CHAPTER 476

AN ACT concerning stroke care, amending and supplementing P.L.2004, c.136, supplementing Title 27 of the Revised Statutes, and repealing sections 3 and 4 of P.L.2004, c.136.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.2004, c.136 (C.26:2H-12.28) is amended to read as follows:

C.26:2H-12.28 Designation of hospitals as stroke centers.

2. The Commissioner of Health shall designate hospitals that meet the criteria set forth in this section as primary, thrombectomy-capable, or comprehensive stroke centers or acute stroke ready hospitals.

a. A hospital shall apply to the commissioner for designation and shall demonstrate to the satisfaction of the commissioner that the hospital has been certified as a primary, thrombectomy-capable, or comprehensive stroke center or as an acute stroke ready hospital, respectively, by the Joint Commission, the American Heart Association, DNV GL, or another organization that provides such certifications as may be approved by the commissioner. A facility designated as a primary or comprehensive stroke center prior to the effective date of P.L.2019, c.476 (C.26:2H-12.28a et al.) shall retain such designation by obtaining, and providing the commissioner with documentation of, the appropriate certification by the Joint Commission, the American Heart Association, DNV GL, or other approved organization within three years of the effective date of P.L.2019, c.476 (C.26:2H-12.28a et al.), except that the commissioner may grant the facility up to two one-year extensions to obtain the appropriate certification, provided the facility certifies that the additional time is necessary to obtain the appropriate certification. Failure to meet the requirements of this subsection shall be deemed a voluntary surrender of the hospital's prior designation as a primary or comprehensive stroke center. A hospital that has its certification by the Joint Commission, the American Heart Association, DNV GL, or other certifying organization revoked shall report the revocation to the Department of Health no later than five days after the date the hospital receives notice of the revocation from the certifying entity.

b. The commissioner shall designate as many hospitals as primary stroke centers as apply for the designation, provided that the hospital meets the certification requirements set forth in subsection a. of this section.

c. The commissioner shall designate as many hospitals as thrombectomy-capable stroke centers as apply for the designation, provided that the hospital meets the certification requirements set forth in subsection a. of this section.

d. The commissioner shall designate as many hospitals as comprehensive stroke centers as apply for the designation, provided that the hospital meets the certification requirements set forth in subsection a. of this section.

e. The commissioner shall designate as many hospitals as acute stroke ready hospitals as apply for the designation, provided that the hospital meets the certification requirements set forth in subsection a. of this section.

f. The commissioner shall appropriately recognize stroke centers that have attained a level of stroke care distinction recognized by the Joint Commission, the American Heart Association, DNV GL, or another nationally-recognized, guidelines-based organization that provides such distinctions and is approved by the commissioner. Stroke centers that have attained a distinction that shall be recognized pursuant to this subsection may include, but shall not be not limited to, centers that offer mechanical endovascular therapies.

g. The commissioner may suspend or revoke a hospital's designation as a stroke center or acute stroke ready hospital, after notice and hearing, if the commissioner determines that the hospital is not in compliance with the requirements of this act.

h. The commissioner shall encourage primary, thrombectomy-capable, and comprehensive stroke centers to coordinate, by written agreement, with acute stroke ready hospitals throughout the State to provide appropriate access to care for acute stroke patients. Agreements made pursuant to this subsection shall include: (1) transfer agreements for the transport to and acceptance of stroke patients by stroke centers for the provision of stroke treatment therapies an acute stroke ready hospital is unable to provide; and (2) any communication criteria and protocols as shall be necessary to effectuate the agreement.

i. Each hospital that is not a designated comprehensive stroke center shall, no later than 180 days after the effective date of P.L.2019, c.476 (C.26:2H-12.28a et al.), enter into an agreement with at least one State-designated comprehensive stroke center, which agreement shall, at a minimum:

(1) include protocols for engaging in prompt telephonic or video consultation to assess and make treatment recommendations for suspected stroke patients;

(2) provide, where most clinically appropriate, consistent with patient safety and patient consent, for the effective and efficient transfer of patients needing the services of the comprehensive stroke center, particularly in time-sensitive cases including, but not limited to, large vessel occlusion; and

(3) include a provision to access educational resources available from the comprehensive stroke center to expand the knowledge base of providers at the acute care general hospital.

