

The Senate Health and Human Services Committee offered the following substitute to SB 549:

A BILL TO BE ENTITLED
AN ACT

1 To amend Chapter 11 of Title 31 of the Official Code of Georgia Annotated, relating to
2 emergency medical services, so as to enact the "Coverdell-Murphy Act"; to establish a two
3 level system of certified stroke centers; to provide for legislative findings; to provide for
4 definitions; to provide for the identification of primary stroke centers and remote treatment
5 stroke centers; to provide for a grant program; to provide for the distribution of a list of state
6 identified stroke centers to emergency medical services providers; to provide for the
7 development of a model stroke triage assessment tool; to provide for the establishment of
8 protocols related to the assessment, treatment, and transport of stroke patients by licensed
9 emergency medical services providers; to provide for annual reporting; to provide for
10 statutory construction; to provide that a hospital shall not advertise that it is identified by the
11 state as a primary or remote treatment stroke center unless so identified; to provide for rules
12 and regulations; to provide for related matters; to repeal conflicting laws; and for other
13 purposes.

14 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

15 This Act shall be known and may be cited as the "Coverdell-Murphy Act" in honor of the late
16 Georgia Congressman Paul D. Coverdell and the late Georgia Speaker of the House of
17 Representatives Thomas B. Murphy, both revered politicians of the great State of Georgia,
18 and victims of massive strokes.
19

SECTION 2.

20 Chapter 11 of Title 31 of the Official Code of Georgia Annotated, relating to emergency
21 medical services, is amended by adding a new Article 6 to Chapter 11 to read as follows:
22

"ARTICLE 6

31-11-110.

The General Assembly finds and declares that:

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

(2) Despite significant advances in diagnosis, treatment and prevention, stroke is the third leading cause of death and the biggest cause of disability in this country; an estimated 700,000 to 750,000 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) Although new treatments are available to improve the clinical outcomes of stroke, many acute care hospitals often face challenges in obtaining staff and equipment required to optimally triage and treat stroke patients, including the provision of optimal, safe, and effective emergency care for these patients;

(4) Although the Georgia Coverdell Acute Stroke Registry currently exists within the Department of Human Resources as a program whose purpose is to increase improvement of the quality of acute stroke care through collaborative efforts with participating hospitals in this state, less than one-third of Georgia's hospitals are currently enrolled in the program. Therefore increased participation in and funding of this program in conjunction with the adherence to the tenets of this article would have profound effects on the quality of care for acute stroke victims in this state;

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

(6) Two levels of stroke centers should be established for the treatment of acute stroke:

(A) Primary stroke centers should be established in as many acute care hospitals as possible to evaluate, stabilize, and provide or arrange for treatment, care, and rehabilitative services to patients diagnosed with acute stroke; and

(B) Because access to stroke care is limited in the rural areas of the state due to the limited availability of professional specialists, high-tech imaging equipment, and transportation services, remote treatment stroke centers should be established to

1 evaluate, stabilize, and provide treatment to patients diagnosed with acute stroke in
2 rural portions of the state;

3 (7) Coordination between primary stroke centers and remote treatment stroke centers
4 should be encouraged through the establishment of coordinated stroke care agreements
5 between primary stroke centers and remote treatment stroke centers; and

6 (8) Therefore, it is in the best interest of the residents of this state to establish a program
7 to identify certified stroke centers throughout the state, to provide specific patient care
8 and support services criteria that stroke centers must meet in order to ensure that stroke
9 patients receive safe and effective care, and to provide financial support to acute care
10 hospitals to encourage them to develop stroke centers in all areas of the state. Further, it
11 is in the best interest of the people of this state to modify the state's emergency medical
12 response system to assure that stroke victims may be quickly identified and transported
13 to and treated in facilities that have specialized programs for providing timely and
14 effective treatment for stroke victims.

15 31-11-111.

16 As used in this article, the term 'department' means the same state agency or state board
17 which regulates emergency medical services personnel and providers pursuant to this
18 chapter.

19 31-11-112.

20 (a) The department shall identify hospitals that meet the criteria set forth in this article as
21 primary or remote treatment stroke centers.

