



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

STROKE SYSTEM EXECUTIVE COMMITTEE

June 3, 2009 – 9:00 A.M.

MEMBERS PRESENT

David Slattery, MD, Chairman
Christopher Roller, American Heart Assoc.
William Wagon, MountainView Hospital

Richard Henderson, MD, (Alt)
Derek Cox, EMT-P, LVF&R
Anna Smith, RN, Valley Hospital

MEMBERS ABSENT

Allen Marino, MD, MAB Chairman
Scott Selco, MD, Sunrise Hospital

Chad Henry, EMT-P, MWA
Bobbette Bond, Health Services Coalition

SNHD STAFF PRESENT

Joseph J. Heck, DO, Operational Medical Director
Mary Ellen Britt, Regional Trauma Coordinator
Judy Tabat, Administrative Assistant

Rory Chetelat, EMS Manager
Lan Lam, Recording Secretary

PUBLIC ATTENDANCE

Jackie Levy, University Medical Center
Chief Scott Vivier, HFD
Carol McLeod, Spring Valley Hospital
Bernadette Olah, RN, St. Rose de Lima
Eric Anderson, MD, FES
Murray Flaster, MD, UMC
John Henner, MountainView Hospital

Kim Voss, UMC
Amelia Hoban, Sunrise Hospital
Sue Hoppler, Desert Springs Hospital
Billie Meador, Desert Springs Hospital
Mary Ann Dube, St. Rose Siena
Virginia Rosini, UMC
Susan Prey, Genentech

I. CONSENT AGENDA

The Stroke System Executive Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, June 3, 2009. Chairman Slattery called the meeting to order at 9:09 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 Executive Committee Meeting February 4, 2009.

Dr. Slattery asked for a motion to approve the minutes of the February 4, 2009 Stroke System Executive Committee meeting. A motion to accept the minutes was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

Dr. Slattery asked each Taskforce to update the Committee on their objectives and what they were able to accomplish:

A. Progress Report from Stroke System EMS Protocol and Education Development Taskforce – Derek Cox

This item was not discussed.

B. Progress Report from EMS Quality Assurance/Performance Taskforce – 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

Anna Smith reported that the primary criteria would be certification as a Primary Stroke Center by the Joint Commission (JC). The measurement tool used will be the measures outlined by JC.

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

Ms. Smith stated once the prehospital stroke care management protocol is approved, they will follow that protocol, use that to gauge the care provided and adjust the standards to that protocol.

Dr. Slattery stated he would like this taskforce to consider which patients, charts, and patient care records the QA Directors and agencies should be applying this tool towards. Another point to consider is the inclusion criteria for meeting the review. Ms. Smith replied that the tool should apply towards the critical patients whom either suffered a hemorrhagic or ischemic stroke. She agreed to review the suggestions and return with a formalized proposal.

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

Important Data Collection Points – EMS

1. Was the Cincinnati stroke scale completed?
2. Were mimics identified? (Blood sugar, postictal, etc.)
3. Was a time identified when stroke symptoms started?
4. Was telemetry radioed to receiving hospital?
5. Were arrival, scene, departure and hospital times documented?
6. Were protocol variations documented?
7. Was the patient taken to the appropriate facility?

Dr. Slattery asked the taskforce to provide a data dictionary of the above elements for the purpose of consistency. He'd like the data collection points to show "yes" it was met, or "no" it was not to reduce the chances of confusion.

Dr. Heck questioned if Ms. Smith had a benchmark for timeframes. For example, when responding should the Cincinnati Stroke Scale be completed within so many minutes of arrival. Ms. Smith stated that according to the May 2009 guidelines, the American Stroke Association recommends using the trauma model of load and go; a time is not given, but the trauma timeframe is 10-20 minutes. Dr. Heck believes the timeframe should be definitive to be able to look at triggers. Ms. Smith stated a time to consider is 15 minutes but she would defer this decision to the Medical Advisory Board (MAB).

Will Wagon felt the most important point to consider would be #3 which states, "Was a time identified when stroke symptoms started?" Ms. Smith agreed with Mr. Wagon that the care of a patient is based on the onset of symptoms but stated that although time is indicative of care, it isn't where you transport the patient. Dr. Flaster proposed getting contact information when dealing with an acute patient. If a patient is unable to communicate, the emergency department has a contact to get the patient's medical history. Amy Hoban stated this issue was discussed and definitely included in EMS education but did not

believe it was included in protocol. Dr. Flaster noted that the information is important and should be included in the protocol.

Mr. Wagon felt it would be worthwhile to find out how many confirmed strokes the system is getting outside the window to see if something could have been done differently in the future to capture those patients. Ms. Smith stated JC recommends performing all workups on patients coming in within 45 minutes regardless of whether they are within the 3 hour window or not. Ms. Smith felt this data would be easily accessible as it is the basic data collected at the hospitals.

Mr. Chetelat stated an important component to consider when establishing this system is prevention and education. It would be helpful to know how many stroke patients are not getting to the hospital in time. The Chronic Disease Prevention & Health Promotion office at SNHD would be able to assist in getting the message out to the community. Dr. Flaster concurs that finding the number of patients who are not getting to the hospital in time would be helpful, but he believes it would be difficult to find.

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

Important Data Collection Points – Hospital

1. Percentage of patients that arrive by EMS.
2. Percentage of patients that telemetry received.
3. Code 100 activation percentage vs. EMS perceived Code 100.
4. Number/percentage of patients who receives tPA.
5. Accuracy in identification of stroke percentage. Based on D/C ICD-9 code (compared to initial EMS interpretation).
6. Mortality/discharge percentages.