The agreement shall be filed with the Department of Health within 30 days.

j. The Commissioner of Health shall prepare, maintain, and make available on the Department of Health website a list of facilities designated as primary stroke centers, thrombectomy-capable stroke centers, comprehensive stroke centers, and acute stroke ready hospitals. A current copy of the list shall be transmitted to each emergency medical services provider, as defined in subsection e. of section 3 of P.L.2019, c.476 (C.27:5F-27.1), no later than June 1 of each year.

k. (1) Primary, thrombectomy-capable, and comprehensive stroke centers and acute stroke ready hospitals shall, on a quarterly basis, submit to the department data concerning stroke care that are deemed appropriate by the Department of Health, and that, at a minimum, align with the stroke consensus measures jointly supported by the Joint Commission, the United States Centers for Disease Control and Prevention’s Paul Coverdell National Acute Stroke Registry, American Heart Association, and the American Stroke Association.

(2) Data submitted pursuant to paragraph (1) of this subsection shall be compiled by the department into a Statewide stroke database, which shall be made available on the department website.

(3) Data submitted pursuant to paragraph (1) of this subsection shall not contain or be construed to require disclosure of confidential or personal identifying information.

C.26:2H-12.28a Stroke Care Advisory Panel.

2. a. In order to ensure the implementation of a strong Statewide system of stroke care, there is established in the Department of Health the Stroke Care Advisory Panel, which, subject to subsection c. of this section, shall consist of 18 members, as follows: the Commissioner of Health, or a designee, who shall serve ex officio; the Director of the Office of Emergency Medical Services in the Department of Health, or a designee, who shall serve ex officio; and 16 public members to be appointed by the Governor. The public members shall include two

nurses who provide stroke care at a comprehensive stroke center; one nurse who provides stroke care at a primary stroke center; three hospital physicians who are fellowship trained neuro-interventionalists in neurosurgical or neuroendovascular intervention for stroke and who serve as the director of a primary, thrombectomy-capable, or comprehensive stroke center; two physicians who are board-certified in neurology or neurosurgery who provide stroke care, and who serve as the medical director of a primary or comprehensive stroke center; a hospital physician who has clinical experience in non-surgical intervention for stroke; a patient advocate; a representative from a New Jersey facility that provides rehabilitation services to stroke patients; two representatives from emergency medical services providers that transport possible acute stroke patients; a representative from the American Stroke Association; a representative from the New Jersey Hospital Association; and a representative from the Medical Society of New Jersey. Public members shall serve for a term of two years and shall be eligible for reappointment.

b. The Stroke Care Advisory Panel established under this section shall organize as soon as practicable but no later than 60 days after the effective date of P.L.2019, c.476 (C.26:2H-12.28a et al.), and, except as provided in subsection c. of this section, shall select a chairperson and a vice-chairperson from among its members. The chairperson shall appoint a secretary who need not be a member of the panel. The panel shall meet no less than four times per year and at such other times as may be necessary to discharge its duties. Members shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their duties within the limits of funds appropriated for that purpose. The Department of Health shall provide staff services to the panel.

c. The chairperson, vice-chairperson, and any public members of the Stroke Advisory Panel constituted in the Department of Health as of the effective date of P.L.2019, c.476 (C.26:2H-12.28a et al.) may choose to remain on the Stroke Care Advisory Panel for up to one year following the effective date of P.L.2019, c.476 (C.26:2H-12.28a et al.). Thereafter, the public members shall be eligible for reappointment pursuant to subsection a. of this section, and the chairperson and vice-chairperson shall be eligible for re-selection for their positions pursuant to subsection b. of this section.

d. The Stroke Care Advisory Panel established pursuant to this section shall continue any duties and responsibilities vested in the Stroke Advisory Panel constituted in the Department of Health as of the effective date of P.L.2019, c.476 (C.26:2H-12.28a et al.). In addition, the Stroke Care Advisory Panel shall be charged with assessing the stroke system of care in New Jersey and identifying and recommending means of improving the provision of stroke care. In addition to any other actions or recommendations as it finds necessary and appropriate, the panel shall:

