

HOSPITAL ADVISORY COUNCIL
Regular Quarterly Meeting
Thursday, November 20, 2014 at 3:30 p.m.

Location: Oklahoma State Department of Health building
1000 NE 10th Street, Room 307
Oklahoma City, OK 73117
Telephone: 405-271-6576

Regular Quarterly Meeting Minutes
Approved 02/18/2015

The Hospital Advisory Council Regular Meeting Notices for the calendar year 2014 were filed with the Oklahoma Secretary of State's (SOS) website located at www.sos.state.ok.us/meetings.htm and the Oklahoma State Department of Health's (OSDH) website located at www.mfs.health.ok.gov on December 11, 2013.

The agenda for this regular meeting was posted on the OSDH website and at the OSDH building's front entrance on November 19, 2014.

1. Call to Order

Dr. Bell, Chair called the meeting to order at approximately 3:39 p.m.

2. Roll Call

Devyn Tillman called roll. The following members were present when roll was called: Heather Bell, D.O.; Jeffrey Berong; Darrel Morris; Darin Smith; Dave Wallace. A quorum is present.

The following member was absent: Dale Bratzler, D.O.

Identified OSDH staff members present were: Lee D. Martin, Jr., Chief-Medical Facilities Services, Brandon Bowen, Assistant Director-Medical Facilities Service; Dr. Timothy Cathey-Medical Director for Protective Health Services; Dale Adkerson, Administrative Programs Manager-Emergency Medical Services; Jan Fox, OSDH HIV/STD Svc; Devyn Tillman, AAll-Medical Facilities Service.

Identified guests: Jonathan Rule, Integris; Michelle Steele, Genentech; PJ Richards, Genentech; John Henry, Genentech; Charles Lutten, MD, Eastar; Gwen Harrington, Integris Baptist Medical Center; Lela Luper, Mercy Hospital Ada; Gayla Middlestead, TMF; Naomi Amaha, American Heart Association; Anna Wanaheta, SJMC; Lawrence Davis, Integris Baptist Hospital; David Lee Gordon, OUMC/OUHSC; Richard V. Smith, MD, Mercy Hospital; LaWanna Halstead, Oklahoma Hospital Association.

3. Distribution of the August 2014 Meeting Minutes Summary.

No official business could be conducted due to the lack of quorum.

4. Approval of the May 22, 2014 Regular Meeting Minutes.

Darrell Morris made a motion to approve the May 22, 2014 regular meeting minutes. Darin Smith seconded the motion. The motion carried.

Ayes: 5	Nays: 0	Abstain: 0	Absent: 1	Motion Carried: Yes
Dr. Bell		Aye	Darrel Morris	Aye
Dr. Bratzler		Absent	Darin Smith	Aye
Jeff Berong		Aye	Dave Wallace	Aye

5. Update: Hospital Advisory Council Membership

Mr. Martin reported the department has received two (2) applications for the one (1) hospital employee vacancy as well as (2) applications for the (2) of the now (3) public member vacancies. (Jeffrey Berong has resigned his public member position, effective November 30, 2014.) These names will be submitted to the December Board of Health meeting for their consideration. There is one opening left for a public member. Nominations for this vacancy are needed as quickly as possible. The members briefly discussed the qualifying criteria for these as outlined in the statute at *Oklahoma Statute Title 63-1-707. (D.) (1.) (d).* "three members shall be citizens representing the public who: (1) are not hospital employees, (2) do not hold hospital staff appointments, and (3) are not members of hospital governing boards."

6. Update: 2013 Hospital Annual Report

The 2013 Hospital can be found on the Department's webpage located at the following link:
http://www.ok.gov/health2/documents/MFS%20HospitalAnnualRpt_2013.pdf

7. Review and possible rulemaking action: Title 310: Chapter 667. Hospital Standards.

- Subchapter 59-20 [AMENDED]

Dr. Cathey presented the group with the final rule document resulting from the Stroke Classification Workgroup. This rule will provide a great opportunity make thrombolytic available to a larger segment of Oklahoma's population. The only change to the document will be regarding the Level IV Stroke Center at Title 310:667-59-20, (d), anywhere in that segment where it states level IV stroke, the word, *referral center*, will be inserted before this goes before the Board of Health. This rule is adaptable enough for it to be malleable in the future.

Jeff Berong made a motion to recommend this rule be adopted at the December 2015 Oklahoma State Board of Health meeting. Darin Smith seconded. Motion Carried.

