**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ENACTING THE “STROKE PREVENTION ACT OF 2011” BY ADDING ARTICLE 6 TO CHAPTER 61, TITLE 44 SO AS TO ESTABLISH A STATEWIDE SYSTEM OF STROKE CARE, WHICH REQUIRES THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL TO RECOGNIZE AND DESIGNATE HOSPITALS THAT ARE CERTIFIED TO BE PRIMARY STROKE CENTERS AND ACUTE STROKE CAPABLE CENTERS, TO DISTRIBUTE A LIST OF PRIMARY STROKE CENTERS AND ACUTE STROKE CAPABLE CENTERS TO EACH EMERGENCY MEDICAL SERVICES PROVIDER AND TO POST THIS LIST ON IT’S WEBSITE, TO ADOPT AND DISTRIBUTE A NATIONALLY STANDARDIZED STROKE‑TRIAGE ASSESSMENT TOOL TO EACH EMERGENCY MEDICAL SERVICES PROVIDER, TO ESTABLISH PRE‑HOSPITAL CARE PROTOCOLS FOR THE CARE AND TRANSPORT OF STROKE PATIENTS BY EMERGENCY MEDICAL SERVICE PROVIDERS, TO ESTABLISH A STROKE REGISTRY TASK FORCE TO ANALYZE AND IMPROVE STROKE CARE IN THIS STATE, AND TO ENSURE CONFIDENTIALITY IN SHARING HEALTH CARE INFORMATION; AND TO PROVIDE THAT THE DEPARTMENT’S RESPONSIBILITIES PURSUANT TO THIS ARTICLE ARE CONTINGENT UPON ADEQUATE FUNDING.

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

SECTION 1. Chapter 61, Title 44 of the 1976 Code is amended by adding:

“Article 6

System of Stroke Care

Section 44‑61‑610. This article may be cited as the ‘Stroke Prevention Act of 2011’.

Section 44‑61‑620. The General Assembly finds that:

(1) The rapid identification, diagnosis, and treatment of stroke can save the lives of stroke patients and in some cases can reverse neurological damage such as paralysis and speech and language impairments, leaving stroke patients with few or no neurological deficits, rather than disabled, dependent, and unable to work or live independently.

(2) Despite significant advances in diagnosis, treatment, and prevention, stroke is a leading cause of death and disability in the United States; an estimated seven hundred eighty thousand new and recurrent strokes occur each year in this country; and with the aging of the population, the number of persons who have strokes is projected to increase.

(3) South Carolina has consistently had one of the highest stroke death rates in the nation; in 2009, 15,659 people were treated for stroke in South Carolina hospitals, for a total cost of $559,190,500; and African Americans in South Carolina are fifty three percent more likely to die from stroke than the white population.

(4) Care for stroke patients is currently fragmented and not coordinated. Such coordination of care is a major goal of this legislation.

(5) Although new treatments are available to improve the clinical outcomes of stroke, many acute care hospitals lack the necessary staff and equipment to optimally triage and treat stroke patients, including the provision of optimal, safe, and effective emergency care for these patients.

(6) An effective system to support optimal stroke care is needed in our communities in order to treat stroke patients in a timely manner and to improve the overall treatment of stroke patients to increase survival and decrease the disabilities associated with stroke. There is a public health need for acute care hospitals in this State to become primary stroke centers and acute stroke capable centers, to ensure the rapid triage, diagnostic evaluation, and treatment of patients suffering a stroke. There is also a need for a prehospital emergency transport system that identifies and transports potential stroke patients as quickly as possible to the most appropriate stroke‑capable facility, which may not be the closest hospital.

(7) Primary stroke centers for the treatment of acute stroke should be established in as many acute care hospitals as possible. In addition, hospitals that do not have primary stroke center certification but use telemedicine or other means to facilitate acute or early stroke treatment should be integrated, along with primary stroke centers, within a system of care to evaluate, stabilize and provide emergency and inpatient care to patients with acute stroke.

(8) It is in the best interest of the residents of South Carolina to establish a program to facilitate identification and development of stroke treatment capabilities throughout the State. This program will provide specific patient care and support services criteria that stroke centers must meet in order to ensure that stroke patients receive safe and effective care. It is also in the best interest of the people of South Carolina to modify the state’s emergency medical response system to ensure that potential stroke patients are quickly identified and transported to and treated in facilities that have specialized programs for providing timely and effective treatment for stroke patients.