22 (b) A hospital shall apply to the department for such identification and shall demonstrate
23 to the satisfaction of the department that the hospital meets the applicable criteria set forth
24 in Code Section 31-11-113.

25 (c) The department shall identify as many hospitals as primary or remote treatment stroke
26 centers as apply for the identification, provided that each applicant meets the applicable
27 criteria set forth in Code Section 31-11-113.

28 (d) The department may suspend or revoke a hospital's identification as a primary or
29 remote treatment stroke center, after notice and hearing, if the department determines that
30 the hospital is not in compliance with the requirements of this article.

31 31-11-113.

32 (a) A hospital identified as a primary stroke center shall be certified as such by the Joint
33 Commission on Accreditation of Healthcare Organizations. Any hospital wishing to
34 receive official identification under this Code section must submit a written application to

1 the department, providing adequate documentation of the hospital's valid certification as
2 a primary stroke center by the commission.

3 (b) Remote treatment stroke centers shall be certified and identified by the department
4 through an application process to be determined by the department. Said process shall
5 contain, at minimum, the following requirements:

6 (1) Remote treatment stroke center certifications and identifications by the department
7 are limited to those hospitals that utilize current and acceptable telemedicine protocols
8 relative to acute stroke treatment as defined by the department;

9 (2) Upon receipt of complete and proper application for certification as a remote
10 treatment stroke center, the department shall schedule and conduct an inspection of the
11 applicant's facility no later than 90 days after receipt of application; and

12 (3) Any hospital, upon certification by the department as a remote treatment stroke
13 center, shall automatically be identified as a remote treatment stroke center and shall be
14 added to the list of such hospitals as defined in subsection (a) of Code Section 31-11-115.

15 (c) Primary stroke centers are encouraged to coordinate, through agreement, with remote
16 treatment stroke centers throughout the state to provide appropriate access to care for acute
17 stroke patients. The coordinating stroke care agreements shall be in writing and include
18 at minimum:

19 (1) Transfer agreements for the transport and acceptance of all stroke patients seen by
20 the remote treatment stroke center for stroke treatment therapies which the remote
21 treatment stroke center is not capable of providing; and

22 (2) Communication criteria and protocols with the remote treatment stroke centers.

23 31-11-114.

24 (a) In order to encourage and ensure the establishment of stroke centers throughout the
25 state, the department shall award grants, subject to appropriations from the General
26 Assembly, to hospitals that seek identification as remote treatment stroke centers and
27 demonstrate a need for financial assistance to develop the necessary infrastructure,
28 including personnel and equipment, in order to satisfy the criteria for identification as a
29 remote treatment stroke center pursuant to subsection (b) of Code Section 31-11-113.

30 (b) A hospital seeking identification as a remote treatment stroke center pursuant to this
31 article may apply to the department for a grant, in a manner and on a form required by the
32 department, and provide such information as the department deems necessary to determine
33 if the hospital is eligible for the grant.

1 (c) The department may provide grants to as many hospitals as it deems appropriate,
2 subject to appropriations, taking into consideration adequate geographic diversity with
3 respect to locations.

4 (d) The department shall, not later than September 1, 2009, prepare and submit to the
5 Governor, the President of the Senate, and the Speaker of the House of Representatives a
6 report indicating, as of June 30, 2009, the total number of hospitals that have applied for
7 grants pursuant to this Code section, the number of applicants that have been determined
8 by the department to be eligible for such grants, the total number of grants to be awarded,
9 the name and address of each grantee hospital, the amount of the award to each grantee, the
10 amount of each award to be disbursed to the grantee, and whether or not, in the opinion of
11 the department, each grantee would be able to attain identification as a remote treatment
12 stroke center pursuant to subsection (b) of Code Section 31-11-113.

13 31-11-115.

14 (a) Beginning June 1, 2009, and each year thereafter, the department shall send the list of
15 primary and remote treatment stroke centers identified pursuant to Code Section 31-11-113
16 the medical director of each licensed emergency medical services provider in this state,
17 shall maintain a copy of the list in the office designated with the department to oversee
18 emergency medical services, and shall post a list of primary and remote treatment stroke
19 centers on the department's website.

