



# **Rhode Island Department of Health Rhode Island Stroke Task Force FY 2010-2011 Annual Report Stroke Prevention and Treatment Act of 2009**

## **Background**

On July 9, 2004 the General Assembly enacted *An Act Relating to Health and Safety – Stroke Task Force* (Chapter 544 2004-§2905 Substitute A). The Act identified stroke as a leading cause of death and permanent long-term disability and declared that currently available prevention and treatment strategies could reduce the number of deaths and disabilities caused by strokes. The legislative assembly mandated the establishment of a Rhode Island Stroke Task Force and charged the Task Force with ensuring that “state-of-the-art information on stroke education, prevention, and treatment is available to healthcare providers and patients.” The General Assembly defined fourteen points of inquiry for Task Force review and requested an interim report followed by final recommendations.

A report to the General Assembly from the Stroke Task Force was disseminated in May 2008 (see <http://www.health.ri.gov/programs/heartdiseaseandstrokeprevention/index.php> for report) that included a summary of findings and Stroke Task Force recommendations. The report identified gaps in existing stroke systems of care in the state and the report recommended steps to establish a statewide integrated and coordinated response to stroke care in Rhode Island.

Recognizing the importance of quality stroke care for Rhode Island’s citizens, and to address the recommendations of the Stroke Task Force 2008 Report, the General Assembly enacted the Stroke Prevention and Treatment Act of 2009 (23-71.8). This legislation, included as Appendix A, recognized the need for “rapid identification, diagnosis, and treatment of stroke victims” and the need to “improve the overall treatment of stroke patients in order to increase survival and decrease the disabilities associated with stroke.” The General Assembly defined and recommended the development of “an effective system to support stroke survival”. This system would include: the designation of Rhode Island primary stroke centers, acute care hospitals maintaining readiness to treat stroke patients, the triage and transportation of stroke patients by emergency medical services providers, and the continuous improvement of quality care for individuals with stroke.

## **HEALTH’s Heart Disease & Stroke Prevention Program**

In 2007, the Rhode Island Department of Health (HEALTH), Division of Community, Family Health, and Equity, responded to a RFP from the Centers for Disease Control and Prevention (CDC) and was awarded a capacity-building grant to establish the Rhode Island Heart Disease and Stroke Prevention (RI HDSP) Program. A Program Manager and a half-time Epidemiologist were hired to coordinate the development, implementation, and evaluation of the RI HDSP Program. The capacity-building grant allowed for the establishment of a RI HDSP Steering Committee,

whose membership represents over sixty organizations and individuals. The RI Stroke Task Force has been integrated under the umbrella of the Steering Committee Work Groups. The mission of the RI HDSP Steering Committee is to guide, promote, and participate in the RI HDSP strategic planning process, develop the RI HDSP statewide plan, and assist in its implementation. There are currently four RI HDSP Program Work Groups: Community and Worksites, EMS (Emergency Medical Services), Health Care Systems, and Stroke.

In 2008, HEALTH applied for, and was awarded, three-year HDSP Program Optional funding. The Optional RI HDSP Program builds on the programming of the Rhode Island Chronic Care Collaborative (RICCC) to improve clinical care for cardiovascular disease (CVD) using existing RICCC sites.

By the Year 2012, HEALTH will have implemented a 5-year RI HDSP Program that addresses environmental supports and policy changes: (1) to sustain individual behavior change, (2) to enhance access to effective medical care, and (3) to improve health status with a special focus on the elimination of racial and ethnic disparities in heart disease and stroke prevention.

### **Progress Report**

The purpose of this report is to describe progress toward implementation of the Stroke Prevention and Treatment Act of 2009 (23-71.8). Over the past year, HEALTH has taken significant steps to carry out the intent of the Act. A formal process was established to designate Primary Stroke Centers in RI; revisions were made to the EMS Pre-Hospital Care Protocol and point of entry plan for stroke patients; and planning is underway for data collection that will be utilized to evaluate the system of care and make recommendations moving forward.

#### *RI Primary Stroke Center Designation*

HEALTH personnel met to develop the RI Primary Stroke Center designation process; the ad-hoc group included representation from the Rhode Island Heart Disease and Stroke Prevention Program, the Office of Facilities Regulation, the Division of Emergency Medical Services, and the Director's Office. As a result of these discussions, hospitals must now meet the following criteria to be designated by HEALTH as a RI Primary Stroke Center:

1. Certification by the Joint Commission as a primary stroke center under the JCAHO Disease Specific Care program; and
2. Report data consistent with nationally recognized guidelines ("Get With The Guidelines-Stroke") to the Rhode Island Department of Health.

HEALTH's Office of Facilities Regulation crafted a letter regarding the specifics of the Stroke Prevention and Treatment Act of 2009 including RI Primary Stroke Center designation. This letter was disseminated to all licensed hospitals in Rhode Island in July 2010. In addition to outlining the RI Primary Stroke Center Designation process, the letter summarized the requirements for all acute care hospitals under the Act including:

1. 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;
2. Adherence with American Heart Association/American Stroke Association guidelines;

3. Participation in “Get With The Guidelines-Stroke” to collect nationally recognized stroke measures and ensure continuous quality improvement; and,
4. Participation in the Rhode Island Stroke Task Force and the Rhode Island Stroke Coordinators Network to provide oversight for the stroke system of care and to share best practices.