Ayes: 5	Nays: 0	Abstain: 0	Absent: 1	Motion Carried: Yes
Dr. Bell		Aye	Darrel Morris	Aye
Dr. Bratzler		Absent	Darin Smith	Aye
Jeff Berong		Aye	Dave Wallace	Aye

8. Review and possible rulemaking action: Title 310: Chapter 667. Hospital Standards.

- Subchapter 13. Infection Control
- 310:67-13-6 [NEW]

Dale Adkerson, Administrative Program Manager for the EMS Division provided the following background to the council regarding this rule draft. This rulemaking is being submitted as a result of a statute change in 2013 due to Enrolled HB 1641. The EMS Division as well as staff from the Infectious Disease/STD Division created the draft language. This has gone through the Trauma and EMS Advisory Council in its current form, with one minor change not shown on this document, from a 4 hour to a 2 hour window. This is an attempt to provide an avenue/process for a good samaritan who provides emergency care and receives an exposure which is not affiliated with an ambulance service as a part of their response would not necessarily be entitled to notification of the exposure. The good samaritan would through a process would be able to gain access to this information.

After discussions regarding the wording of this rule and the intent versus what is written the council determined a working group would be the best avenue to review and revise the wording the this rule

change. Dr. Heather Bell, Chairperson she would like to oversee and organize a working group to discuss this further. As soon as a meeting room and date are arranged, all interested parties will be notified by Council Secretary, Devyn Tillman. This group will report back to this Council at the February 2015 meeting.

9. Update: Title 310: Chapter 600. Abortion Facility Regulations.

· Subchapter 15. Abortion Medical Procedure Standards [NEW]
Dr. Timothy Cathey reported that Senate Bill 1848 legislation required the Board of Health to promulgate rules according to this statute, which went into precise detail. The Department spent several months during the past summer drafting rules for this. However, the Oklahoma Supreme Court has stepped in and notified the Agency to stop drafting these rules. There will be no further action taken on this matter by the Hospital Advisory Council at the current time.

10. CY 2015 Regular Quarterly Meeting Dates:

Dr. Heather Bell, Chair, requested Council Secretary, Devyn Tillman to send an email to the council members so the members could reference their calendars. The proposed meeting dates scheduled for 2015 are as follows:

Wednesday, February 18, 2015 @ 2:30 p.m.	OSDH, Central Office, Room 307
Wednesday, May 20, 2015 @ 2:30 p.m.	OSDH, Central Office, Room 307
Wednesday, August 19, 2015 @ 2:30 p.m.	OSDH, Central Office, Room 307
Wednesday, November 18, 2015 @ 2:30 p.m.	OSDH, Central Office, Room 307

11. Public Comment

There was no public comment.

12. Adjourn

This meeting adjourned at approximately 4:27 p.m.

Respectfully submitted,
Devyn Tillman
Secretary to the Hospital Advisory Council

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 667. HOSPITAL STANDARDS**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 59. Classification of Hospital Emergency Services
310:667-59-20 [AMENDED]

SUMMARY:

The amendments to OAC 310:667 revise sections of rule within Subchapter 59, Classification of Hospital Emergency Services, to update classification standards for stroke centers. These standards are intended to stratify hospitals into those hospitals capable of providing comprehensive care for all stroke patients from those with limited or no capability to care for the acutely ill, time sensitive stroke patient.

The proposed rules would allow the Oklahoma State Department of Health (OSDH) to recognize four levels of hospital based stroke care. Level I would be a comprehensive center capable of care for all stroke patients. The Level II would represent the most current standard required to be a primary stroke center. OSDH will recognize certification from a Center for Medicare and Medicaid Services deemed accrediting agency or an OSDH approved organization using nationally recognized guidelines for Level I and II facilities.

The Level III stroke facility will be mainly focused on the acute care of a patient presenting to the emergency room who is likely to benefit from stabilization and expeditious thrombolytic therapy prior to transfer to a higher level of care. The Level IV hospital reflects a facility without the resources to provide acute care for the time sensitive needs of the stroke patient. They would be organized to quickly evaluate, stabilize and arrange transfer of the acute stroke patient. OSDH would recognize a Level III facility by way of a current certification as an Acute Stroke Ready Hospital from a deemed accrediting agency, a department approved nationally recognized guidelines based organization or through OSDH. The Level IV facility would be certified only by OSDH.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. Section 1-270; and Title 63 O.S. Section 1-705.

