COMMITTEE REPORT

March 24, 2009

**S. 26**

Introduced by Senators Jackson and Rose

S. Printed 3/24/09--S.

Read the first time January 13, 2009.

**THE COMMITTEE ON MEDICAL AFFAIRS**

To whom was referred a Joint Resolution (S. 26) to establish the Stroke Systems of Care Study Committee to develop recommendations for a state stroke systems of care comprehensive service delivery system, etc., respectfully

**REPORT:**

That they have duly and carefully considered the same and recommend that the same do pass with amendment:

Amend the joint resolution as and if amended, by striking the Joint Resolution in its entirety and inserting:

/ A JOINT RESOLUTION

TO ESTABLISH THE STROKE SYSTEMS OF CARE STUDY COMMITTEE WITHIN THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL TO DEVELOP RECOMMENDATIONS FOR A REGIONALLY ORGANIZED AND STATEWIDE COMPREHENSIVE PLAN FOR A STROKE SYSTEMS OF CARE.

Whereas, stroke is the third leading cause of death in South Carolina resulting in 2,284 deaths and 14,002 hospitalizations that cost $395.8 million in 2006 ; and

Whereas, South Carolina is among a group of Southeastern states with high stroke death rates commonly referred to as the “Stroke Belt”; and

Whereas, the highest stroke rates within the State are clustered in counties along the Interstate 95 corridor, known as the buckle of the “Stroke Belt”, in which the African American population is in excess of the State’s average and are forty-six percent more likely to die from a stroke than Caucasians in South Carolina; and

Whereas, stroke does not discriminate as to age and strikes young people—including infants and children; and

Whereas, South Carolina ranked fifth in stroke mortality among the states and the District of Columbia in 2005; and

Whereas, urgent stroke care, inclusive of drugs that dissolve blood clots, otherwise known as thrombolytics, has been shown to improve stroke outcome; and

Whereas, time limits for the use of thrombolytics make it critical that the patient be taken to the appropriate stroke treatment center; and

Whereas, science has concluded that fragmentation of the health care delivery system frequently results in sub‑optimal treatment, safety concerns, and inefficient use of health care resources and, accordingly, recommends the establishment of a coordinated system of care that integrates preventive and treatment services and promotes patient access to evidence‑based care; and

Whereas, the fragmented approach to stroke care that exists in South Carolina fails to provide an effective, integrated system for stroke prevention, treatment, and rehabilitation because of inadequate linkages and coordination among the fundamental components of stroke care, which may be well developed but often operate in isolation; and

Whereas, the problem of access to coordinated and time sensitive stroke care is exacerbated in rural underserved areas due to inadequate access to neurological expertise; and

Whereas, it is in the best interest of this State and its residents to convene a Study Committee to conduct a review of state resources and make recommendations for the establishment of a seamless system of care for stroke patients throughout South Carolina; and

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. (A) There is created the Stroke Systems of Care Study Committee composed as follows:

(1) one physician actively involved in stroke care from each of the following fields:

(a) neurology;

(b) neuroradiology;

(c) neurosurgery;

(d) pediatrics;

(e) emergency medicine;

(f) rehabilitation medicine;

(g) internal medicine, general practice, or family practice actively involved in stroke care;

(h) cardiology; and

(2) one emergency medical services provider actively involved in direct stroke care;

(3) one registered professional nurse actively involved in direct stroke care;

(4) one licensed physical therapist actively involved in direct stroke care and research;

(5) one representative of the South Carolina Office of Rural Health;

(6) one physician or representative of an organization actively involved in addressing minority health issues;

(7) one representative of the South Carolina Hospital Association;

(8) one administrator of an acute stroke rehabilitation facility;

(9) one representative from the American Stroke Association;

(10) the Deputy Commissioner of the South Carolina Department of Health and Environmental Control, Health Services Division or his designee; and

(11) the director of the South Carolina Department of Health and Environmental Control Emergency Medical Services, or his designee.

(B) The South Carolina Board of Health and Environmental Control shall appoint the members and the chairperson of the South Carolina Stroke Systems of Care Study Committee.

(C) Vacancies occurring on the committee must be filled in the same manner as the original appointment.

