COMMITTEE REPORT

May 18, 2011

**S. 588**

Introduced by Senators Jackson, Hayes, O’Dell, Rose, Ford and Knotts

S. Printed 5/18/11--H.

Read the first time April 26, 2011.

**THE COMMITTEE ON MEDICAL,**

**MILITARY, PUBLIC AND MUNICIPAL AFFAIRS**

To whom was referred a Bill (S. 588) 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, etc., respectfully

**REPORT:**

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

Amend the bill, as and if amended, by deleting Section 44-61-650(C) on page 4 and inserting:

/ (C) The Stroke Advisory Council is responsible for advising the department on the development and implementation of a statewide system of stroke care in accordance with this article. /

Renumber sections to conform.

Amend title to conform.

LEON HOWARD for Committee.

**STATEMENT OF ESTIMATED FISCAL IMPACT**

ESTIMATED FISCAL IMPACT ON GENERAL FUND EXPENDITURES:

A Cost to the General Fund (See Below)

ESTIMATED FISCAL IMPACT ON FEDERAL & OTHER FUND EXPENDITURES:

$0 (No additional expenditures or savings are expected)

**EXPLANATION OF IMPACT:**

Department of Health & Environmental Control

The department indicates this bill would require additional General Funds of the State totaling $456,200 the first year. Recurring costs include $243,817 for salary and fringe benefits for 4.00 FTE positions needed to perform the tasks outlined in the bill and $201,883 in operating expenses. One time expenditures of $10,500 would be needed for computer software and other equipment. Therefore, annual recurring expenses are estimated at $445,700.

*Approved By:*

Harry Bell

Office of State Budget

**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 ITS 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 System of Care Act of 2011’ and is based on recommendations of the Stroke System of Care Study Committee provided for in Act 121 of 2009.

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

(1) An effective system to support optimal stroke care is needed in our communities in order to treat stroke patients in a timely manner, improve the overall treatment of stroke patients, increase survival, and decrease the disabilities associated with stroke.

(2) There is a public health need for acute care hospitals in this State to become primary stroke centers to ensure the rapid triage, diagnostic evaluation, and treatment of patients suffering a stroke. There is also a need for a pre‑hospital emergency transport system that identifies and transports potential stroke patients as quickly as possible to the most appropriate facility for stroke treatment.

(3) 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.

(4) 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 a system of stroke care that will include specific patient care and support services criteria that will ensure stroke patients receive safe and effective care in stroke care centers statewide.

(5) 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 the capability 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 and stroke enabled centers through telemedicine.

(B) The department shall establish a process to recognize 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 and notifies the department in a timely manner of initial and subsequent certification or accreditation.

(C) As nationally recognized, disease-specific certification or accreditation programs 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 and recognize those hospitals that have achieved the certification or accreditation.

(D) A hospital that no longer meets nationally recognized, evidenced‑based standards for primary stroke centers, or other programs as they become recognized by the department, shall notify the department and the Stroke System of Care Advisory Council within thirty days.

Section 44‑61‑650. (A) There is a established a Stroke System of Care Advisory Council to be appointed by the director of the department. Representation on the council must be as geographically diverse as possible and composed of, but not limited to, knowledgeable and experienced individuals from the following areas:

(1) a hospital administrator, or designee, from a primary stroke center, upon the recommendation of the South Carolina Hospital Association;

(2) a hospital administrator, or designee, from a hospital with a stroke telemedicine program that is not a primary stroke center upon the recommendation of the South Carolina Hospital Association;

(3) a hospital administrator, or designee, from a hospital capable of providing emergent stroke care as levels of nationally recognized, disease-specific certification or accreditation programs become available, upon the recommendation of the South Carolina Hospital Association;

(4) a licensed neurologist from a primary stroke center, upon the recommendation of the South Carolina Medical Association;

(5) a licensed emergency department physician that also serves as an emergency medical services medical director from a hospital capable of providing emergent stroke care, upon the recommendation of the South Carolina Chapter of the College of Emergency Physicians;

(6) a licensed emergency medical services agency representative, upon the recommendation of the South Carolina Emergency Medical Services Advisory Council of the Department of Health and Environmental Control;

(7) a licensed emergency medical services agency representative, upon the recommendation of the South Carolina Emergency Medical Services Association;

(8) a licensed air ambulance representative, upon the recommendation of the South Carolina Association of Air Medical Services;

(9) a representative from a rehabilitation facility that provides comprehensive inpatient post‑acute stroke services, upon the recommendation of the South Carolina Hospital Association;

(10) an acute stroke patient advocate; and

(11) a representative from the American Stroke Association.

(B) Members shall serve terms of three years and may be reappointed. Vacancies must be filled in the manner of the original appointment for the unexpired portion of the term. The director shall appoint the chairman of the council from the membership of the council, and council members may select a vice chairman from their membership. The council shall meet at least twice a year or at the call of the chairman.

(C) The Stroke Advisory Council, in consultation with the department’s Division of Heart Disease and Stroke Prevention and the Division of Emergency Medical Services, is responsible for developing and implementing the statewide system of stroke care in accordance with this article.

(D) Members of the council shall serve without compensation, mileage, per diem, or subsistence.

(E) The director shall provide a formal progress report of the status of this statewide system of stroke care to the General Assembly no later than January 15, 2014.

Section 44‑61‑660. (A)(1) The department, before June first of each year, shall distribute the list of primary stroke centers, stroke enabled centers through telemedicine, and other centers that meet the criteria for disease‑specific certification or accreditation programs as they become available to each licensed emergency medical services provider in this State. This list must be posted on the department website and be continuously updated.

(2) For the purposes of this article, the department may include on its distribution list pursuant to subsection (A)(1) 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, in consultation with the Stroke System of Care Advisory Council, 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 31, 2012. Each licensed emergency medical services provider must establish a stroke assessment and triage system that incorporates the department approved stroke‑triage assessment tool.

(C) The department, through the Division of Heart Disease and Stroke Prevention and the Division of Emergency Medical Services, shall develop and implement the statewide system of stroke care in accordance with this article and shall give consideration to recommendations submitted by the Stroke Advisory Council.

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

Section 44‑61‑670. (A) The department, in consultation with the Stroke System of Care Advisory Council, 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 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) set expectations for hospitals and emergency medical services agencies to report data on the treatment of individuals with suspected stroke within the statewide system of stroke care; and

(5) establish a Stroke Registry Task Force, as a subcommittee of the Stroke System of Care Advisory Council, which shall 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 the stroke registry data platform of ‘Get With The Guidelines-Stroke’ 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) The Stroke Registry Task Force shall:

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

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

(c) 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 44‑61‑680. 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 44‑61‑690. (A) The department has the authority to promulgate regulations to carry out the purposes of this article, including penalties for violations of the provisions under 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. 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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