MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

STROKE DESTINATION TASK FORCE

February 6, 2008--10:00 A.M.

SNHD STAFF PRESENT

Rory Chetelat, EMS Manager
Trish Beckwith, EMS Field Rep
Moana Hanawahine-Yamamoto, Administrative Assistant
Mary Ellen Britt, Regional Trauma Coordinator
John Hammond, EMS Field Rep
Lan Lam, Recording Secretary

PUBLIC ATTENDANCE

Allen Marino, M.D., MedicWest Ambulance
Robert Byrd, EMT-P, American Medical Response
Sandy Young, RN, Las Vegas Fire & Rescue
Brian Rogers, EMT-P, MedicWest Ambulance
Larry Johnson, EMT-P, MedicWest Ambulance
Ian Smith, EMT-P, North Las Vegas Fire Department
Joseph Melchiode, MountainView Hospital
Davette Shea, RN, Southern Hills Hospital
Chief Mike Myers, Las Vegas Fire & Rescue
Jennifer Poyer, RN, Desert Springs Hospital
Anna Smith, RN, Valley Hospital
Jennifer Wing, EMT-I, North Las Vegas Fire Department
Victor Montecerin, EMT-P, MedicWest Ambulance
Walt West, EMT-P, Boulder City Fire Department
David Peterson, Mesquite Fire & Rescue
Marla Kiff, Desert Springs Hospital
Gail Yedinak, University Medical Center
Virginia DeLeon, RN, St Rose de Lima Hospital
Richard Henderson, M.D., Henderson Fire Dept.
Syd Selitzky, EMT-P, Henderson Fire Dept.
Chris Jones, Valley Hospital
Melissa Ermenio, ZOLL Medical
Matt Leist, College of Southern Nevada
Tue Nguyen, American Heart Association
K. Alexander Malone, MD, North LV Fire Dept.
Bruce Evans, EMT-P, North Las Vegas Fire Department
Josiam Jensen
Jeff Davidson, M.D., Valley Hospital
Scott Selco, M.D., Sunrise Hospital
Jo Ellen Hannom, RN, Clark County Fire Dept
Troy Tuke, EMT-P, Clark County Fire Dept
Ron Tucker, EMT-P, MedicWest Ambulance
Bobbette Bond, Culinary Health Fund
Randy Howell, EMT-P, Henderson Fire Dept
Christian Young, M.D., Boulder City Fire Dept
Jarrod Johnson, D.O. Mesquite Fire & Rescue
Jarod Barto, EMT-I, American Medical Response
Kristin Stockbridge, EMT-I, MedicWest Ambulance
Sherri Allen, COO, Valley Hospital
Amanda Curran, EMT-P, MedicWest Ambulance
Mary Ann Dube, RN, St. Rose Siena Hospital
Patty Holden, Sunrise Hospital
Jason Meilleur, EMT-P, American Medical Response
Kathy Banusevich, MountainView Hospital
Carrie Krumtum, Desert Springs Hospital
E. P. Homansky, M.D., American Medical Response
Sam Scheller, EMT-I, MedicWest Ambulance
Rod Hackwith, EMT-P, MedicWest Ambulance
Matt Hall, ZOLL Medical
James Holtz, Valley Hospital
Christopher Roller, American Heart Association
Tim Crowley, EMT-P, Las Vegas Fire & Rescue
Ourida Diktakis, St. Rose Siena Hospital

I. ITEMS FOR DISCUSSION

Rory Chetelat called the meeting to order at 10:14 a.m.

A. Review of Findings From December 5, 2007 Stroke Destination Task Force Meeting

Dr. Henderson questioned whether having designated stroke centers gives the hospitals the advantage of charging the payers any amount they choose. He asked how it is currently being handled with trauma patients. Bobbette Bond stated that the Culinary Health Fund has contracts with all the hospitals within the city but her concern lies with what would happen if they didn't. She suggested that if a protocol was put in place to transport stroke patients to stroke centers then those hospitals should be required to accept a reasonable rate. Patty Holden replied to Dr. Henderson's question stating that trauma contracts state that the patient can be transferred to a contracted facility once the patient is stabilized. Ms. Holden suggested that another resolution would be for the insurance payers to approach facilities they already have contracts with to help build a program to become a stroke designated facility. Dr. Henderson stated that he would like for the hospitals to look at the accepted contract rate to see if it's a workable model so that the process for a stroke designation facility could move forward. Ms. Holden stated that she could work within their system and sit down to talk about it.

