CORRECTED MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

STROKE SYSTEM DEVELOPMENT STEERING COMMITTEE

June 17, 2008 -- 9:00 A.M.

SNHD STAFF PRESENT

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

PUBLIC ATTENDANCE

David Slattery, M.D., Chairman, Las Vegas Fire & Rescue
Victor Montecerin, EMT-P, MedicWest Ambulance
Anna Smith, R.N., Valley Hospital
Tami Vogel, Spring Valley Hospital
Amelia Hoban, Sunrise Hospital
Carol Butler, Centennial Hills Hospital
Brent Hall, EMT-P, Clark County Fire Dept
Chad Henry, EMT-P, MedicWest Ambulance
Hilary Crawford, University Medical Center
Eric Anderson, M.D., Fremont Emergency Services
Janae Stroner, BMS
Susan Prey, Genentech
Richard Henderson, M.D., St. Rose
Will Wagnon, CEO, Mountain View Hospital
Sandy Young, R.N., Las Vegas Fire & Rescue
Kim Voss, University Medical Center
Carrie Krumtum, Desert Springs Hospital
Don Hales, EMT-P, MedicWest Ambulance
Troy Tuke, EMT-P, Clark County Fire Dept
Ian Smith, EMT-P, North Las Vegas Fire Department
Jason Belland, American Heart Association
Ginny Rosini, University Medical Center
Sharon Dorris, BMS

CALL TO ORDER:

Dr. David Slattery called the meeting to order at 9:07 a.m.

I. CONSENT AGENDA:

There were no minutes to be approved.

II. ITEMS FOR DISCUSSION:

A. Discussion of Vision Statements

No discussion

B. Mission of Steering Committee

No discussion

C. Comparison of Stroke & Trauma Systems

Mary Ellen Britt gave an overview of the current trauma system in Southern Nevada and explained that it could be used as a model for the development of a stroke system as follows:

- ❖ Mission: To ensure a quality system of patient care for the victims of stroke within Clark County and its surrounding areas through recommendations related to the ongoing design, operation, evaluation and revision of the system from initial patient access to definitive patient care to reduce stroke morbidity and mortality in the region.
- ❖ The process for authorization of designation as a Primary Stroke Center will be based on recommendations made by Joint Commission (JC).
- ❖ RSAB (Regional Stroke Advisory Board); would include standing members (a stroke medical director and stroke program manager from each stroke center, and the chairman of the MAB); and non-standing members (an administrator from a non-stroke hospital, a representative from a public and private EMS transport service, an AHA/ASA representative for stroke prevention, a payor of medical benefits and a stroke patient/advocate).
- ❖ SMAC (Stroke Medical Audit Committee); would include a stroke medical director and stroke program manager from each stroke center, the County Medical Examiner or designee, the regional stroke coordinator, a neurosurgeon, a neurologist (primary stroke call), an anesthesiologist, a radiologist, and an emergency physician from a non-stroke hospital.
- ❖ The Office of EMSTS will develop and implement a regional stroke performance improvement plan, ensure appropriate transport and transfer of stroke patients, serve as a central repository for stroke data collection, organization, analysis and reporting; and will provide periodic reports on performance of stroke system at least every two years.
- ❖ Stroke centers will be required to submit data when requested specific to planning, research and evaluation of the effectiveness of stroke system.
- ❖ EMS must assure that EMS personnel have basic knowledge and awareness of the stroke system including entry criteria and they are recognized as an integral part of the system.

Dr. Slattery solicited input from those present and the group agreed to adopt this framework to guide the system development process.

D. Strategic Planning and Committee Assignments

Dr. Slattery suggested putting together four workgroups to address the issues in the development of a stroke system. The four workgroups and their proposed tasks are as follows:

1. EMS Protocol and Education Development – This workgroup will be tasked with assessing current dispatch center management and identification of stroke patients; developing a list of areas for improvement and making recommendations to the Executive Committee regarding the management of 911 calls. The workgroup will also determine education needs of EMS providers for all agencies including the necessary level of knowledge and pertinent history, exams, and documentation in the field. In addition, the workgroup will decide which pre-hospital stroke scale will be used and develop a pre-hospital stroke care management protocol, but exclude destination criteria as this will be addressed by another workgroup.
2. Designated Stroke Receiving Hospital Workgroup – This workgroup will be responsible for encouraging all hospitals in Southern Nevada that are interested to become stroke centers. They will also assess each of the hospitals in Southern Nevada for their readiness for stroke care management which includes determining which facilities have 24-hour imaging capability, dedicated personnel, personnel education, protocol for administration for tPA, stroke clinical pathways, stroke pre-printed orders, and a list of stroke care quality indicators/performance measures. The workgroup will also determine each hospital's resources and commitment related to eligibility for receiving EMS stroke patients and designing a process for keeping up-to-date information for system-wide decision making.