Dr. Slattery advised with the utilization of EMS system, there are different methods of notification to the hospitals other than telemetry. Ms. Smith stated that notification does not need to be done via telemetry; any notification would be helpful. Dr. Slattery stated the method of notification would depend on what's written in the protocol.

The ICD-9 codes will offer answers as to whether mimics of stroke are being ruled out. Ms. Smith believes mortality and discharge percentages would be imperative to know as this will show if the system is improving. Dr. Slattery questioned whether mortality rate is a good indicator. Ms. Smith stated that although mortality rate is not a good indicator, it goes hand in hand with discharge rate. In stroke, discharge locations such as home, home with healthcare or inpatient rehab are viewed as being positive outcomes; therefore, mortality and discharge would be good indicators together. Dr. Slattery related that intracranial bleeding and the percentage of patients that receive tPA who bleed would be important indicators to consider. After much discussion, Ms. Smith stated that she would replace mortality with symptomatic intracranial hemorrhage.

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

Ms. Smith stated that she would require input from the Office of EMS & Trauma System (OEMSTS) in order to complete this objective. Dr. Slattery questioned the process in trauma. Rory Chetelat advised that the state once collected large fees from the trauma centers but they've recently cut down on those fees and the OEMSTS has not proceeded with reallocating those fees. There is no anticipation for these fees covering all costs at the OEMSTS so he would be glad to assist in coming up with a reasonable number.

Ms. Smith presented data that was collected from November 1 through December 31, 2008 from Spring Valley, Sunrise and Valley Hospitals. She noted 8 of the 10 measures that are collected are core measures.

Total of 168 patients

- Spring Valley Hospital: 10
- Sunrise Hospital: 74
- Valley Hospital: 84

The Cincinnati Stroke Scale was utilized 94% of the time and mimics were evaluated 100% of the time. Ms. Smith reported that due to time and financial restraints, individual chart evaluation to determine symptom onset is not being performed at this time; nor is tracking of telemetry. Total scene times are 40 minutes average including dispatch, arrival, scene, departure and arrival at hospital. There are no protocol deviations until the protocol is approved and utilized. There are also no hospital destinations.

Patients arriving by EMS

- Spring Valley Hospital: 58%
- Sunrise Hospital: 83%
- Valley Hospital: 86%

Telemetry received

- Spring Valley Hospital: 30%
- Sunrise: not collecting this data
- Valley Hospital: 49%

Code 100 activation vs. EMS perception

- Spring Valley Hospital: 93%
- Sunrise Hospital: not collecting this data
- Valley Hospital: not collecting this data

of patients that received tPA

- Spring Valley Hospital: 1
- Sunrise Hospital: 12
- Valley Hospital: 6

EMS vs. Hospital accuracy

- None of the hospitals are collecting this data at this time.

Mortality/Discharge

- Spring Valley Hospital: 2 deaths, 57 positive discharges
- Sunrise Hospital: 13% mortality, 73% positive discharges
- Valley Hospital: 7.5% mortality, 78% positive discharges

Ms. Smith added that once the protocol is approved and the data elements are fine tuned, the data will be presented quarterly at the QA Directors meeting.

C. Progress Report from Stroke System Hospital Taskforce – Will Wagnon

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

Mr. Wagnon reported that all invited hospitals participated in the assessment process.

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

Ms. Hoban provided a list of hospitals along with their capabilities. Dr. Slattery thought this provided a lot of great information and expressed a desire to keep this list updated either on a semiannual or annual basis as more hospitals become certified in stroke management.

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 Taskforce to be eligible for designation as a Stroke Receiving Hospital for the EMS System in Southern Nevada

Mr. Wagon presented a document which outlined the final recommendation to the Executive Committee regarding the criteria for designation as a Stroke Receiving Hospital for EMS. It states:

“All patients experiencing stroke symptoms within Clark County should be transported to the nearest JC certified primary stroke center. These centers must provide the Clark County Health District with a current copy of their JC certification. For patients experiencing stroke symptoms outside a 50 mile radius from a JC Stroke Center, the licensee providing emergency medical care shall call and consider transport to the nearest receiving facility. If the receiving facility is not certified as a stroke center they must have a transfer agreement in place with a stroke center of the highest possible JC certification.”

Mr. Wagon asked for a motion to accept the criteria as written. Dr. Heck questioned whether the word “shall” should be used in place of “should.” Ms. Hoban advised that this was mirrored with the trauma protocol. Dr. Henderson agreed with Dr. Heck stating the utilization of “should” will allow for medics to make a judgment call.

Dr. Flaster stated that he was under the impression that the criteria would include not only JC certified hospitals but also hospitals that are in the process of getting certified; he anticipates becoming certified by August. Mr. Wagon informed Dr. Flaster that a discussion took place with all hospitals and the consensus was to allow only JC certified hospitals to receive stroke patients. Once a hospital is certified, they would be added as a receiving facility. Dr. Heck added that this protocol will roll out along with the rest once revisions are completed. It is not expected to be completed until December or January.

Mr. Wagon rescinded his previous motion to approve the criteria as it was written and made another motion to approve the criteria with the change of the word “should” to “shall.” The motion was seconded, and approved unanimously.

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

Ms. Hoban provided a list of the ten JC data measures to review. Dr. Slattery deferred the discussion to their next meeting.

D. Discussion of Timelines for Finalizing of Objectives

Dr. Slattery stated he would like to wrap up this process and make final recommendations to the MAB. He asked the subcommittees if they felt they would be ready to do so by then. The Chairs of the subcommittees felt that they were far enough in the process to be able to wrap up and finalize their objectives. The goal of the group is to present their final recommendations to the MAB by August 2009.

III. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None

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 10:02 a.m.