Mr. Myers stated that he is concerned with transfer of care as this is still an issue with regular patient flows. Dr. Henderson stated that he suggested that hospitals wanting to be a designated stroke center must be required to hit the 30 minute drop off time for all patients the majority of the time. Mr. Myers agreed and expressed a concern that there will be only two hospitals designated. Mr. Myers stated that as he understood, two hospitals were not successful in Santa Clara and they had to increase it to four hospitals. He didn't want to end up in the same situation. Dr. Selco clarified that Dr. Ghilarducci stated that Santa Clara began with two hospitals but there were two other hospitals that expressed an intention. Dr. Selco addressed Mr. Myers' concern regarding the two designated hospitals by stating that it would begin with two and then more would come online. Dr. Selco also expressed a concern with access to these services. He suggested telestroke as an option. This is when a remote rolling camera with a computer is rolled to the bedside of a patient in the ER to give the patient access to the specialist. Dr. Selco stated that this could accomplish access issues. Mr. Myers felt that telemedicine would be something worth looking into. Dr. Henderson stated that this would allow for more hospitals to come online but a protocol would still be required.

Dr. Henderson also mentioned that he does not see many patients that fall into the category of "acute deficit, last seen normal less than six hours;" so he believes the stroke designated hospitals would not be overwhelmed with increased patient flow. Dr. Henderson suggested researching the criteria where people reported to EMS as "last seen normal less than six hours" because those are the patients that will be re-directed to the stroke designated hospitals. Dr. Henderson suggested that a way to get a rough number is to look at Henderson Fire because they've been taking patients that meet the stroke criteria to Sunrise Hospital for the past few months. With this information you can obtain an extrapolation of the county's population.

Dr. Selco related that in 2006 Sunrise Hospital treated approximately 1,000 patients with stroke and stroke related ICD-9 discharge codes. Of those, 76 were treated with intravenous TPA. There were a few not treated because their symptoms were mild or they improved substantially by the time they arrived in the ER so he estimated that 100 of those 1,000 or 10% of patients brought to Sunrise were within the three to six hour window and potentially treatable. Dr. Selco pointed out that in the best places in the country, 2-4% of all stroke victims receive TPA. Ms. Bond surmised that a new problem would be created if only 76 people needed to be treated and 1,000 were transported to one particular hospital. Dr. Selco clarified that the number is not 76. Based on discharge data from 2000 and 2003 there were an estimated 6,300 total stroke and stroke related ICD-9 discharges in Clark County; 2-4% of 6,300 would be 120-250 acute stroke patients that could be going to any one of a number of hospitals. Dr. Selco stated that the disease is bad enough that patients would want to get

treated to avoid disability, lost productivity, and nursing home care. From an insurance point of view, treating with TPA will save money. Ms. Bond acknowledged what Dr. Selco was saying, but stated that it is still a lot of money. Anna Smith compared the stroke model with the trauma model. Ms. Smith pointed out that it isn't possible to look at stroke and say only patients who are going to get thrombolytic or interventional radiology are worthy of going to a stroke center; there isn't a way to extrapolate that data without missing a lot of patients. Ms. Smith stated that stroke centers have been proven nationally to improve patient outcome. Ms. Smith noted that Valley Hospital received 897 stroke DRG's. Ms. Smith pointed out that 76% of those patients had a positive discharge home, home health, or to rehab. Ms. Smith stated that stroke is not as easy to look at compared to trauma and STEMI because it's harder to distinguish a significant stroke; therefore, you've done the patient a service by sending them to the appropriate facility. Dr. Henderson agreed with Ms. Smith and stated that he did not believe a stroke designated facility should be debated as it is a national recommendation. The focus should be on insuring the receiving facilities continue to take care of other EMS patients.