(D) The Study Committee shall accept committee staffing and coordination under the authority of the Department of Health and Environmental Control.

(E) Members of the Study Committee shall serve without mileage, per diem, and subsistence.

SECTION 2. (A) The Study Committee shall develop a plan for a statewide stroke system of care using the resources of both the public and private sectors incorporating flexibility to best fit the needs of each region or locality. The plan must address, but is not limited to:

(1) development and implementation of an urgent response system that is built on the Primary Stroke Center model as designated by the Joint Commission’s primary stroke systems model to develop a statewide system of care that will provide appropriate care to stroke patients in the timeliest manner possible.

For purposes of this section, the Joint Commission is the independent, not‑for‑profit organization that accredits and certifies more than 15,000 health care organizations and programs in the United States, formerly known as the Joint Commission on Accreditation of Healthcare Organizations. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.

(2) development of methods to promote greater stroke prevention and more effective rehabilitation after stroke;

(3) development of methods in which systems will be evaluated and monitored to demonstrate the impact on the burden of strokes in South Carolina;

(4) development of a public education and awareness program on the signs and symptoms of stroke;

(5) recognition and implementation of a standardized stroke triage assessment tool that will be used by all certified EMS personnel and for the education of pre‑hospital and hospital health care providers on the signs and symptoms of stroke;

(6) identification of a strategy to reduce stroke and stroke treatment disparities among minority, rural, uninsured, and underinsured populations;

(7) recommendations for policy and legislative changes that may be needed including appropriations, designation of facilities based on stroke treatment capabilities, and program development and implementation based on national standards.

(8) compiling and assessing peer‑reviewed and evidence‑based clinical research and guidelines that provide or support recommended treatment standards;

(9) assessing the capacity of the emergency medical services system and hospitals to deliver recommended treatments in a timely fashion;

(10) coordinating with the state trauma regions for the purposes of coordinating the delivery of stroke care within those regions; and

(11) creating criteria for the designation of acute stroke capable hospitals within the state of South Carolina.

(B) The Study Committee shall meet as often as is necessary and shall convene no later than sixty days after the effective date and at time at least a majority of the members have been appointed. The Study Committee shall submit its report electronically to the General Assembly and the Governor no later than December 1, 2010, at which point the Study Committee will dissolve.

SECTION 3. This resolution takes effect upon approval by the Governor. /

Renumber sections to conform.

Amend title to conform.

HARVEY S. PEELER, JR. for Committee.

**STATEMENT OF ESTIMATED FISCAL IMPACT**

ESTIMATED FISCAL IMPACT ON GENERAL FUND EXPENDITURES:

Minimal

ESTIMATED FISCAL IMPACT ON FEDERAL & OTHER FUND EXPENDITURES:

$0 (No additional expenditures or savings are expected)

**EXPLANATION OF IMPACT:**

The Department of Health & Environmental Control (DHEC) is to provide coordination and support for the work of the committee. DHEC estimates the cost of supplies and support services is estimated at $5,000 annually until such time as the work of the committee is concluded by no later than December 31, 2010.

*Approved By:*

Harry Bell

Office of State Budget

**A** **JOINT RESOLUTION**

TO ESTABLISH THE STROKE SYSTEMS OF CARE STUDY COMMITTEE TO DEVELOP RECOMMENDATIONS FOR A STATE STROKE SYSTEMS OF CARE COMPREHENSIVE SERVICE DELIVERY SYSTEM AND TO PROVIDE FOR THE MEMBERSHIP, DUTIES, AND RESPONSIBILITIES OF THE STUDY COMMITTEE.