COMMENT PERIOD:

October 1, 2014, through November 5, 2014. Interested persons may informally discuss the proposed rules with the contact person identified below; or may, through November 5, 2014, submit written comment to the contact person identified below; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on November 5, 2014, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 1102 beginning at 10:00 a.m. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with

information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule. Business entities may submit this information in writing through November 5, 2014, to the contact person identified below.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the contract person identified below or via the agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available at the location listed above for obtaining copies of the rule.

CONTACT PERSON:

Timothy Cathey, M.D., Medical Director, Protective Health Services, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, or by e-mail to TimC@health.ok.gov.

**RULE IMPACT STATEMENT
HOSPITAL 310:667 [AMENDED]**

1. **DESCRIPTION:** The amendments to OAC 310:667 revise sections of rule within SUBCHAPTER 59. CLASSIFICATION OF HOSPITAL EMERGENCY SERVICES to establish classification standards for These standards are intended to stratify hospitals into those hospitals capable of providing comprehensive care for all stroke patients from those with limited or no capability to care for the acutely ill, time sensitive stroke patient.

The proposed rules would allow OSDH to recognize four levels of hospital based stroke care. Level I would be a comprehensive Center capable of care for all stroke patients. The Level II would represent the most current standard required to be a Primary Stroke Center. OSDH will recognize certification from a CMS deemed accrediting agency or a department approved nationally recognized guidelines based organization for level I and II facilities.

The level III stroke facility will be mainly focused on the acute care of a patient presenting to the emergency room who is likely to benefit from stabilization and expeditious thrombolytic therapy prior to transfer to a higher level of care. The level IV hospital reflects a facility without the resources to provide acute care for the time sensitive needs of the stroke patient. They would be organized to quickly evaluate, stabilize and arrange transfer of the acute stroke patient. OSDH would recognize a level III facility by way of a current certification as an Acute Stroke Ready Hospital from a deemed accrediting agency, a department approved nationally recognized guidelines based organization or through OSDH. The level IV facility would be certified only by OSDH.

2. **CLASSES OF PERSONS AFFECTED:** Affected persons are operators of licensed hospitals in the State of Oklahoma.
3. **CLASSES OF PERSONS BENEFITED:** Current and emerging technologies and treatments now allow a much higher likelihood of benefit over a longer window of time than the current system we use. The benefit is time sensitive and linearly deteriorates with delays in definitive care. These delays often result in death, permanent disability and an enormous financial burden to families of surviving stroke patients. A four level system that classifies all licensed hospitals will simplify the identification and triage of these patients not only by hospitals but also by the EMS out-of-hospital providers as well as the public at large. Once

this system is established it could be used to implement a state level referral network similar to what is currently used for severely injured trauma patients.

The current system has almost exclusively focused on the patient with an ischemic stroke. This new system would also provide a framework from which we could launch a more timely and useful triage of patients with the most severe presentations including hemorrhagic stroke. We are in the early stages of advanced medical teletechnology applications and this system will allow providers to better focus their efforts to the greatest benefit for acutely ill Oklahomans.

Most important, to the time critical ischemic stroke patient is this new system will result in more thrombolytic agent being provided in more areas of the state, and in a more timely fashion than currently exists.

4. **ECONOMIC IMPACT:** This rule involves no additional fees. There will be no economic impact on any political subdivision by the proposed rule changes. Several hospitals already pay for national accreditation to be "Primary Stroke Centers" and a few have become Comprehensive Stroke Centers. The cost at this time is approximately \$8k to \$10k per year depending on which national accrediting body is used. Hospitals that are currently state designated as "Primary Stroke Centers" could easily transition to be designated as level III facilities and function much as they do now for no added cost.
5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY** The cost to the Department to implement the amendments will be approximately \$1500.00 to distribute the amended rules. The proposed rules will be implemented and enforced by existing Department personnel. In order to offset, the increased number of hospitals requiring state certification, EMS administrators will also be cross-trained to perform level III and IV visits. The time required for each visit will be significantly reduced compared to the current rules due to a much shorter checklist and use of an internal quality assurance approach method.
6. **IMPACT ON POLITICAL SUBDIVISIONS:** This rule will have no economic impact on any governmental entity, and it will not require their cooperation in implementing or enforcing the rule.
7. **ADVERSE EFFECT ON SMALL BUSINESS:** Very few hospitals can be classified as small businesses; these amendments are not expected to have any adverse impact on any licensed hospital.
8. **EFFORTS TO MINIMIZE COSTS OF RULE:** OSDH could take on the responsibility of on-site certification of all hospitals which may result in less cost to the hospitals but would require a significant infusion in

resources and infrastructure by OSDH to meet this requirement. We expect to require 1 FTE to cover the hospital survey process. In order to save money and yet maintain a high quality of care we chose the tiered accreditation system mentioned previously.