B. Discussion of Criteria to Determine an Approved Stroke Specialty Care Hospital

Mr.Chetelat asked the group to identify the criteria they would like to have for the stroke specialty care hospital. Dr. Malone stated that since JCAHO (Joint Commission of Accreditation of Healthcare Organizations) is the gold standard, it would be a reasonable starting point. Dr. Selco agreed stating that he felt it was a reasonable level to start. Mr. Chetelat also agreed and stated that if a problem is recognized an alternative could then be employed. Dr. Henderson agreed that the criteria should begin with JCAHO but stated that if anyone had a program they'd like to have reviewed; it could be petitioned for entry.

Mr. Myers expressed concern regarding the two destination hospitals and stated that he is interested in any method that would get EMS closer to the goal of patient choice and closer facilities. Dr. Henderson stated that the destination protocol is a national recommendation; although it's not the most convenient to EMS, it is recommended as the best practice for EMS. Dr. Malone stated that one of the concerns should be standard of care for treatment although patient choice should be incorporated into the final decision. Dr. Davidson explained that interest in a destination protocol surfaced because resources in the community nationwide have become limited and he believes that centralizing certain resources makes sense.

Mr. Chetelat stated that the simplest way to implement the system would be using JCAHO's criteria with an opportunity for a hospital to step in with other possibilities through telemedicine which could be piloted. He suggested putting together small work groups to discuss other issues that have been identified.

C. Discussion of Data Collection to Determine Need and Impact of EMS Transport of Patients to Stroke Specialty Care Hospitals

Mr. Chetelat stated that the Office of Emergency Medical Services & Trauma System does not want to designate a stroke facility until a determination has been made of the resultant impact on the system. Mr. Chetelat suggested doing a prospective study of the actual patients that are going to need to be transported under the JCAHO criteria. Dr. Henderson suggested using Henderson Fire Department's data in lieu of a prospective study. He stated he would bring data from the last six months for review.

Dr. Selco asked if EMS gives Valley and Sunrise Hospitals preferential delivery of stroke patients because Valley is getting 900 patients and Sunrise is getting 1,000 patients. Brian Rogers replied that medics try to steer patients with their consent to one of the two facilities. Although there isn't a protocol in place, the medics know through the education available that Sunrise and Valley Hospitals may be designated facilities someday. Mr. Rogers stated that he does not know how many of those patients actually go to one of those facilities. Dr. Marino asked how many of those delivered were

activated. Dr. Selco stated that his guess would be 1,300-1,400. He added that 50% of the activations prove not to be a stroke. Davette Shea stated that 60% are truly Code 100 ischemic or intracranial hemorrhage patients at Southern Hills Hospital. Ms. Shea added that 89% of Code 100 patients come in by ambulance. Ms. Shea believes it's about 3 a day and doesn't impact a high acuity busy ER. Mr. Myers stated that it isn't the number of patients coming through the ER that's a concern; it's the amount of resources and time spent on that patient. Mr. Myers stated that he wants to properly inform the patient so they can make the right decision on where they want to go. Mr. Myers is concerned with transfer of care, whether or not the facilities could afford these extra patients that are going to take resources away from patients that are holding, and whether the hospitals will be able to meet the 30 minute rule 90% of the time.

Mr. Chetelat reiterated that Dr. Henderson will be providing data from Henderson Fire Department from the past six months so that it could be extrapolated to get an idea of what sort of impact the hospitals will be seeing. Mr. Chetelat asked that Dr. Henderson get that to him prior to the next MAB meeting. Mr. Chetelat recommended forming a workgroup of the payer's representatives and administrative level people to work on the financial impact, and a workgroup to work on the designation process. Items for discussion will be the application process for designation as a stroke center, limitations of choice and the 30 minute rule. Dr. Henderson stated that he believes it should be required for the facilities to meet the 30 minute rule 90% of the time. Dr. Marino stated that there also must be assurance that all patients are well taken care of.

D. Public Appearance/ Citizen Participation

None.

II. ADJOURNMENT

There being no further business, Rory Chetelat adjourned the meeting at 11:01 a.m.