20 (b) The department shall adopt or develop a sample stroke triage assessment tool. The
21 department shall post this sample assessment tool on its website and distribute a copy of
22 the sample assessment tool to each licensed emergency medical services provider no later
23 than December 31, 2008. Each licensed emergency medical services provider shall use a
24 stroke triage assessment tool that is substantially similar to the sample stroke triage
25 assessment tool provided by the department.

26 (c) The office designated within the department to oversee emergency medical services
27 shall establish protocols related to the assessment, treatment, and transport of stroke
28 patients by licensed emergency medical services providers in this state.

29 31-11-116.

30 (a) In order to assure that the patients are receiving the appropriate level of care and
31 treatment at each primary stroke center in the state, each hospital identified as a primary
32 stroke center shall annually report the following information to the department:

33 (1) The number of patients evaluated;

34 (2) The number of patients receiving acute interventional therapy;

- 1 (3) The amount of time from patient presentation to delivery of acute interventional
- 2 therapy;
- 3 (4) Patient length of stay;
- 4 (5) Patient functional outcome;
- 5 (6) Patient morbidity;
- 6 (7) Deep vein thrombosis prophylaxis given;
- 7 (8) Number of patients discharged on antiplatelet or antithrombotics medication;
- 8 (9) Number of patients with atrial fibrillation receiving anticoagulation therapy;
- 9 (10) Patients on which the administration of tissue plasminogen activator was
- 10 considered;
- 11 (11) Antithrombotic medication administered within 48 hours of hospitalization;
- 12 (12) Number of lipid profiles ordered during hospitalization;
- 13 (13) Number of screens for dysphagia performed;
- 14 (14) Stroke education provided;
- 15 (15) Number of smoking cessation programs provided or discussed;
- 16 (16) The number of patients assessed for rehabilitation and whether a plan for
- 17 rehabilitation was considered;
- 18 (17) The number of emergency medical services stroke patients who were transported
- 19 to the facility;
- 20 (18) The number of emergency medical services stroke patients who were admitted to
- 21 the facility;
- 22 (19) The number and percentage of stroke cases treated with intravenous or intra-arterial
- 23 tissue plasminogen activator; and
- 24 (20) The number of patients discharged on cholesterol reducing medication.
- 25 (b) In order to assure that the patients are receiving the appropriate level of care and
- 26 treatment at each remote treatment stroke center in the state, each hospital identified as a
- 27 remote treatment stroke center shall annually report the following information to the
- 28 department:
- 29 (1) The number of patients evaluated;
- 30 (2) The number of patients receiving acute interventional therapy;
- 31 (3) The amount of time from patient presentation to delivery of acute interventional
- 32 therapy;
- 33 (4) Patient length of stay;
- 34 (5) The number of emergency medical services stroke patients who were transported to
- 35 the facility;
- 36 (6) The number of emergency medical services stroke patients who were admitted to the
- 37 facility; and

1 (7) The number and percentage of stroke cases treated with intravenous or intra-arterial
2 tissue plasminogen activator.

3 (c) The department shall collect the information reported pursuant to subsections (a)
4 and (b) of this Code section and shall post such information in the form of a report card
5 annually on the department's website and present such report to the Governor, the
6 President of the Senate, and the Speaker of the House of Representatives. The results of
7 this report card may be used by the department to conduct training with the identified
8 facilities regarding best practices in the treatment of stroke.

9 (d) In no way shall this article be construed to require disclosure of any confidential
10 information or other data in violation of the federal Health Insurance Portability and
11 Accountability Act of 1996, P.L. 104-191.

12 31-11-117.

13 This article shall not be construed to be a medical practice guideline and shall not be used
14 to restrict the authority of a hospital to provide services for which it has received a license
15 under state law. The General Assembly intends that all patients be treated individually
16 based on each patient's needs and circumstances.

17 31-11-118.

18 A hospital may not advertise to the public, by way of any medium whatsoever, that it is
19 identified by the state as a primary or remote treatment stroke center unless the hospital has
20 been identified as such by the department pursuant to this article.

21 31-11-119.

22 The department shall be authorized to promulgate rules and regulations to carry out the
23 purposes of this article."

24 **SECTION 3.**

25 All laws and parts of laws in conflict with this Act are repealed.