(1) analyze the Statewide stroke database maintained pursuant to paragraph (2) of subsection k. of section 2 of P.L.2004, c.136 (C.26:2H-12.28) to identify potential interventions to improve the provision of stroke care in the State, with a focus on identifying and improving care in underserved regions and populations of the State;

(2) encourage the sharing of information and data among health care providers on ways to improve the quality of care provided to stroke patients in the State;

(3) facilitate the communication and analysis of health information and data among the health care professionals providing care for stroke patients;

(4) enhance coordination and communication between hospitals, primary, thrombectomy-capable, and comprehensive stroke centers, acute stroke ready hospitals, and other support services necessary to assure access to effective and efficient stroke care, particularly in time-sensitive cases including, but not limited to, large vessel occlusion;

(5) develop treatment protocols regarding the transitioning of patients 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 stroke;

(6) establish a data oversight process and implement a plan for achieving continuous quality improvement in the quality of care provided under the Statewide stroke system of care; and

(7) develop model protocols for the assessment, treatment, and transport of stroke patients for use by emergency medical services providers, which shall include best practice standards for the triage and transport of acute stroke patients.

e. The Department of Health shall assign a current employee to the Stroke Care Advisory Panel, which employee shall have primary responsibility for assisting the panel in carrying out its responsibilities with respect to data analysis, data sharing, data oversight, and data reporting. If the department does not have a current employee available who has the requisite skills, training, and experience to fulfil this role, the department may contract with an appropriate third party patient safety organization to perform this function for the panel on an at cost or no cost basis.

f. No later than one year after the date of organization, and annually thereafter, the Stroke Care Advisory Panel shall submit a report to the Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, detailing its activities, findings, and proposals for legislative, executive, or other action to improve and enhance the Statewide stroke system of care.

C.27:5F-27.1 Standardized stroke triage assessment tool.

3. a. No later than June 1 of each year, the Commissioner of Health shall adopt a nationally recognized standardized stroke triage assessment tool to be used by emergency medical services providers and protocols for the treatment and timely transport of acute stroke patients to the hospital with the most appropriate level of stroke care capability for the effective and efficient treatment of the patient's condition. No later than May 1 of each year, the Office of Emergency Medical Services in the Department of Health, in consultation with the Stroke Advisory Panel established pursuant to section 2 of P.L.2019, c.476 (C.26:2H-12.28a), shall provide the commissioner with a non-binding list of recommendations to assist the commissioner in adopting a stroke triage assessment tool and protocols pursuant to this subsection.

b. Each emergency medical services provider in the State shall implement the nationally-recognized standardized stroke triage assessment tool adopted pursuant to subsection a. of this section. Nothing in this section shall be construed to prevent an emergency medical services provider from adopting, or require an emergency medical services provider to adopt, additional stroke assessment protocols.

c. Each emergency medical services provider in the State shall establish pre-hospital care protocols related to the assessment, treatment, and transport of stroke patients, which shall include, but not be limited to, plans for the triage and transport of acute stroke patients to the most appropriate primary, thrombectomy-capable, or comprehensive stroke center or, when appropriate, acute stroke ready hospital, which is capable of providing the most effective and efficient treatment within a specified timeframe following the onset of symptoms.

d. Each emergency medical services provider in the State shall incorporate training on the assessment and treatment of stroke patients in its training requirements for emergency medical services personnel.

e. As used in this section, "emergency medical services provider" means any association, organization, company, department, agency, service, program, unit, or other entity that provides pre-hospital emergency medical care to patients in this State, including, but not limited to, a basic life support ambulance service, a mobile intensive care program or mobile intensive care unit, an air medical service, or a volunteer or non-volunteer first aid, rescue and ambulance squad.

C.27:5F-27.2 Rules, regulations.

4. The Commissioner of Health shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), promulgate rules and regulations as may be necessary to implement this act.

Repealer.

5. The following sections are repealed:

Section 3 of P.L.2004, c.136 (C.26:2H-12.29); and

Section 4 of P.L.2004, c.136 (C.26:2H-12.30).

6. This act shall take effect immediately.

Approved January 21, 2020.