INYO COUNTY

EMERGENCY MEDICAL CARE COMMITTEE

Big Pine Fire Department
181 North Main Street
Big Pine, CA

May 23, 2011
QI Committee --CANCELLED
EMCC -- 6:00 p.m.

A G E N D A

I. CALL TO ORDER

II. APPROVAL OF MARCH 28, 2011 MINUTES — **ACTION**

III. ICEMA UPDATE — **INFO/ACTION**
- A. QI Plan
- B. Intubation CQI Project
- C. Data System RFP

IV. EMS SYSTEM MANAGEMENT REPORTS — **INFO/ACTION**
- A. Base Hospital Report
- B. Scantron/ePCR Report

V. OLD BUSINESS — **INFO/ACTION**

VI. NEW BUSINESS — **INFO/ACTION**
- A. Proposed 2011-12 Fee Schedule
- B. Continuation of Trauma Care Protocol
- C. Neurovascular Stroke Receiving Center Designation Criteria

VII. OTHER/PUBLIC COMMENT

VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

IX. NEXT MEETING DATE AND LOCATION

X. ADJOURNMENT

The Inyo County Emergency Medical Care Committee (EMCC) meeting facility is accessible to persons with disabilities. If assistive listening devices or other auxiliary aids or services are needed in order to participate in the public meeting, requests should be made through the Inland Counties Emergency Medical Agency at least three (3) business days prior to the EMCC meeting. The telephone number is (909) 388-5823, and office is located at 515 North Arrowhead Avenue, San Bernardino, CA.

INYO COUNTY EMCC MEETING

Bishop Fire Training Facility, 960 Poleta Rd, Bishop CA 93514
Hosted by:
Sierra LifeFlight
MINUTES
March 28, 2011

Voting Members Present:

Paul Postle, Chairperson	So. Inyo Fire Prot. District, Chief	paul2701@wildblue.net
Judd Symons, Vice Chair	Symons Emergency Specialties, Inc.	juddsymons@aol.com
Dr. Michael Dillon	ER Physician	MichaelDillon@qnet.com
Dr. Rick Johnson	Inyo County Public Health	drrickjohn@gmail.com
Le Roy Kritz	Lone Pine Fire Department, Chief	LChief2401@lonepinetv.com
Lloyd Wilson	Big Pine Fire Department	dlwilson41@msn.com
Mike Patterson	Sierra Life Flight, Program Director	mike@sierraaviation.com
Phil Ashworth	Independence Fire Department	philinyo@usamedia.tv
Steven Davis	Olancha Cartago Fire Dept., Chief	olanchafire@aol.com
Andrew Stevens	Northern Inyo Hospital	Andrew.stevens@nih.org

Voting Members Absent:

Martha Reynolds	Northern Inyo Hospital	marthareynolds@nih.org
Lee Barron	Southern Inyo Hospital	leebee40@aol.com
Joe Cappello	Independence Fire Department	jcappello@cebridge.net

Other Attendees:

Denice Stiles	ICEMA	dwicker-stiles@cao.sbcounty.gov
Gina Ellis	ICHHS, Recording Secretary	gellis@inyocounty.us
Jean Turner	Health & Human Services, Director	jturner@inyocounty.us
John Marzano	Big Pine Fire Department	BigPineFire@chilitech.net
Lisa Erwin	Northern Inyo Hospital	Lisa.Erwin@NIH.org
Marty Fortney	Inyo County Supervisor	mfortney@inyocounty.us
Paul Easterling	ICEMA	peasterly@cao.sbcounty.gov
Ray G. Seguine	Bishop Fire Department	Seguine@ca-bishop.us
David Calloway	Big Pine Fire Department	

I. CALL TO ORDER

Chairperson, Paul Postle called the meeting to order at 6:07 p.m.

II. APPROVAL OF JANUARY 24, 2011 MINUTES

Andrew Stevens requested a correction to the January 24, 2011 meeting minutes. The minutes reflected that he had made a motion to adjourn the meeting, however, he was not at the meeting. Motion Leroy Kritz, seconded by Michael Dillon to approve the minutes of the January 24, 2011 with the recommended correction. Motion carried unanimously.

III. ICEMA UPDATE

A. Legislative Update

The EMSAAC Legislative Report dated 3/16/11 was included in the meeting packets.

B. QI Plan

Denice Stiles reported that the state approved the QI plan without changes. The February 2011 QI Plan was included in the meeting packet.

IV. EMS SYSTEM MANAGEMENT REPORTS

A. Base Hospital Report

Nothing to report

B. Scantron/ePCR Report

Scantron reports for the 2010 calendar year were distributed at Q.I. meeting earlier in the evening. If anyone has questions, they should call Moises Evangelista at ICEMA. Regarding the new software system, a Request For Proposal went out today. ICEMA hopes to have a more user-friendly new non-web hosted software system by July 1st. The goal is to have all agencies on the ePCR system, as it will help with data collection, quality improvement and reimbursement.

V. OLD BUSINESS

A. EMS Strategy Subcommittee Report

The EMS Strategy Subcommittee has been tabled. Steven Davis spoke about a grant that he had applied for, stating that he had not yet received an award notice, but anticipated that he would within the next few weeks. He will inform the EMCC by sending out an e-mail once he receives a notice.

B. EMT Education/NREMT Testing Sites

Denice reported that an e-mail was sent out two weeks ago confirming that the Cerro Coso College in Ridgecrest had been approved as a testing site. ICEMA is working with the Bishop campus for approval as an additional test site, but she has had trouble getting a response from Cerro Coso. She also spoke about the new testing standards and the EMSA website. She provided a handout that had the testing result numbers for the pass rate by region. She spoke about how the schools are doing, and will be working with educational providers for best practice recommendations.

DRAFT

C. EMS Debriefing Program

Nothing to report. This item should be removed from future agendas.