Eight hospitals responded to the letter with interest to become a RI Primary Stroke Center. Five of the eight hospitals have been deemed to fulfill the designation requirements. Designated stroke centers have been posted on the Department of Health website and have been incorporated into the Rhode Island EMS Pre-Hospital Care Protocol for Stroke.

#### *EMS Pre-Hospital Care Protocol for Stroke*

HEALTH’s Division of Emergency Medical Services (EMS) and the Rhode Island Stroke Task Force worked in collaboration to update the existing statewide EMS Pre-Hospital Care Protocol for Stroke. The revised protocol, effective as of August 1, 2011, includes sections on stroke recognition and treatment. The new protocol states that if a Primary Stroke Center is within a 30-minute transport radius of the patient, it should be the preferred receiving hospital for patients with suspected stroke. EMS will update a list of designated primary stroke centers to the EMS Stroke Protocol as hospitals are approved by HEALTH. EMS has disseminated the final updated protocols to EMS providers via the Department of Health web site and to all licensed ambulance services and hospital Emergency Departments.

#### *Data Collection & Continuous Quality Improvement*

The Rhode Island Stroke Task Force is working with HEALTH’s Center for Health Data and Analysis and the Heart Disease and Stroke Prevention Program on a data collection plan that aligns with “the stroke consensus metrics developed and approved by the American Heart Association/Stroke Association, Center for Disease Control and Prevention and the Joint Commission.” HEALTH has purchased software to access “Get With The Guidelines-Stroke” data from the eleven participating Rhode Island hospitals.

The Rhode Island Stroke Coordinators Network is providing a mechanism “for sharing information and data on ways to improve the quality of care.” The Rhode Island Stroke Coordinators Network is open to all Rhode Island acute care hospitals and public health partners, including representation from the RI HDSP Program. There are members who sit on both the Rhode Island Stroke Task Force and the Stroke Coordinators Network. This group’s mission is to build a statewide community for stroke coordinators to improve patient care statewide. The group has identified collaboration, communication, and education as the areas of focus. The Stroke Coordinator’s Network accomplishments include hosting a statewide conference, “Stroke Care in Rhode Island.” The program objective was to increase professionals’ knowledge of current cerebrovascular issues confronting healthcare professionals caring for stroke patients across the continuum of care. A second statewide stroke conference is scheduled for February 2012.

For further information:

Patricia Affleck, Program Manager  
RI Heart Disease & Stroke Prevention Program  
RI Department of Health, Room 408  
3 Capitol Hill  
Providence, RI 02908

[Patricia.Affleck@health.ri.gov](mailto:Patricia.Affleck@health.ri.gov)

(401) 222-3667

Rhode Island Heart Disease & Stroke Prevention Program website:

<http://www.health.ri.gov/programs/heartdiseaseandstrokeprevention/index.php>

# 2009 -- H 5798 SUBSTITUTE A AS AMENDED

=====

LC01508/SUB A/2

=====

## STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2009

---

### A N A C T

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

Introduced By: Representatives Naughton, McNamara, Watson, and M Rice

Date Introduced: February 26, 2009

Referred To: House Health, Education & Welfare

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby

2 amended by adding thereto the following chapter:

3 CHAPTER 78.1

4 STROKE PREVENTION AND TREATMENT ACT OF 2009

5 **23-78.1-1. Short title.** – This chapter shall be known and may be cited as the “Stroke  
6 Prevention and Treatment Act of 2009.”

7 **23-78.1-2. Legislative findings.** – It is hereby found and declared as follows:

8 (1) The rapid identification, diagnosis, and treatment of stroke can save the lives of stroke  
9 victims and in some cases can reverse neurological damage such as paralysis and speech and  
10 language impairments, leaving stroke victims with few or no neurological deficits;

11 (2) Despite significant advances in diagnosis, treatment and prevention, stroke is the third  
12 (3<sup>rd</sup>) leading cause of death and a leading cause of disability; an estimated seven hundred eighty  
13 thousand (780,000) new and recurrent strokes occur each year in this country; and with the aging  
14 of the population, the number of persons who have strokes is projected to increase;

15 (3) This year in Rhode Island, more than three thousand (3,000) people will fall victim to  
16 a potentially treatable stroke and more than six hundred (600) Rhode Islanders will die from  
17 stroke-related complications. This tragic loss of life and viability creates an annual financial  
18 burden for the state of over three hundred twelve million dollars (\$312,000,000) in medical costs,  
19 supportive care, and lost productivity;

2

1 (4) Although new treatments are available to improve the clinical outcomes of stroke,  
2 some acute care hospitals may lack the necessary staff and equipment to optimally triage and treat  
3 stroke patients, including the provision of optimal, safe and effective emergency care for these  
4 patients;

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

10 (6) Primary stroke centers should be established for the treatment of acute stroke. Primary  
11 stroke centers should be established in as many acute care hospitals as possible. These centers  
12 would evaluate, stabilize and provide emergency and in patient care to patients with acute stroke;  
13 and

14 (7) That it is in the best interest of the residents of this state to establish a program to

15 facilitate development of stroke treatment capabilities throughout the state. This program will  
16 provide specific patient care and support services criteria that stroke centers must meet in order to  
17 ensure that stroke patients receive safe and effective care. It is also in the best interest of the  
18 people of this state to modify the state's emergency medical response system to assure that acute  
19 stroke victims may be quickly identified and transported to and treated in facilities that have  
20 appropriate programs for providing timely and effective treatment for stroke victims.

