

September 21, 2006

Texas Governor's EMS and Trauma Advisory Council (GETAC) Stroke Committee Chair Neal Rutledge, MD, is inviting public comment on this draft document titled "Early Treatment Protocols For Rapid Transport" of stroke victims.

Please submit written comments or questions to the following e-mail address: txstroke@gmail.com

DRAFT DOCUMENT

Early Treatment Protocols for Rapid Transport

Prior to finalizing these protocols, input from the Regional Advisory Committee ("RAC") chairs, the Governor's EMS and Trauma Advisory Council ("GETAC") medical directors subcommittee, and other interested stakeholders should be sought.

The initial concept for stroke transport has 4 components that each RAC should implement:

1. Appointment of a "stroke committee" to develop a region-specific stroke plan.
Concerned about the method (carrot) to get the 'stroke' experts to the RAC. In our area, will be difficult to get them to the table without directive/guidance from the stroke professional community. They will have to be 'wanting' to come into the RAC. Are there plans at the State level to give the stroke providers the information/education they will need regarding the RACs and the concept of a regional triage plan?
2. A region-specific stroke plan wherein;
 - a. hospitals in a region are categorized based on ability to provide definitive stroke diagnosis and care. With such categorization hospitals should put a premium on 24/7 availability of stroke expertise, and ability to track essential outcomes. The following plan is recommended:
 - (i) There will be a 3 level categorization of hospitals/facilities.
 - (ii) Levels 1 and 2 will be Comprehensive Stroke Centers ("CSCS") and Primary Stroke Centers ("PSCS") respectively, using criteria similar to those established by JCAHO and the Brain Attack Coalition.
 - (iii) Level 3 facilities will be similar to those defined by the Stroke Facility Criteria subcommittee as "Support Stroke Facilities". Level 3 hospitals will be called Stroke Facilities and not centers.
 - (iv) Criteria can and should be "Texas and region specific".
A STATE standard for stroke care and stroke center categorization should be established, so that there is ONE standard of care in Texas. Only the regional triage plan should be marginally different among the 22 RACs.
However, existing national guidelines and credentialing systems (such as JCAHO) for primary and comprehensive stroke centers

should be incorporated. Hospitals should be prohibited from claiming Stroke Center or Facility status without meeting verification guidelines. Systems for recognizing/verifying non-JCAHO credentialed Stroke Facilities must follow the Brain Attack Coalition guidelines.

3. A regional triage plan that includes the following general principles:
 - a. A written plan is developed for regional triage of stroke patients to hospitals best able to care for them.

Shouldn't the primary focus for the 'acute' phase for EMS be to get the patient to a facility with a CT machine/teleradiology, thrombolytics, and neurology consultation (person/phone)? I think most hospitals, even the small-town hospitals have these components in place. Shouldn't this be the immediate focus, with transfer to a tertiary center at some point early in the hospitalization or from the ED where thrombolytic care can be initiated?
 - b. Patients out to 8 hours from symptom onset. This time window can be altered as new therapies become available.
 - c. Instruct paramedics to take patients to the highest level Stroke Center available within the region (or adjacent region, if a higher level Stroke Center in the adjacent region is closer than a lower level Stroke Center in the region). *See previous comment about getting the patient to a facility able to rule-out intercerebral bleed and administering thrombolytics.* In making this determination, distance and time parameters should be considered. There should be no more than a 15 minute delay caused by taking a patient to the next highest level of stroke care. *Generally, in our rural TSA, the distance to the next highest level of care will always be greater than 15 minutes (via ground and air).* Where the available stroke care level and Stroke Centers/Facilities are comparable, a rotating scheme could be developed to ensure a fair distribution of patients among qualified Stroke Centers/Facilities. *While a rotating scheme sounds 'fair', real world dispositions are guided by closest facility, insurance, personal physicians, and most importantly patient choice!*
4. Creation of a system to maintain a registry of the number and destination of stroke patients transported. *This needs to be further clarified. Will there be a single state registry that all entities and/or RAC submit data to, or will there be 22 individual RAC registries.*

The Deep East Texas RAC is totally in support of developing a state/regional stroke system. And developing a 'system' similar to the Trauma system is likely to be successful. We just think that while the major trauma patient needs a surgeon and surgical access, the acute embolic stroke patient needs imaging and medication, which can be provided at most hospitals. The state/regions should focus developing triage schemes to get the patient to A hospital ASAP, and help all hospitals develop teams/processes for quick door-drug times and transfer to an appropriate level of care.