D. MCI Plan

Dr. Johnson spoke about the January 11, 2011 version of the MCI Plan that was included in the packet. After some discussion, it was decided that the plan did not need to go back out for public comment. The plan will go back to ICEMA for one more review and approval, and then will be sent out as a final protocol. Dr. Johnson thanked Steven Davis for his help with the plan.

E. Other

VI. NEW BUSINESS

A. EMCC Annual Report – First Reading

Denice presented the group with a draft version of the 2010 EMCC Annual Report. She opened a discussion session asking for comments from the committee. Many comments, revisions were suggested, and it was decided that the report should be revised. The presentation of the report to the Inyo County Board of Supervisors was discussed. Some of the committee members felt that the Board of Supervisors should be made aware of the challenges that local agencies are facing with EMS education, including a lack of funding. Supervisor Marty Fortney stated that he had worked with the Inyo County Sheriff's Department to contribute $30,000 for EMS education in addition to the $10,000 contribution from ICEMA and the $5,000 from the Maddy Funds, so the funding issues for EMS education had been addressed for this year. This may have to be revisited later, once things are decided in Sacramento, and it could change if there is a new Sheriff. Suggestion were made to include the following items in the report: 1) changes in the requirements such as the EMT course going from 120 to 160 hours 2) the declining number of volunteers 3) the increase in regulations 4) the possibility of an insufficient number of students for Bishop Cerro Coso program 5) recommendations for stabilized future funding. Denice will revise and email the report to members. A comment was made that the medical control segment looked a little backwards, and that there were numbering or formatting issues in the report. There was some concern that some of the communities were not included in the census data. Dr. Dillon stated that there are three different levels layers of medical control. Denice asked that the group help with the details, and send her all suggestions and comments. Deadline for comments on the report is April 8, 2011. Final draft will be emailed to members so that it can go to the Board of Supervisors at the same time as the EMS week items.

DRAFT

B. Tactical Interoperable Communications Plan (TCIP)

Marty Fortney reported that the Sheriff is putting together a committee to work on the narrow banding project, and that a representative is needed. Mr. Fortney had volunteered Steven Davis. Motion Leroy Kritz, to appoint Steven Davis to the TCIP committee. Mr. Davis accepted the committee appointment.

C. EMS Volunteer of the Year

Steven Davis spoke about EMS Volunteer of the Year nomination that was received. The award will be presented in May. The nomination form was distributed to the group for their review. There was group discussion, and Andrew Stevens added that the nominee was a great choice. Motion Michael Dillon, seconded by Phil Ashworth to select David Calloway as the 2010 EMS Volunteer of Year. Motion carried unanimously. Denice asked that photos of presentation at the Board of Supervisors meeting be sent to her office to be included in the newsletter. Staff will work to have the presentation at the Tuesday, May 17, 2011 Board of Supervisors meeting, which would coincide with EMS week May 15-21, 2011. This would be subject to change if Mr. Calloway could not make that date.

VII. OTHER/PUBLIC COMMENT

Andrew Stevens presented the group with a resignation letter from Martha Reynolds, which Jean Turner read aloud. A recommendation was made that Ms. Reynolds be recognized for her 25 years of membership on the committee in conjunction the Volunteer of the Year presentation. Health and Human Services staff will take care of the advertisement to fill the vacancy for the remainder of her term.

Denice said that the ICEMA newsletter was recently mailed out. ICEMA would really appreciate receiving articles from Inyo and Mono counties to include in the newsletter.

VIII. COMMITTEE MEMBER REQUEST FOR TOPICS FOR NEXT MEETING

Meeting topics should be sent to ICEMA no later than one week prior to the meeting.

IX. NEXT MEETING DATE AND LOCATION

Monday, May 23, 2011 Big Pine Fire Department
Q.I. 5:00 p.m., EMCC 6:00 p.m.

X. ADJOURNMENT

The meeting was adjourned at 6:57 p.m.

2011-2012 PROPOSED FEE SCHEDULE

PURPOSE

To establish the ICEMA fee schedule for 2011/2012.

FEE SCHEDULE

ADMINISTRATION

1. Transportation (annual)

   A. EMS Pre-hospital Provider Permit/Authorization $1,570.00

   B. EMS Pre-hospital Provider Permit/Authorization - Late Penalty $315.00

   C. EMS Aircraft Provider $15,000.00

   D. EMS Drug and Equipment Inspection $315.00/unit

2. EMS Certification Fees (bi-annual)

   A. Mobile Intensive Care Nurse (MICN)

      1. Certification $90.00

      2. Recertification $90.00

      3. Challenge $225.00

   B. Flight Nurse (FN)

      1. Authorization $45.00

      2. Reauthorization $45.00

   C. Emergency Medical Technician - Paramedic (EMT-P)

      1. Accreditation $90.00

      2. Re-verification $50.00

3. Failure to Complete EMT-P Continuing Education - Penalty Fee (per course) $100.00

D. Emergency Medical Technician (EMT)

1. Certification $45.00

2. Recertification $45.00

E. Emergency Medical Services Dispatchers (EMSD)

1. Certification $45.00

2. Recertification $45.00

3. Challenge $60.00

F. Emergency Medical Responders (EMR)

1. Certification $45.00

2. Recertification $45.00

3. Challenge $75.00

G. Accreditation/Certification Re-test $55.00

H. Certification/Accreditation Card Replacement $20.00

I. Certification/Accreditation Card Name Change $20.00

3. Training Program Approval Fees (every four years)

A. MICN $300.00

B. EMR.....$575.00

C. EMT $575.00

D. EMT-P $1,000.00

E. Annual Review Curriculum Instruction $400.00

F. Continuing Education Provider $500.00

4. Hospitals

A. Base Hospital Application Fee.....$5,000.00

B. Base Hospital Re-designation Fee (bi-annual) $2,500.00

C. Trauma Hospital Application Fee $5,000.00

D. Trauma Hospital Re-designation Fee (annual) $25,000.00

E. ST Elevation Myocardial Infarction (STEMI) Receiving Center Designation Application Fee $5,000.00

F. ST Elevation Myocardial Infarction (STEMI) Receiving Center Designation Fee (annual) $20,560.00

G. Neurovascular Stroke Receiving Center Designation Application Fee.....$2,500.00

H. Neurovascular Stroke Receiving Center Designation Fee (annual) $20,560.00

5. EMS Temporary Special Events

A. Minor Event Application $75.00

B. Major Event Application $315.00

6. Protocol Manual

A. With Binder $26.00

B. Inserts Only $15.00

C. CD $5.00

7. Equipment Rental

A. Standard Equipment $10.00/item

B. Deluxe Equipment $25.00/item

8. Statistical Research $50.00/hour

This rate schedule shall take effect July 1, 2011.

Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director
Reza Vaezazizi, M.D., Medical Director

DATE: May 4, 2011

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Virginia Hastings, ICEMA Executive Director
Reza Vaezazizi, MD, ICEMA Medical Director

SUBJECT: **CONTINUATION OF TRAUMA CARE - 14 DAY PUBLIC COMMENT**

Attached is the public comment draft of the **CONTINUATION OF TRAUMA CARE** protocol. The protocol has been reviewed extensively by the Trauma System Advisory Committee (TSAC), the Protocol and Education Committee (PEC) and the Medical Advisory Committee (MAC). Due to the extensive committee reviews and the desire to implement this protocol prior to the summer months, we have shortened the comment period to 14 days.

ICEMA encourages all system participants to submit comments in writing to ICEMA during the 14-day comment period. **Written comments will be accepted until May 18, 2011 at noon.** Comments may be sent hardcopy, faxed to (909) 388-5825 or via email to Chris Yoshida-McMath, RN at c.yoshida-mcmath@cao.sbcounty.gov. Comments will be compiled and presented at the Emergency Medical Care Committee (EMCC) meeting on May 19, 2011 at 9 a.m. The protocol will be placed on the Inyo and Mono County EMCC's the following week.

RV/VH/mae

515 North Arrowhead Avenue ▪ San Bernardino, CA. 92415-0060
(909) 388-5823 office ▪ (909) 388-5825 fax ▪ www.icema.net

CONTINUATION OF TRAUMA CARE

THIS POLICY IS FOR TRANSFER OF TRAUMA PATIENTS FROM A REFERRAL HOSPITAL (RH) TO A TRAUMA CENTER (TC) ONLY AND SHALL NOT BE USED FOR ANY OTHER FORM OF INTERFACILITY TRANSFER OF PATIENTS.

PURPOSE:

To support a system of trauma care that is consistent with ACS standards and ensures the minimal time from patient injury to receiving the most appropriate definitive trauma care.

DEFINITIONS:

Trauma Center (TC) - a licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws, regulations and ICEMA policies.

Referral Hospital (RH): any licensed general acute care hospital that is not an ICEMA designated TC.

INCLUSION CRITERIA:

Any patient meeting ICEMA Trauma Triage Criteria, (Reference ICEMA Policy 15030) arriving at a non-trauma hospital by EMS or non-EMS transport.

INITIAL TREATMENT GOALS (at RH)

1. Initiate resuscitative measures within the capabilities of the facility.

2. Ensure patient stabilization is adequate for subsequent transfer.

3. Transfer timeline goal is <30 minutes door-to-transfer out.

4. DO NOT DELAY TRANSFER by initiating any diagnostic procedures that do not have direct impact on IMMEDIATE resuscitative measures.

5. RH ED physician will make direct physician-to-physician contact with the ED physician at the TC.

6. The TC will accept all referred trauma patients unless they are on Internal Disaster as defined in ICEMA Policy# 8060.

7. The TC ED physician is the accepting physician at the TC and will activate the internal Trauma Team according to internal TC protocols.

8. RH ED physician will determine the appropriate mode of transportation for the patient. If ground transportation is >30 minutes consider the use of an air ambulance. Requests for air ambulance shall be made to 9-1-1 and normal dispatching procedures will be followed; however, the air ambulance continuation of trauma run patient will be transported to the TC identified by the RH.

9. Simultaneously call 9-1-1 and utilize the following script to dispatch:

   "This is a Trauma Continuation of Trauma Run Interfacility Transfer from ____hospital to ____Trauma Center"

   Dispatchers will only dispatch transporting paramedic units without any fire apparatus.

10. RH must send all medical records, test results, radiologic evaluations to the TC. DO NOT DELAY TRANSFER- these documents may be FAXED to the TC.

SPECIAL CONSIDERATIONS:

1. If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH.

2. The RH may consider sending one of its nurses with the transporting paramedic unit if deemed necessary due to the patient's condition or scope of practice.

3. Nurse staffed critical care (ground or air) transport units maybe used; but may create a delay due to availability. Requests of nurse staffed critical care transport units must be made directly to the transporter agency by land line.

STROKE "NSRC" RECEIVING CENTERS

PURPOSE

To provide guidelines to rapidly transport stroke patients who access the 9-1-1 system to a designated Neurovascular Stroke Receiving Center (NSRC) when indicated. Patients transported to NSRC will benefit from rapid assessment, intervention and treatment at a dedicated stroke specialty center. Patients will meet the defined criteria for triage as an acute ischemic or hemorrhagic cerebral vascular event. At this present time, this policy is limited to the San Bernardino County area.

DEFINITIONS

1. **Neurovascular Stroke Receiving Centers (NSRC):** ICEMA designated Level I or Level II receiving hospital for patients triaged as having a cerebral vascular event requiring hospitalization for treatment, evaluation and/or management of this event.

2. **NSRC Level I (NSRC-I)**: A twenty-four (24) hours per day, seven (7) days per week acute care hospital that has successfully completed and maintains The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation as a Primary Stroke Center, **has interventional neuroradiologic and neurosurgical capabilities** and enters into a memorandum of understanding with ICEMA relative to being a Stroke Center.

