HOUSE DOCKET, NO. 1768 FILED ON: 1/17/2013

HOUSE . . . . . No. 1974

The Commonwealth of Massachusetts

PRESENTED BY:

Colleen M. Garry

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to acute-care hospitals.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Colleen M. Garry	*36th Middlesex*
Alice Hanlon Peisch	*14th Norfolk*
Carl M. Sciortino, Jr.	*34th Middlesex*

HOUSE DOCKET, NO. 1768 FILED ON: 1/17/2013

HOUSE . . . . . No. 1974

By Ms. Garry of Dracut, a petition (accompanied by bill, House, No. 1974) of Colleen M. Garry, Alice Hanlon Peisch and Carl M. Sciortino, Jr. relative to designating certain medical facilities as primary centers for the treatment of patients suffering a stroke. Public Health.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act relative to acute-care hospitals.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1

Amend Section 51G of the General laws, to add (e) to establish standards for the designation of a Primary Stroke Service in a hospital with licensed Emergency Services.

SECTION 2

Chapter 111 of the General laws, as appearing in the 2010 official addition is hereby amending by inserting after Section 51H the following 2 sections

Section 51I. Definitions for Section 51J

Primary Stroke Service. Emergency diagnostic and therapeutic services provided by a multidisciplinary team and available 24 hours per day, seven days per week to patients presenting with symptoms of acute stroke. Wherein hospitals have the ability to assess acute stroke patients and treat with IV-tPA in the 0-3 hour window. These sites could still admit stroke patients, but might transfer tPA treated patients and those with major stroke syndromes. This program would be ideal for the smallest MA hospitals and would be appropriate for patients arriving within 0-3 hours of stroke symptom onset. These sites could also treat up to 4.5 hours with IV tPA but would not be required to do so.

Primary Stroke Service Plus (PSS+): This would include the current PSS requirements, but further require additional elements to participation:

1) Participation in a national stroke QI program to be chosen by the Dept. This would be chosen from among the CDC Coverdell registry, GWTG-Stroke, or Joint Commission-PSC, and could include more than one option.

2) Mandatory data reporting to the state on an agreed upon expanded set of measures of stroke care quality, and annual evidence of compliance to standards

3) Ongoing professional education requirements similar to the JC-PSC (Joint Commission-Primary Stroke Center) requirements

4) Protocols for administering IV-tPA in the expanded time window (3 - 4.5 hours). Patients with stroke symptom onset between 2.5 - 4 hours would be considered for direct triage/transport to these PSS+ sites when appropriate. The expanded data set might be appropriate for public reporting on the EOHHS website at some point in the future, in the same section as the tPA rates currently posted.

Comprehensive Stroke Center: Comprehensive Stroke Centers designation would require Joint Commission or an equivalent certification. Only the major teaching hospitals in the state would be expected to qualify as it requires 24/7 neurosurgery services and neuro-interventional capabilities in addition to all the primary stroke center requirements. Patients with onset times greater than 4 hours could be considered for direct triage/transport to these sites when appropriate. This designation will also require a substantially greater dataset to be reported as outlined in the published program consensus descriptions (Metrics for measuring quality of care in comprehensive stroke centers. The DPH would determine how much of the additional data would also be required to be reported to the state.

Undesignated Sites: Hospitals that do not seek or sustain a PSS or higher designation will be required to have pre-approved transfer agreements for walk-in or inpatient strokes. They would also be required to partner with a designated hospital for support and implementation of their acute stroke diagnostic and treatment plans.

Section 51J. Application to Provide Primary Stroke Service; Written Protocols

(1)Each hospital seeking designation as a provider of a Primary Stroke Service shall submit an application to the Department, on forms prescribed by the Department, documenting how the hospital will meet the standards in 105 CMR 130.1400 through 130.1413.

Amend to include: Designate/certify Primary Stroke Centers based on Joint Commission/ASA certification or an equivalent process. Modifications to the hospital stroke designation and EMS point of entry criteria to ensure sustainability of the program. Create a sustainable 3-tiered system for MA hospital stroke designation that reflects the current tiered nature of care, and which remains inclusive for hospitals but modifies the “one size fits all”

52 approach. The three designation tiers proposed are as described in 105 CMR 130.020
53 Definitions: (H) Primary Stroke Service:

54 a) Primary Stroke Service (PSS, currently in place in 70 hospitals),

55 b) Primary Stroke Service Plus (PSS+, currently in place as the Coverdell/SCORE
56 stroke program in 58 hospitals),

57 c) Comprehensive Stroke Centers (CSC, soon to be a certified program in the US)

58 (2) As part of the Hospital Licensure Regulations (105 CMR 130.000) 105 CMR
59 130.1400 Primary Stroke Service Licensure Regulations create a statewide stroke registry that
60 aligns with the stroke consensus metrics developed and approved by the AHA/ASA and use Get
61 with the Guidelines

62 "Consensus measures" are a standardized stroke measure set (harmonized measures) as
63 supported by CDC's Paul Coverdell National Acute Stroke Registry, the Joint Commission, and
64 the American Heart Association/American Stroke Association:

65 (a) Deep Vein Thrombosis (DVT) Prophylaxis

66 (b) Discharged on Antithrombotic Therapy

67 (c) Patients with Atrial Fibrillation Receiving Anticoagulation Therapy

68 (d) Thrombolytic Therapy Administered

69 (e) Antithrombotic Therapy By End of Hospital Day Two

70 (f) Discharged on Statin Medication

71 (g) Dysphagia Screening

72 (h) Stroke Education

73 (i) Smoking Cessation / Advice / Counseling

74 (j) Assessed for Rehabilitation

75 (3) State must set up a registry infrastructure and mandatory participation by Primary
76 Stroke Service Plus Hospital as defined by Hospital Licensure Regulations (105 CMR 130.000)
77 105 CMR 130.1400 Primary Stroke Service Licensure Regulations, at a minimum, is necessary.

78 a) The registry must collect at a minimum all ten consensus measures.

79 b) It is strongly encouraged that a stroke registry data oversight committee be
80 created and charged with monitoring registry operations; advise registry investigators, program

81 staff, and relevant stroke systems of stroke stakeholders; and provide direction and plan short
82 and long-term goals for the stroke systems of care, in quality improvement efforts as well as
83 overall sustainability of the stroke systems of care. The SCORE Collaborate can serve in this
84 capacity.

85 c) All hospitals must be afforded the opportunity to participate in the registry (not
86 just Primary Stroke Centers).