Whereas, stroke is the third leading cause of death in South Carolina resulting in 2,449 death and 14,381 hospitalizations that cost $391 million in 2005, and South Carolina is among a group of Southeastern states with high stroke death rates commonly referred to as the “Stroke Belt”; and

Whereas, the highest stroke rates within the State are clustered in counties along the Interstate 95 corridor, known as the “stroke buckle”, in which the African American population is in excess of the State’s average and members of which are 46 percent more likely to die from a stroke than Caucasians in South Carolina; and

Whereas, the Institute of Medicine of the National Academy of Science has concluded that fragmentation of health care service delivery frequently results in sub‑optimal treatment, safety concerns, and inefficient use of health care resources and, accordingly, recommends the establishment of coordinated systems of care that integrate preventive and treatment services and promote patient access to evidence‑based care; and

Whereas, the fragmented approach to stroke care that exists in most regions of the United States fails to provide an effective, integrated system for stroke prevention, treatment, and rehabilitation because of inadequate linkages and coordination among the fundamental components of stroke care, which may be well developed but often operate in isolation; and

Whereas, the problem of access to coordinated stroke care may be exacerbated in rural or neurologically‑underserved areas due to inadequate access to neurological expertise; and

Whereas, a stroke system of care should coordinate and promote patient access to the full range of activities and services associated with stroke prevention, treatment, and rehabilitation, including the following key components: primordial and primary prevention, community education, notification and response of emergency medical services, acute stroke treatment, including the hyper‑acute and emergency department phases, sub‑continuous quality improvement activities; and

Whereas, it is in the best interest of this State and its residents to create a study committee to conduct a review of state resources to account for access to the most advanced treatment in centers that are best designed and equipped to deal with the critical and time sensitive needs of stroke patients and make recommended actions for an effective comprehensive stroke system of care. Now, therefore,

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. (A) There is created the Stroke Systems of Care Study Committee composed of the following members who must be appointed by the Governor and who must represent the geographic regions of the State and be demographically diverse:

(1) one physician actively involved in stroke care upon the recommendation of the South Carolina Medical Association from each of the following fields:

(a) neurology;

(b) neuroradiology;

(c) internal medicine, general practice, or family practice actively involved in stroke care; and

(d) emergency medical services;

(2) one registered professional nurse actively involved in direct stroke care upon the recommendation of the South Carolina Nurses Association;

(3) one representative of the South Carolina Office of Rural Health;

(4) one representative of the South Carolina Hospital Association;

(5) the director of the South Carolina Department of Health and Environmental Control or a designee;

(6) the director of the South Carolina Department of Health and Environmental Control Emergency Medical Services;

(7) one physician or representative of an organization actively involved in addressing minority health issues;

(8) one administrator of an acute stroke rehabilitation facility;

(9) one stroke survivor or caregiver;

(10) one representative of the American Stroke Association.

(B) The Governor shall appoint the chairman of the South Carolina Stroke Systems of Care Study Committee from among the members of the committee upon the recommendation of the American Stroke Association.

(C) Vacancies occurring on the committee must be filled in the same manner as the original appointment.

(D) The study committee shall accept committee staffing and coordination as volunteered by the American Heart Association.

(E) Members of the study committee shall serve without mileage, per diem, and subsistence.

SECTION 2. (A) The committee shall develop a plan for a statewide stroke system of care using the resources of both the public and private sectors incorporating flexibility to best fit the needs of each region or locality. The plan must address, but is not limited to:

(1) effective prevention, treatment, and rehabilitation of stroke through a standardized case management system, utilizing best patient care transcending geo‑political boundaries or corporate affiliations;

(a) interaction and collaboration among health care workers;

(b) performance and continuous quality improvement measures;

(2) development and implementation of an urgent response system to provide appropriate care to stroke patients in the initial ninety minutes post‑event that may dramatically reduce risk for lifelong disability through improved response, diagnosis, and treatment of stroke;

(3) a data system in which stroke can be identified from existing data sources to continually track and monitor the incidence and prevalence of stroke, including mortality and morbidity;

(4) public education programs;

(5) strategy to reduce stroke disparities among minority, rural, uninsured, and underinsured populations;

(6) recommendations for policy and legislative changes that may be needed including, but not limited to, appropriations, definition of a stroke center, program development, and state standards of stroke care.

(B) In carrying out its responsibilities under this joint resolution, the chairman of the committee may appoint subcommittees as appropriate and may utilize the knowledge and expertise of any individual as appropriate.

(C) The committee shall meet at least twice as a full body with the first meeting to take place no later than September 15, 2009, and shall submit its report to the General Assembly and Governor no later than May 5, 2010, at which time the Stroke Systems of Care Study Committee is abolished.

SECTION 3. This joint resolution takes effect upon approval by the Governor.

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