3. **NSRC Level II (NSRC-II)**: A twenty-four (24) hours per day, seven (7) days per week acute care hospital that has successfully completed and maintains The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation as a Primary Stroke Center and enters into a memorandum of understanding with ICEMA relative to being a Stroke Center.

4. **Neurovascular Stroke Referral Hospital(s) (NSRH)**: General acute care hospitals that refer possible stroke patients to NSRC.

5. **Neurovascular Stroke Base Station(s)**: Facilities that have TJC or HFAP Primary Stroke Center accreditation that also function as a Paramedic Base Station.

6. **TJC**: The Joint Commission

7. **HFAP**: Healthcare Facilities Accreditation Program

8. **Interventional Neuroradiologic capabilities**: Facilities with qualified interventional radiologists and/or neurosurgeons able to administer inter-arterial tissue plasminogen activator and/or perform mechanical clot retrieval.

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9. **CQI**: Continuous Quality Improvement.

10. **EMS**: Emergency Medical Services.

11. **CE**: Continuous Education**.**

12. **mLAPSS**: Modified Los Angeles County Prehospital Stroke Screening Scale.

POLICY

The following requirements must be met for a hospital to be an ICEMA designated NSRC-I or NSRC-II:

1. An ICEMA approved paramedic receiving hospital which is a full service acute care facility.

2. Accreditation as a Primary Stroke Center by TJC or HFAP and proof of re-accreditation every two (2) years.

3. A facility alert system for incoming stroke patients available twenty-four (24) hours per day, seven (7) days per week (i.e. in-house paging system).

4. Provide CE opportunities for NSRC, NSRH and EMS personnel in areas of pathophysiology, assessment, triage and management for stroke patients and report annually to ICEMA.

5. Lead public stroke education efforts at the appropriate educational level and report annually to ICEMA.

STAFFING REQUIREMENTS

The hospital will have the following positions filled prior to becoming a NSRC-I or NSRC-II:

1. <u>Medical Directors</u>

   The hospital shall designate two (2) physicians with hospital privileges as co-directors of its NSRC program. One (1) physician shall be Board-certified or Board-eligible by the American Board of Medical Specialties or American Osteopathic Association, neurology or neurosurgery board. The co-director shall be a Board-certified or Board-eligible emergency medicine physician.

2. <u>Nursing Coordinator</u>

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The hospital shall designate a NSRC Nursing Coordinator who has experience in critical care or emergency nursing, and who has advanced education in stroke physiology or at least has two (2) years' dedicated stroke patient management experience. Certification in critical care or emergency nursing is preferred.

3. On-Call Physicians Specialists / Consultants

A daily roster of the following on-call physician consultants and staff must be promptly available within thirty (30) minutes of notification of "Stroke Alert" twenty-four (24) hours per day, seven (7) days per week.

a. Radiologist experienced in neuroradiologic interpretations.

b. On-call Neurologist available twenty-four (24) hours per day; seven (7) days per week.

c. Additional requirements for:

NSRC-I
1) Interventional Neuroradiologist or Interventional vascular neurosurgeon and an angiogram suite available twenty-four (24) hours per day; seven (7) days per week. 2) Neurosurgeon available twenty-four (24) hours per day; seven (7) days per week.

NSRC-II:
1) For NSCR-II designation only, ICEMA may waive the on–call neurologist requirement, for tele-neurology, upon submission of the following written documentation: • Demonstration of geographic and/or population based need. • Demonstration of active planning to obtain a twenty-four (24) hours per day; seven (7) days per week call-panel of neurologists. • Assurance of an in-person neurologist's evaluation of stroke patients within twelve (12) hours of hospital admission. • Assurance of 100% QI of all tele-neurology patients. *Request for waiver must be re-submitted and re-evaluated by ICEMA every 12 months.*

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NSRC-II Continued

2) If neurosurgical services are not available in-house, the facility must have a rapid transfer agreement in place with a facility that provides this service. The agreement must be on file with the local EMS agency. NSRC-I's must promptly accept rapid transfer requests from NSRC-II's. Additionally, the facility must have a rapid transport agreement in place with an ICEMA permitted transport agency for that EOA.

INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

1. Stroke Team alert response policy upon EMS notification of a "Stroke Alert".

2. Rapid assessment of stroke patient by Emergency and Neurology teams

3. Prioritization of ancillary services including laboratory and pharmacy with notification of "Stroke Alert".

4. Arrangement for priority bed availability in Acute Stroke Unit or Intensive Care Unit (ICU) for "Stroke Alert" patients.

   Acknowledges that stroke patients may **only** be diverted during the times of Internal Disaster in accordance to protocol #8060 *Requests for Hospital Diversion*, (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues i.e. bomb threat, earthquake damage, hazardous material or safety and security of the facility.) A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.

5. Additional requirements for:

NSRC-I
a. Emergent thrombolytic and mechanical therapy protocol to be used by Neurology, Emergency, Pharmacy, Interventional and Critical Care teams. b. Maintaining readiness of diagnostic computed tomography (CT), magnetic resonance imaging (MRI) and therapeutic resources such as an interventional suite upon notification of Stroke Team. c. Prompt acceptance of stroke patients from any NSRH as well as referral from NSRC-II to NSRC-I when interventional skills are required.

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NSRC-II
a. Emergent thrombolytic and tele-neurology (if waiver is approved) protocol to be used by Neurology, Emergency, Pharmacy and Critical Care teams. b. Maintaining readiness of diagnostic computed tomography (CT), upon notification of Stroke Team.

DATA COLLECTION

Data will be reported to the ICEMA Medical Director on a monthly basis using an ICEMA approved registry.

CONTINUOUS QUALITY IMPROVEMENT PROGRAM

NSRC shall develop an on-going CQI program which monitors all aspects of treatment and management of stroke patients and identifies areas needing improvement. At a minimum, the program will monitor the following parameters:

1. Morbidity and mortality related to procedural complications.

2. Tracking door to intervention times and adherence to minimum performance standards.

   ICEMA will utilize current Get with the Guidelines (GWTG) performance indicators. Any specific or additional performance indicators will be determined in collaboration with the Stroke CQI Committee.