9. EFFECT ON PUBLIC HEALTH AND SAFETY:

In 2010, Oklahoma had the 4th highest death rate from stroke in the country. Stroke is a leading cause of major disability. Approximately, 150,000 Oklahomans are currently stroke survivors.

This year over 2,000 Oklahomans will die from stroke and over 10,000 will be diagnosed and admitted to the hospital. Hospital costs alone range from \$70,000 to \$90,000 for each event. Half of survivors will be forced to live with moderate to severe disability.

Seven out of eight patients will present with an ischemic stroke which can often be treated with thrombolytic therapy leading to reperfusion and drastically improved outcomes. Even so, within the current dysfunctional system <5% of stroke patients get thrombolytics.

Since our previous rules were passed in 2008, significant improvements in care have been realized. For example, the window of time for thrombolytic use has expanded by 50%. Instead of 3 hours which is in our current rules the new standard is 4.5 hours.

An integrated system would mean pre-hospital identification of stroke patients and earlier activation of the hospital team resulting in a significant time savings and shortened time to reperfusion therapy (Each minute delay in reperfusion results in the death of 2 million neurons).

The overall benefit of an integrated system of care will be to ensure all stroke patients are rapidly identified, stabilized and if necessary, expeditiously transferred to the hospital providing the most appropriate level of care for their needs. A fully functioning system that reduces deaths by just 2%-3% could save another 50-100 lives in our state each year.

10. DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:

Over the past decade, there has been a 53% increase in the incidence of stroke in the 15-44yo age group. Now 1 in 5 strokes occur in someone aged 20-55. Failure to implement an improved, integrated system of care will negatively impact our ability to implement earlier intervention and definitive treatment.

Pre-hospital providers (EMS) will remain confused about how best to triage and where to transport patients resulting in delays. Each added 15 minute delay will mean a 4% decrease in survival, walking independently and going home and living independently.

Not adopting these new rules will also mean we are unable to

strategically develop a system of care where patients receive reperfusion within 90 minutes which would have resulted in a 51% improvement in independent movement and a 33% increased likelihood of living independently. But these long-term goals would never be achieved.

Where you live should not determine if you live but that will be the impact of not creating the framework for an integrated system of acute stroke care.

The group most negatively impacted will be rural Oklahomans living furthest away from our urban centers. The large hospital health systems will continue to develop islands of excellence but with no global strategic focus or collaborative effort large rural geographic areas will continue to be neglected.

11. **This rule impact statement was prepared on**
August 7, 2014

310:667-59-20. Classification of emergency stroke services

(a) **Level I Stroke Center.** A Level I Stroke Center shall be deemed to adhere to primary and secondary stroke recognition and prevention guidelines as required by state law and serve as a resource center for other hospitals in the region and be a comprehensive receiving facility staffed and equipped to provide total care for all major needs of the stroke patient as determined by:

(1) An up-to-date certification as a Comprehensive Stroke Center from a Centers for Medicare and Medicaid Systems deemed accrediting agency or a Department approved organization that uses a nationally recognized set of guidelines; and

(2) Providing quality assurance information, including benchmark tracking and other data to the department upon request.

(b) **Level II Stroke Center.** A Level II Stroke Center shall be deemed to adhere to primary and secondary stroke recognition and prevention guidelines as required by state law and be a receiving center staffed by in-patient stroke services staff and be equipped to provide definitive care for a major proportion of stroke patients within the region as determined by:

(1) An up-to-date certification as a Primary Stroke Center from a Centers for Medicare and Medicaid Systems deemed accrediting agency or a Department approved organization that uses a nationally recognized set of guidelines; and

(2) Providing quality assurance information, including benchmark tracking and other data to the department upon request.

