing education every couple of years to maintain certification but noted this didn't include education in the area of stroke. It was recommended that in the future there be some type of stipulation that they have an hour of continuing education on stroke signs and symptoms. There are no pre-arrival instructions for strokes but there are some post dispatch instructions which are very similar to other injuries and medical emergencies so these will not change. After some discussion with the QA Chairperson, it was recommended that outcome measures for assessing dispatch be evaluated quarterly, or at minimum, annually for continuous quality improvement.

Objective 1B: Develop recommendations (based on that assessment) for improving the management of potential stroke victims during the time period from 911 call to EMS arrival.

Mr. Cox stated that after reviewing the literature there wasn't much recommended for improving management of potential stroke victims during the time period from the 911 call to EMS arrival. The post dispatch instructions would probably just stay the same.

Dr. Selco asked if the current prehospital notification for bringing in a stroke patient is adequate or needs improvement. Mr. Cox noted that Brian Rogers would address that issue in his report.

Objective 1C: Determine educational needs of EMS providers in Southern Nevada in terms of

- *Identification of acute stroke*
- *Performance of appropriate history, exam, diagnostic tests and documentation as it is related to prehospital stroke care*

Objective 1D: Determine which stroke scale will be used by all EMS providers in Southern Nevada

Objective 1E: Draft prehospital stroke care management protocol (to exclude destination criteria)

Brian Rogers stated the protocol and education group met on September 17th. The first decision made was to recommend that all EMS providers utilize the Cincinnati Stroke Scale. They felt it was a little more inclusionary and easier to follow. Mr. Rogers stated that they have a working draft of a protocol and commented that there wasn't a lot for EMS to do except recognition, standard treatment and alert the hospital, which is the most important aspect. Mr. Rogers related that the QA task force made the decision that part of the educational piece will be based on the QA recommendations. He stated the workgroup plans to meet again within the next week or so to review the draft protocol to determine what the educational needs are within the community as it applies to EMS.

Dr. Selco stated that utilizing the Cincinnati Stroke Scale will bring more people in that are not experiencing a stroke, but as the field personnel utilizes the Cincinnati Stroke Scale regularly we should improve as long as the system is not burdened by the few additional transports. Mr. Rogers stated that both stroke centers agreed that they would much rather see an over triage of patients then an under triage.

Mr. Cox added that in the treatment protocol we can outline what the medics should be documenting in their report and also standardize some type of notification for the facilities that are receiving the patients. Dr. Selco expressed that the do's and don'ts of what should happen in the field should be included in any final recommendations of how paramedics respond on scene to stroke calls. He added that if possible he would like the medics to obtain contact information for a relative or proxy decision maker.

In response to a question on whether the prehospital notification is adequate, he stated that when a Code 100 is called, there is a response when the unit arrives. Mr. Cox wants to review the current process and work with the representatives from the hospitals to find out what is needed and draft a procedure to standardize the terminology with the hospitals. Dr. Slattery stated that having one consistent message from EMS to any receiving hospital is important, but to keep in mind the destination criteria of getting a stroke victim to a stroke center from EMS is a separate issue than what happens internally inside the four walls of a facility. He asked Mr. Cox to work with the facilities task force to come up with a universal code and a procedure that delineates the information that needs to be given in telemetry.

III. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Dr. Slattery reminded the committee that the next meeting is scheduled for Wednesday, January 7, 2009.

Dr. Selco stated that he would like the committee to enlist the services of the American Stroke Association through collaboration with the Health District and the National Stroke Association, whose efforts have been more towards education, and to focus on educating the citizens of Southern Nevada on stroke symptoms. Dr. Slattery felt that was an excellent idea since public education in the community is what the Health District does best and it would be a very important community educational message. Mr. Chetelat recommended that we continue to keep the Office of Chronic Disease Prevention & Health Promotion involved.

IV. PUBLIC COMMENT

None

V. ADJOURNMENT

As there was no further business, Dr. Slattery called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 11:05 a.m.