3. Active participation in ICEMA Stroke CQI Committee activities.

PERFORMANCE STANDARDS

Compliance with the American Stroke Association Performance Measures as a Primary Stroke Center.

DESIGNATION

1. The NSRC applicant shall be designated by ICEMA after satisfactory review of written documentation, a potential site survey and completion of an agreement between the hospital and ICEMA.

2. Documentation of current accreditation as a Primary Stroke Center by TJC or HFAP shall be accepted in lieu of a formal site visit by ICEMA.

3. Initial designation as a NSRC shall be for a period of two (2) years. Thereafter, redesignation shall occur every two (2) years contingent upon satisfactory review.

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4. Failure to comply with the agreement, criteria and performance standards outlined in this policy may result in probation, suspension or rescission of the NSRC designation.

PATIENT DESTINATION

1. The NSRC should be considered as the destination of choice if all of the following criteria are met:

   a. Stroke patients eligible for transport to NSRC (identified stroke patients) will be identified using the mLAPSS triage criteria.

   b. Identified acute stroke patients with "last seen normal" time plus transport time equaling greater that (8) eight hours or if "last seen normal" time is unknown, transport to the closest paramedic receiving hospital.

   c. Identified stroke patients with "last seen normal" time plus transport time between (3) three to (8) eight hours will be transported to NSRC-I.

   d. Identified stroke patients with "last seen normal" time plus transport time less than (3) hours will be transported to any closest NSRC-I or NSRC-II.

   e. NSRC Base Station contact is **mandatory** for all patients identified as a possible stroke patient.

   f. The NSRC base station is the only authority that can direct a patient to a NSRC. The destination may be changed at NSRC base station discretion.

   g. The NSRC base station, if different from the NSRC will notify the NSRC of the patient's pending arrival as soon as possible, to allow timely notification of Stroke Team.

   h. Air transport may be considered if ground transport is greater than thirty (30) minutes.

2. The following factors should be considered in determining choice of destination for acute stroke patients. NSRC base station contact and consultation is mandatory in these situations:

   a. Patients with unmanageable airway, unstable cardiopulmonary condition or in cardiopulmonary arrest should be transported to the closest paramedic receiving hospital.

   b. Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to closest NSRC-I.

DRAFT

c. Patients with hemodynamic instability and exhibiting signs of inadequate tissue perfusion should be transported to the closest paramedic receiving hospital.

DRAFT

STROKE TREATMENT - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

Patient exhibiting signs/symptoms of a possible stroke. These signs may include: speech disturbances, altered level of consciousness, parasthesias, new onset seizures, dizziness unilateral weakness and visual disturbances.

BLS INTERVENTIONS

1. Oxygen therapy as clinically indicated.

2. Position patient as tolerated. Consider left lateral position, if indicated.

3. Place patient in axial spinal stabilization, if trauma is suspected.

4. If patient history includes insulin or oral hypoglycemic medications, administer Glucose sublingual.

ALS INTERVENTIONS

1. Obtain vascular access and place on monitor.

2. Obtain blood glucose. If hypoglycemic, refer to Altered Level of Consciousness/Seizures-Adult Protocol Reference #11080.

3. For tonic/clonic type seizure activity, refer to Altered Level of Consciousness /Seizures-Adult Protocol Reference #11080.

Modified Los Angeles County Prehospital Stroke Screen (mLAPSS): A screening tool used by prehospital care providers to assist in identifying patients who may be having a stroke.

mLAPSS CRITERIA

1. Ask when "last seen normal" or without stroke symptoms. Refer to Stroke Decision Tree.

2. No history of seizures or epilepsy.

DRAFT

3. Age greater than or equal to 40. If less than 40, with suspected stroke, continue mLAPSS assessment, make NSRC base station contact for destination.

4. At baseline, patient is not wheelchair bound or bedridden.

5. Blood glucose between 60-400 mg/dl.

6. Motor Exam: Examine for obvious asymmetry-unilateral weakness (exam is positive, if one (1) or more of the following are present).

   a. Facial smile/Grimace asymmetry.

   b. Grip asymmetry.