(c) **Level III Stroke Center.** A Level III Stroke Center shall Be deemed to adhere to secondary stroke recognition and prevention guidelines as required by state law and be staffed and equipped to provide initial diagnostic services, stabilization, thrombolytic therapy, emergency care to patients who have suffered an acute stroke (which is a stroke wherein symptoms have on-set within the immediately preceding twelve (12) hours). They shall have an up-to-date certification as an Acute Stroke Ready Hospital from a Centers for Medicare and Medicaid Systems deemed accrediting agency or from a department approved organization that uses a nationally recognized set of guidelines or from the department for a period not to exceed three years and meet the following requirements:

(1) Stroke Team:

(A) Having a stroke team available twenty-four (24) hours a day, seven (7) days a week;

(B) Having a licensed physician trained in the care of the emergent stroke patient and credentialed by the hospital to provide emergency medical service for stroke patients, including the ability to administer thrombolytic agents

(C) Having designated stroke team(s) that are identified in writing, which is either on-site or each member is able to respond to the hospital within twenty (20) minutes to the emergency department of the Stroke Center;

(D) Having members trained in the care of a stroke patient, with said training updated annually;

(E) Having response times of the stroke team established and tracked in writing;

(F) Adoption of standard practice protocols for the care of a stroke patient in writing, which shall include the appropriate administration of an FDA-approved thrombolytic agent within sixty (60) minutes following the arrival of a patient who has suffered a stroke at the emergency department at least fifty percent (50%) of the time; and

(G) Written emergency stroke care protocols adopted;

(H) A licensed nurse or other health professional designated as the stroke coordinator

(2) Emergency Department:

(A) A licensed independent practitioner able to recognize, assess and if indicated administer thrombolytic therapy to stroke patients and

(B) A licensed independent practitioner will assess potential stroke patients within 15 minutes of arrival

(C) Having nursing personnel available on-site twenty-four (24) hours a day, seven (7) days a week who are trained in emergent stroke care, which is demonstrated at least every two (2) years through evidence of competency;

(D) For a hospital, licensed as a general medical surgical hospital or a specialty hospital, all emergency services shall meet the requirements of Oklahoma Administrative Code (OAC) 310:667-29-1 and 310:667-29-2;

(E) For a hospital, licensed as critical access hospital, all emergency services shall meet the requirements of OAC 310:667-39-14;

(F) Adopt written comprehensive stroke protocols for the treatment and stabilization of a stroke patient, which shall include, but not be limited to:

(i) detailed instructions on IV thrombolytic

- use;
 - (ii) reversal of anticoagulation in patients with hemorrhagic stroke,
 - (iii) a standardized stroke assessment scale;
 - (iv) protocols for the control of seizures;
 - (v) blood pressure management; and
 - (vi) care for patients, who have suffered a stroke, but are not eligible to receive thrombolytic agents; and
 - (G) Collaborate with emergency medical service agencies to develop inter-facility transfer protocols for stroke patients and will only use those emergency medical service agencies that have a Department approved protocol for the inter-facility transfer of stroke patients;
- (3) Supplies and equipment:
- (A) All equipment and supplies shall meet the requirements of OAC 310:667-59-9 (a);
 - (B) Have available on-site, twenty-four (24) hours a day, seven (7) days a week, thrombolytic agents, which are FDA approved for the treatment of acute non-hemorrhagic stroke;
 - (C) Have available on-site, twenty-four (24) hours a day, seven (7) days a week, seizure control agents;
 - (D) Have available on-site, twenty-four (24) hours a day, seven (7) days a week, thiamine and glucose for intravenous administration;
- (4) Neuroimaging services:
- (A) Have available on-site, twenty-four (24) hours a day, seven (7) days a week diagnostic x-ray and computerized tomography (CT) services;
 - (B) Have on duty or on call with a twenty (20) minute response time, twenty-four (24) hours a day, seven (7) days a week radiologic technologist and CT technologist. A single technologist designated as qualified in both diagnostic x-ray and CT procedures by the radiologist may be used to meet this requirement if an on-call schedule of additional diagnostic imaging personnel is maintained;
 - (C) For a hospital licensed as a general medical surgical hospital or specialty hospital, diagnostic imaging services shall also comply with the applicable requirements in OAC 310:667-23 of this Chapter; and
 - (D) For a hospital licensed as a critical access hospital, diagnostic imaging services shall also comply with the applicable requirements in OAC 310:667-39;

(6) Laboratory services:

(A) Laboratory services shall be provided on-site and available twenty-four (24) hours a day, seven (7) days a week, and a minimum provide the following:

- (i) A complete blood count;
- (ii) Metabolic profile;
- (iii) Coagulation studies (prothrombin time, international normalized ratio);
- (iv) Pregnancy testing; and
- (v) Troponin I;