Section 44‑61‑630. As used in this article:

(1) ‘Department’ means the South Carolina Department of Health and Environmental Control.

(2) ‘Director’ means the Director of the South Carolina Department of Health and Environmental Control.

(3) ‘Joint Commission’ means the Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, a not‑for‑profit organization that accredits hospitals and other health care organizations.

Section 44‑61‑640. (A) The director shall identify hospitals that meet the criteria set forth in this article as primary stroke centers or acute stroke capable centers.

(B) The department shall establish a process to designate as ‘primary stroke centers’ as many accredited acute care hospitals as apply and are certified as primary stroke centers by the Joint Commission or another nationally recognized organization that provides disease specific certification or accreditation for stroke care, provided that each applicant continues to maintain this certification or accreditation.

(C) As nationally recognized designations become available at more comprehensive and less comprehensive levels, including, but not limited to, a designation for ‘acute stroke capable centers’, the department may adopt those designations.

(D) The director may deny, suspend, or revoke a hospital’s state designation as a primary stroke center or acute stroke capable center, or impose a monetary penalty, after notice and a hearing pursuant to the provisions of Section 44‑1‑60 if the department determines that the hospital is not in compliance with the requirements of this article.

Section 44‑61‑650. (A) Before June first of each year, the department shall distribute the list of primary stroke centers and acute stroke capable centers to each licensed emergency medical services provider in this State and shall post a list of primary stroke centers and acute stroke capable centers on the department website. For the purposes of this article, the department may include primary stroke centers in North Carolina and Georgia that are certified by the Joint Commission, or are otherwise designated by those states’ departments of public health as meeting the criteria for primary stroke centers.

(B) The department shall adopt and distribute a nationally recognized standardized stroke‑triage assessment tool. The department must post the stroke‑triage assessment tool on its website and provide a copy, which may be an electronic copy, of the stroke‑triage assessment tool to each licensed emergency medical services provider before January 1, 2012. Each licensed emergency medical services provider must use the department approved stroke‑triage assessment tool.

(C) The department shall establish, in consultation with primary stroke centers and acute stroke capable centers, pre‑hospital care protocols related to the assessment, treatment, and transport of stroke patients by licensed emergency medical services providers in this State. These protocols must include plans for the triage and transport of stroke patients to the most appropriate primary stroke center or acute stroke capable center, including the bypass of health care facilities not designated as primary stroke centers or acute stroke capable centers, as appropriate, and within a specified timeframe of the onset of symptoms.

(D) Each emergency medical services provider must comply with all sections of this article before June 1, 2012.

Section 44‑61‑660. (A) The department shall:

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

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

(3) collect data regarding the transition of care to community‑based follow‑up care in hospital outpatient, physician office and ambulatory clinic settings for ongoing care after hospital discharge following acute treatment for a stroke;

(4) require hospitals and emergency medical services agencies to report data on the treatment of individuals with suspected stroke within the statewide system of stroke care;

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

(6) establish a Stroke Registry Task Force which shall:

(i) analyze data generated by the statewide stroke registry database on stroke care;

(ii) identify potential interventions to improve stroke care in geographic areas or regions of the State; and

(iii) provide recommendations to the department and the General Assembly for the improvement of stroke care in the State.

(B) Except to the extent necessary to address continuity of care issues, health care information must not be provided in a format that contains individually identifiable information about a patient. The sharing of health care information containing individually identifiable information about patients must be limited to that information necessary to address continuity of care issues, and otherwise must be in accordance with, and subject to, the confidentiality provisions required by applicable state and federal law, including, but not limited to, the federal Health Insurance Portability and Accountability Act and regulations pursuant to that act.

Section 44‑61‑670. This article is not a medical practice guideline and may not be used to restrict the authority of a hospital to provide services for which it has received a license under state law. The General Assembly intends that all patients be treated individually, based on each patient’s needs and circumstances.

Section 44‑61‑680. (A) The department has the authority to adopt rules and promulgate regulations to carry out the purposes of this article.

(B) All of the department’s duties pursuant to this article are contingent upon adequate funding to cover the department’s operating and administrative costs and upon the promulgation of regulations and adoption of rules. If adequate funding does not exist, the department is not obligated to carry out any duties pursuant to this article. The department is not obligated to carry out any duties pursuant to this article until the applicable regulations have been promulgated.”

SECTION 2. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

SECTION 3. This act takes effect upon approval by the Governor.

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