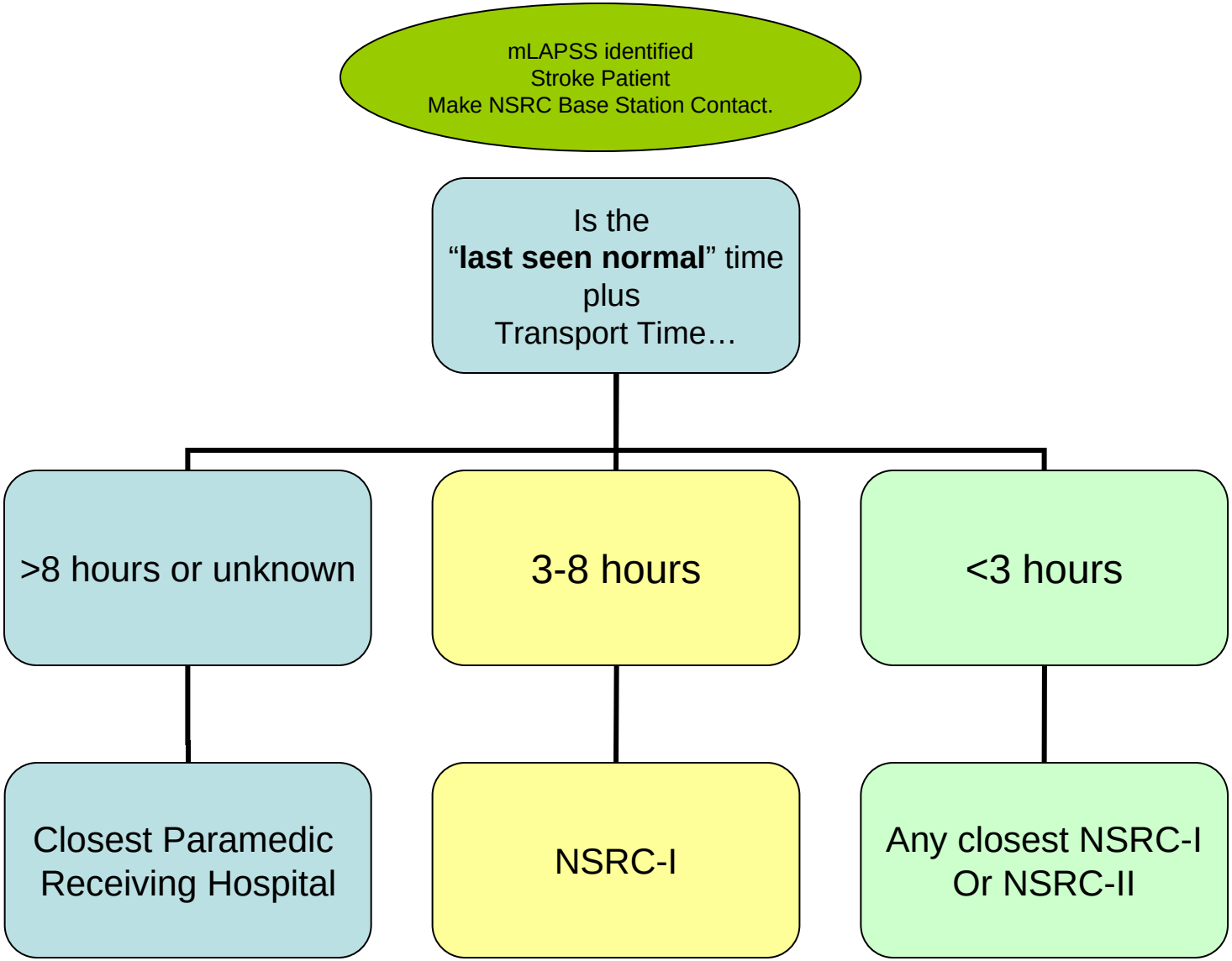
   c. Arm Strength asymmetry.

If Stroke Scale is positive, initiate "Stroke Alert", contact NSRC base station and transport immediately.

If time is available, and the patient or family can provide the information, assess the patient using the criteria listed below and report to ED personnel:

THROMBOLYTIC ASSESSMENT

Onset greater than 4 hours?	Yes	No
History of recent bleeding?	Yes	No
Use of anticoagulant?	Yes	No
Major surgery or serious trauma in the previous fourteen (14) days?	Yes	No
Sustained systolic blood pressure above 185mm Hg.?	Yes	No
Recent stroke or intracranial hemorrhage?	Yes	No



Stroke Decision Tree

Protocol Reference #'s XXXX & XXXX

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Stroke "NSRC" Receiving Center Policy	Redlands Community Hospital (RCH)	STAFFING REQUIRMENTS: • "Medical Director- The protocol establishes the standard that the NSRC must have a board certified emergency room physician and board-certified neurologist as the medical director. All physicians at RCH who participate in the hospital's stroke program are board certified; the neurologist providing initial response are not only board certified but have a specialty focus in stroke, which is a higher level than that at our neighboring facilities."	Policy revised. • NSRC-II Tele-neurology waiver.
	RCH	STAFFING REQUIRMENTS: • "Nursing Coordinator-The protocol asserts that this position be certified in critical care nursing, Not only do the critical care nurses care for the acute stroke, so do the emergency care nurses, in fact, emergency care nurses see and care for more stroke patients than any critical care nurse. Experience and certification in either should be acceptable to ICEMA."	Policy revised. • CCRN/CEN preferred. • Critical care, emergency nursing experience and has advanced education in stroke physiology or at least 2 years of dedicate stroke patient management.
	RCH	STAFFING REQUIREMENTS: • "On-call Physicians Specialists/Consultants- According to the ICEMA stroke protocol, the NSRC must have a neurologist on call 24 hours/day, seven days per week. At RCH, <u>we do not have board-certified neurologists</u> available 24 hours/day, seven days per week. As stated about the neurologists are not only board certified but have <u>a specialty focus in</u>	Policy revised. • NSRC-II Tele-neurology waiver.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		stroke which is a higher level than that at our neighboring facilities." *Several other documents and letters were submitted to ICEMA regarding the support of tele-neurology. Please contact ICEMA to view these letters.*	
Stroke "NSRC" Receiving Center Policy	St. Mary's Medical Center (SMMC)	PURPOSE • "Last line should probably read Trauma related cranial cerebral events will be managed in the ICEMA "Trauma system" rather than the current 'stroke system'	Policy revised. • Statement removed.
	SMMC	STAFFING REQUIREMENTS • " Does neurologist need to be board certified? What about board eligible? Currently we have a BC neurologist but thinking of the future that might be too restrictive.	Policy revised. • Added 'board-eligible'.
	SMMC	STAFFING REQUIREMENTS • On-call specialists: "No where does it exclude "teleneurology" service it just says 'on call' neurologist 24 hours a day. If I had not come to the meeting the other day, I would not have interpreted that to exclude on call teleneurology as they are often referred to	Policy revised. • NSRC-II tele-neurology waiver.
	SMMC	INTERNAL HOSPITAL POLICIES • Mechanical therapy protocol referenced in item # 1 should be level one centers only.	Policy revised. • NSRC-I added.
	SMMC	STAFFING REQUIREMENTS • Rapid transfer agreement please explain what rapid is. HFAP expects ICH transfer to take place in 2 hours as well as TJC may have similar requirements. We need accountability from the level one centers that they will accept these patients. What about	Policy revised. • Will be monitored in CQI process.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		inpatient strokes? Will that be problematic or will level ones be expected to receive them also rapidly? There needs to be express transport through the usual bed control	
	SMMC	• What does item "e" mean "interventional team" is that the stroke team? Level II's are not interventional maybe it should be referenced as stroke team if so	Policy revised. • Clarified. • Interventional Neuroradiologist or Interventional vascular surgeon and angiogram suite.
	SMMC	**DATA COLLECTION** • Is the ICEMA approved registry the same as the ICEMA stroke database? If not we are using AHA get with the guidelines stroke	No change. • Yes, the ICEMA approved registry is the same as the ICEMA stroke database. • Clarified below.
	SMMC	**CQI** • I am not sure what the national quality forum (NQF) measures are for stroke do you have them to share?	Policy revised. • Clarified. • GWTG & Indicators selected by Stroke CQI committee.
	SMMC	I love the stroke decision tree	
Stroke "NSRC" Receiving Center Policy	Barstow FD	"the protocol is good as written. we just have to train the guys to use the thrombolytic assessment, and the stroke decision tree. and we need only to emphasize that those who do not meet criteria go the closest hospital."	