21 (8) For the purposes of pre-hospital transfer and triage clarification, an "acute stroke" is  
22 defined as any new-persistent focal neurological deficit determined to be less than six (6) hours  
23 since last seen normal.

24 **23-78.1-3. Designation of Rhode Island primary stroke centers.** – (a) The director of  
25 the department of health shall establish a process to recognize primary stroke centers in Rhode  
26 Island. A hospital shall be designated as a "Rhode Island primary stroke center" if it has received  
27 a certificate of distinction for primary stroke centers issued by the joint commission on  
28 accreditation of healthcare organizations (joint commission);

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

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

3

1 **23-78.1-4. Acute care hospitals.** – (a) All acute care hospitals shall maintain readiness to  
2 treat stroke patients. This shall include:

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

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

8 (3) Participation in Get With The Guidelines/Stroke to collect nationally recognized  
9 stroke measures and ensure continuous quality improvement;

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

12 **23-78.1-5. Emergency medical services providers; triage and transportation of**

13 **stroke patients.** – (a) The department of health, division of EMS and the ambulance service  
14 advisory board shall adopt and distribute a nationally recognized standardized assessment tool  
15 for stroke. The division of EMS shall post this stroke assessment tool on its website and provide a  
16 copy of the assessment tool to each licensed emergency medical services provider no later than  
17 January 1, 2010. Each licensed emergency medical services provider must use the stroke-triage  
18 assessment tool provided by the department of health, division of EMS;

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

24 (c) By June 1 of each year, the department of health, division of emergency medical  
25 services (EMS), shall send the list of primary stroke centers to each licensed emergency medical  
26 services agency in this state and shall post a list of primary stroke centers on the division of EMS  
27 website. For the purposes of this chapter, the division of EMS may include primary stroke centers  
28 in Massachusetts and Connecticut that are certified by the joint commission, or are otherwise

29 designated by that state's department of public health as meeting the criteria for primary stroke  
30 centers as established by the brain attack coalition;

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

33 **23-78.1-6. Continuous improvement of quality of care for individuals with stroke. –**

34 (a) The department of health shall establish and implement a plan for achieving continuous  
4

1 quality improvement in the quality of care provided under the statewide system for stroke  
2 response and treatment. In implementing this plan, the department of health shall undertake the  
3 following activities:

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

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

8 (3) Require the application of evidence-based treatment guidelines regarding the  
9 transitioning of patients to community-based follow-up care in hospital outpatient, physician  
10 office and ambulatory clinic settings for ongoing care after hospital discharge following acute  
11 treatment for a stroke;

12 (4) Require primary stroke center hospitals and emergency medical services agencies to  
13 report data consistent with nationally recognized guidelines on the treatment of individuals with  
14 confirmed stroke within the statewide system for stroke response and treatment;

15 (5) Analyze data generated by the statewide system on stroke response and treatment; and

16 (6) The department of health shall maintain a statewide stroke database that compiles  
17 information and statistics on stroke care that align with the stroke consensus metrics developed  
18 and approved by the American Heart Association/American Stroke Association, Centers for  
19 Disease Control and Prevention and The Joint Commission. The department of health shall utilize  
20 Get With The Guidelines Stroke as the stroke registry data platform or another nationally  
21 recognized data set platform with confidentiality standards no less secure. To every extent  
22 possible, the department of health shall coordinate with national voluntary health organizations  
23 involved in stroke quality improvement to avoid duplication and redundancy.

24 (b) Except to the extent necessary to address continuity of care issues, health care  
25 information shall not be provided in a format that contains individually-identifiable information  
26 about a patient. The sharing of health care information containing individually-identifiable  
27 information about patients shall be limited to that information necessary to address continuity of  
28 care issues, and shall otherwise be released in accordance with chapter 37.3 of title 5 and subject  
29 to the confidentiality provisions required by that chapter and by other relevant state and federal  
30 law.

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

5

1 **23-78.1-7. Patient treatment. –** This chapter is not a medical practice guideline and may  
2 not be used to restrict the authority of a hospital to provide services for which it has received a  
3 license under state law. The general assembly intends that all patients be treated individually  
4 based on each patient's needs and circumstances.

5 **23-78.1-8. Regulatory authority. –** The department of health shall have the authority to

6 adopt rules to carry out the purposes of this chapter.

7 SECTION 2. This act shall take effect upon passage.

8

=====

LC01508/SUB A/2

=====

6

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

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

\*\*\*

1 This act would create “the Stroke Prevention Act of 2009.”

2 This act would take effect upon passage.

=====

LC01508/SUB A/2

=====