   Dr. Henderson questioned the purpose of this particular workgroup as JC determines accreditation for hospitals. Anna Smith pointed out that JC has guidelines for best practices on

everything from timely care, how soon to get a CT scan, labs, x-rays, basic infrastructure of the program, the medical director, and quality assurance. It's a very detailed process to get to the end result of certification. Ms. Smith stated that although certification occurs every two years, there are daily and monthly chart reviews performed to make sure the stroke care that is provided is adequate. She indicated that the process will be duplicated if hospitals will have to report to the Office of EMSTS as well as JC. Ms. Smith noted that JC requires continued community and pre-hospital education from hospitals that would like to become or stay certified as a primary stroke center, which is the responsibility of the EMS Protocol & Education Development Workgroup. Dr. Slattery clarified that the purpose of this particular workgroup is not to determine certification of the hospitals, but rather to get an idea of the stroke care that is available in non-stroke hospitals.

Carrie Krumtum stated that the information identified from this workgroup may be helpful in identifying additional destinations for EMS, such as facilities that have begun the accreditation process and have been collecting data. In response to a question, Ms. Smith explained that the accreditation process begins by collecting four months of data. Amelia Hoban clarified that the data requested is specific and may take several months if not years to track to ensure the hospital is proficient. Ms. Smith related that the collection of data serves as a measure of the hospital's capabilities and helps in identifying where improvements are needed before applying for certification. The process is not just data collection, but fine tuning and reviewing the data to identify needed improvements. This ensures that key components are in place.

3. Quality Assurance/Performance Workgroup – This workgroup will determine the performance, quality and safety measures that will be used for assessing initial and continued stroke receiving hospitals; determine the method and process for performing peer review; determine how outcome data will be obtained and disseminated to the participating members; determine the criteria for losing stroke receiving designation; and determine the projected budget for data collection, clerical, and statistical support.

   Dr. Slattery noted that in determining the criteria for losing designation as a stroke receiving facility, the Executive Committee will make the final decision. The Office of EMSTS will be responsible for determining the budget for data collection and maintenance as it will serve as the central repository.

   Dr. Slattery stated that it would be up to this committee to decide that JC approval may be sufficient but noted that certification only takes place once every two years. Ms. Hoban pointed out that although certification is every two years, data is still submitted to JC quarterly for review. Ms. Smith stated that the data is collected on a monthly basis so the facility will notice if they fall below benchmark. If this continues for the quarter, the facility could expect a visit or at least a phone call from JC.

   Dr. Slattery indicated that one of the tasks of this workgroup will be to decide on the surveillance of the community for the Health District in terms of safety outcomes and performance measures. Like the trauma system, there are performance measures and a peer review process that would be essential and should be included in the stroke system. Dr. Slattery expressed that he did not feel that relying solely on JC would be sufficient. He feels hospitals should report to a committee for review. Ms. Krumtum stated that there will be other quality measures that will not be reviewed by hospitals participating as stroke proficient hospitals so those facilities and EMS should submit data to review their progress.

   Dr. Slattery noted that one of the responsibilities of a stroke center is to act as a resource for non-stroke hospitals. Non-stroke hospitals should be able to provide basic care and have a system in place for rapid transfer to one of the stroke centers. William Wagnon expressed a concern that there could be confusion with stroke proficient facilities. He believes the determination of how patients get to the appropriate facility should be defined. Carol Butler stated that ideally, it is the consensus of the group that all hospitals should be stroke proficient.

Ms. Butler felt that some patients may be best served by stopping at a nearby stroke proficient facility as their condition may not permit further transport; this will not be determined until every hospital's stroke capability is assessed. Dr. Richard Henderson stated that he opposed the idea of delivering a stroke patient to a facility that isn't a certified stroke center. Ms. Smith believes with the proper education led by the committee and primary stroke centers, the idea of having stroke proficient hospitals could work.

Hilary Crawford questioned how other non-certified stroke centers will be able to gather enough data for JC certification if there are currently only two stroke centers in the valley. Ms. Smith stated that the number of stroke patients in the valley is high so receiving enough patients will not be an issue. Dr. Henderson questioned whether there is a minimum number of stroke patients that are needed to become certified. Ms. Smith replied there isn't a minimum, but the facility will need to perform well on the ones they receive; however, volume dictates proficiency. She clarified that this doesn't mean smaller volumes can't be proficient but they have to be diligent in managing stroke patients. Mr. Wagnon stated that the results will show if facilities are willing to invest in the infrastructure to deliver optimal care to stroke patients. He feels that if facilities are able to meet and maintain the criteria, there shouldn't be a barrier to enter as a stroke proficient hospital. On the other hand, if a facility is not able to meet this requirement, they should not be allowed to accept stroke patients.

Dr. Slattery stated that with other systems, the hospitals have financially participated to help offset the costs incurred with collecting and maintaining the data. He asked the Health District to determine the associated costs.

Dr. Slattery asked Jason Belland if he would ask one or two stroke survivors to serve on the committee as their perspective and input would be invaluable to the committee's future endeavors. Mr. Belland agreed.

4. Executive Committee – This workgroup will make recommendations and decisions regarding the stroke receiving hospitals' designation, determining the cost for participating hospitals, participating in the peer review process with the quality assurance workgroup, and serving as the liaison between the payor groups and the stroke committee.

III. INFORMATIONAL ITEMS / DISCUSSION ONLY

None

IV. PUBLIC COMMENT

None

V. ADJOURNMENT

There being no further business, Dr. Slattery adjourned the meeting at 9:56 a.m.