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Stroke "NSRC" Receiving Center Policy	Mammoth Hospital	PATIENT DESTINATION 1. The NSRC should be considered as the destination of choice if all of the following criteria are met: a. Stroke patients eligible for transport to NSRC (identified stroke patients) will be identified using the mLAPSS triage criteria. b. Identified stroke patients with "last seen normal" time plus transport time equaling greater that (8) eight hours or if "last seen normal" time is unknown, transport to the closest Paramedic Receiving Hospital. c. Identified stroke patients with "last seen normal" time plus transport time between (3) three to (8) eight hours will be transported to NSRC-I. d. Identified stroke patients with "last seen normal" time less than (3) hours will be transported to any closest NSRC-I or NSRC-II. e. NSRC Base Station contact is **mandatory** for all patients identified as a possible stroke patient. f. The NSRC Base Station is the only authority that can direct a patient to a	Policy revised. • Limited policy to San Bernardino County area.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	Mammoth Hospital	NSRC. The destination may be changed at Base Station discretion. g. The NSRC Base Station, if different from the NSRC will notify the NSRC of the patient's pending arrival as soon as possible, to allow timely notification of neurovascular team. h. Air transport may be considered if ground transport is greater than 30 minutes. By my reading of the guidelines, if one of our paramedic units picks up a patient in our town (which is four square miles in size), then that unit will need to contact an outside-the-county NSRC base station and transport the patient to an outside-the-county facility and will mandatorily bypass the only hospital in the county, one which is no further than 2 or 3 miles away. Aside from that, there are other problems: 1) The NSRC base station will not be able to provide adequate transportation direction as it is very difficult for helicopters to reach us—most of our transports are by fixed-wing. 2) Flights are often impossible due to adverse weather. 3) The paramedic unit that is being tied up by the NSRC base station is the only one in our town and must be free to take on new patients. 4) Our closest stroke referral center is in Reno, not in ICEMA territory. Patients close to our hospital should generally be transported to our facility, so that we can make an appropriate transfer as needed in a manner that	

PROTOCOL #	AGENCY	COMMENT	RESPONSE
		would be far faster than anything the NSRC base station could do. Patients in Mono County who are not close to our facility may be transferred by air when possible to Reno, where there is a very good stroke center.	
Stroke "NSRC" Receiving Center Policy	Mammoth Hospital	Stroke patients are treated the same as our STEMIs in Mono County. Medic units north of Mammoth Hospital contact Careflight for these patients depending on our weather. From Mammoth Lakes toward the south county the patients will come to our facility to be evaluated and transferred. The STEMI receiving center protocol does not really address Mono and Inyo Counties either. It has been "assumed" that we do the best we can because of our very remote locations. The STEMIs our flown to Renown or St. Mary's in Reno Nevada, sometimes Carson Tahoe Regional Medical Center in Carson, Nevada. However we cannot predict the weather. We have kept STEMIs in our ED until there was a break in the weather sometimes 24 hours or more. There are times you cannot even ground a patient north or south of here because of severe weather conditions. Hope this helps to understand our situation	Policy revised. • Limited to San Bernardino County area.
Stroke "NSRC" Receiving Center Policy	CDCR/CPHCS	We believe that policy is well written. We look forward to it's implementation and the development Neurovascular Stroke Receiving Centers in the ICEMA Region.	
Stroke Treatment Protocol	AMR	Small minor question…..should we add make "NSRC BASE CONTACT" to top of tree? This is found - *Under Patient Destination*	Policy revised. • NSRC base contact added

PROTOCOL #	AGENCY	COMMENT	RESPONSE
Stroke "NSRC" Receiving Center Policy	LLUMC	**Under stroke NSRC receiving center**, page 6: *"Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to closet paramedic receiving hospital".* Recommendation: Even if patients have contraindications to thrombolytic therapy, they may be candidates for intra-arterial thrombolysis or clot retrieval. There are absolute and relative contraindications to IV thrombolytic therapy and not all are created equal. For instance, systolic blood pressure of >185 mm Hg is considered a contraindication at the same level as a patient presenting with a seizure; however, BP may be reduced in the ED vs the field so that patients can receive IV TPA. We believe patients should be transferred to a level one NSRC receiving center despite a field assessment of 'contraindications', instead of closet paramedic receiving hospital. If they are transferred to the closest hospital, they may be denied other treatment modalities for acute stroke.	Policy revised. • NSRC-I
	LLUMC	*Obvious contraindication" is a vague term.* Recommendations: What's obvious to one EMS may not be obvious to another and what's obvious to one neurologist may not be obvious to another. We suggest changing the term or clearly defining subsets of contraindications instead of "Obvious contraindication".	No change. • Will be clarified via education.

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	LLUMC	**Under stroke NSRC receiving center**, page 3**:** *"Neurovascular team alert response policy upon EMS notification of a 'Stroke alert'".* Question: We find that the rate of actual acute stroke patients to acute stroke activation is around 1:20. Our neurovascular team responds within minutes of acute stroke activation but if we have to respond when the EMS activation occurs, there will be significant downtime waiting for the patient to arrive and for the initial ED assessment. This affects the efficiency neurovascular team since they are often rounding on patients throughout the day. If we can show acceptable response and assessment times if the neurovascular responds not when EMS activates the stroke protocol but when our own ED activates the stroke protocol during their initial assessment, is that acceptable? We used to activate the stroke team each time EMS called in for a possible stroke but found that the rate of activations for non-stroke patients was inappropriately high. Our current policy is to have the ED attending assess the patient and activate the internal neurovascular team, which responds rapidly. The key is door to TPA infusion time and our times are < 60 min on average.	No change. • ICEMA would like to see the internal hospital stroke alert policy.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	LLUMC	**Under the stroke decision tree, in the top blue box**, page 10**:** *"Is the Stroke Symptom Time (last seen normal) Plus Transport Time…"* Recommendation: We suggest using one term i.e., "Last seen normal time" throughout the Stroke Center protocol. People may think of "stroke symptoms time" as the time patients are found rather then when their stroke symptoms began.	Policy revised. • "Stroke Symptom Time" removed. • Will be reinforced by education.
Stroke Treatment Protocol	LLUMC	**Under Stroke Treatment-adult** page 8: *"mLAPSS criteria: age > 40"* Question: Since the medical literature includes patients over the age of 18 and does not specify a maximum age, what is the reason to contact the base station if a patient is < 40 years old? We agree that the mLAPSS process should continue during that time but please describe why the additional call is necessary.	No change. • Statement is written to reinforce that EMS providers are to make NSRC base station contact, even if the patient is <40 yrs. Old.
Stroke Treatment Protocol	San Manuel FD	1. BLS INTERVENTIONS #2 Re write sentence. It is unclear. Trauma is covered by #3, SUGGEST THE FOLLOWING SENTENCE; Position of comfort, consider left lateral position. 2. mLAPSS CRITERIA #3 There is a cut off age of 40. Both options are either less than or equal or Greater than or equal. Only one option can include the age 40. Remove the "or equal sign" from one of the options.	Policy revised. • Language clarified. Policy revised. • "If <40…" • Symbols removed, and spelled out.

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	San Manuel F.D.	Several of the criteria are unclear as to which is a positive (included) or negative (excluded) finding. Define the criteria to identify the result of the exam as (+) or (-). EG, #2 states" No history of seizures or epilepsy. Is "no history included or excluding criteria? #4 baseline wheelchair or bed ridden. Positive or negative? #5 Blood Glucose 60-400mg/Dl Is an included range? Outside this range is an excluding factor? Maybe include a (+) or (–) to help clarify the assessment results. 3. THROMBOLITIC ASSESSMENT State that this assessment is to be delivered to the ED with the pt. For agencies not on EMS solutions, include an attachment, with the official ICEMA thrombolytic assessment.	No change. • Follows closely with the mLAPSS format. • Will be clarified with education. Policy revised. • Added…"and report to ED personnel."
Stroke "NSRC" Receiving Center Policy	Specialists On-Call	Letter summarizing support of Tele-neurology.	Policy revised. • NSRC-II Tele-neurology waiver added.
Stroke "NSRC" Receiving Center Policy	Crest Forest FPD	"Crest Forest Fire Protection Districts has no comments. Thank you!"	
Stroke "NSRC" Receiving Center Policy	LLUMC	"INTRODUCTION" *Track changes in policy summarized. Original copy may be requested.*	No change. • Does not fit ICEMA policy and protocol format.
	LLUMC	JC: Joint Commission	No change. • The Joint Commission (TJC)

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	LLUMC	CME:	No change. • Continuous education (CE)
	LLUMC	ACT F.A.S.T	No change, • The pre-hospital assessment tool will be the mLAPSS.
	LLUMC	Medical Directors: • Delete Certified by ABMS or AOA • Add board-eligible • ED MD: active privileges	Policy revised. • Added board eligible. No other changes made.
	LLUMC	Nursing Coordinator: • CCRN • Add: who will educate and gather data on stroke.	Policy revised. • Changed CCRN requirement to “preferred”.
	LLUMC	On-Call Physicians Specialists/ Consultants • On-call neurologist available in-house neurology residents…	Policy clarified. • NSRC-II Tele-neurology added.
	LLUMC	Delete Neuro-radiologist avail 24/7…	Policy revised. • Clarified language.
	LLUMC	Interventional team: description added.	Policy revised. Added: • Interventional neuroradiologist • Interventional vascular radiologist
	LLUMC	Internal Hospital Policies: • Deleted Critical care team	Policy revised and language clarified. • No content change.

Protocol Reference # 3020 and 5040

PROTOCOL #	AGENCY	COMMENT	RESPONSE
	LLUMC	Internal Hospital Policies: Prompt acceptance of stroke patients from NSRH and NSRC-II to NSRC I.	Policy language clarified. • No content change.
	LLUMC	Internal Hospital Policies: Rapid assessment-reworded statement.	Policy language clarified. • No content change.
	LLUMC	Internal Hospital Policies: Maintaining readiness of CT-reworded statement.	Policy language clarified. • No content change.
	LLUMC	Internal Hospital Policies: Arrangement of bed availability-changed Interventional Team to Stroke Team.	Policy language clarified. • No content change.
	LLUMC	Continuous Quality Improvement Program: Core Measures-added Joint Commission	Policy revised. • Added GWTG and Stroke CQI collaboration for performance indicators.
	LLUMC	Patient Destination: Several changes made.	Policy language clarified. • No content change.
Stroke Policy	ICEMA	Layout change. Deleted statement: “An Emergency Medical Physician will be in the hospital at all times.”	Policy language clarified. • To clearly define NSRC-I and NSRC-II requirements. • No content change. Deleted statement. • Addressed elsewhere.