(B) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in OAC 310:667-23; and

(C) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in OAC 301:667-39;

(7) Outcome and quality improvement:

Outcome and quality improvement activities shall include the tracking of all stroke patients, appropriate use of thrombolytic therapy, performance measures and at a minimum the following steps shall be accomplished, which shall be verifiable and made available upon request by the Department:

(A) The facility will track the number of stroke and acute stroke patients, the number treated with thrombolytic therapy, including how soon after hospital presentation (arrival to needle time), the number of acute stroke patients not treated and indications for why they were not treated;

(B) There will be an official policy to review the care of all acute stroke patients that were eligible for thrombolytics and did not receive them;

(C) There will be a policy for and review of all patients who received thrombolytics more than 60 minutes after hospital presentation;

(D) If a facility fails to provide thrombolytics within 60 minutes to at least 50% of eligible patients for two consecutive quarters, they will develop and implement an internal plan of corrections;

(E) Provide no less than quarterly feedback to:

- (i) Hospital physicians and other health professionals;
- (ii) Emergency medical service agencies; and
- (iii) Referring hospitals;

(F) There will be a review of all acute stroke patients who require more than 2 hours to be transferred (arrival-to-departure time);

(G) The time from ordering to interpretation of a head CT or MRI will be tracked; and

(H) Door-to-computer link time for cases where a tele-technology is used;

(8) Agreements and policies:

(A) The stroke center shall develop and implement a written plan for transfer of patients to a Level I or Level II stroke facility as appropriate, defining medical conditions and circumstances for those emergency patients who:

(i) May be retained for treatment in-house;

(ii) Require stabilizing treatment; and

(iii) Require transfer to another facility; and

(B) If a stroke telemedicine program is utilized, there will be a written, contractual agreement addressing, at a minimum, performance standards, legal issues and reimbursement.

(d) **Level IV Stroke Center.** A level IV stroke center shall be deemed to adhere to secondary stroke recognition and prevention guidelines as required by state law and is a referral center lacking sufficient resources to provide definitive care for stroke patients. A Level IV Stroke Center shall provide prompt assessment, indicated resuscitation and appropriate emergency intervention. The Level IV Stroke Center shall arrange and expedite transfer to a higher level stroke center as appropriate. A hospital shall receive a Level IV Stroke Center designation by the Department, which shall be renewed in three (3) year intervals, providing the hospital is not certified as a level I, II or III stroke center and meets the following requirements:

(1) Emergency Department:

(A) For a hospital licensed as a general medical surgical hospital or specialty hospital, emergency services shall comply with the requirements of OAC 310:667-29-1 and OAC 310:667-29-2;

(B) For a hospital licensed as a critical access hospital, emergency services shall comply with OAC 310:667-39-14;

(C) For acute stroke patients requiring transfer by emergency medical services, said services will be contacted and emergently requested no more than 20 minutes after patient arrival;

- (D) Enter into transfer agreements for expeditious transfer of acute stroke patients to stroke centers able to provide a higher level of care; and
- (E) Have a comprehensive plan for the prompt transfer of acute stroke patients to higher level stroke centers which includes an expected arrival-to-departure time of < 60 minutes, with the ability to provide documentation demonstrating the ability to meet this requirement at least 65% of the time on a quarterly basis;
- (F) A health care professional able to recognize stroke patients will assess the patient within 15 minutes of arrival
- (G) Collaborate with emergency medical service agencies to develop inter-facility transfer protocols for stroke patients and will only use those emergency medical service agencies that have a Department approved protocol for the inter-facility transfer of stroke patients;

(2) Supplies and equipment:

All Level IV Stroke Centers shall meet the requirements of OAC 310:667-59-9(a)(3);

(3) Laboratory services:

- (A) For a hospital licensed as a general medical surgical hospital or specialty hospital, clinical laboratory services shall also comply with the applicable requirements in OAC 310:667-23; and
- (B) For a hospital licensed as a critical access hospital, clinical laboratory services shall also comply with the applicable requirements in OAC 310:667-39;

(4) Outcome and quality improvement:

The following outcome and quality improvement requirements are applicable to Level IV Stroke Centers, which include tracking of all patients seen with acute stroke:

- (A) A facility will meet the applicable outcome and quality measures listed in section 310:667-59-20(G); and
- (B) Track and review all acute stroke transfer cases requiring longer than an arrival-to-departure time of > 60 minutes. If over two consecutive quarters inter-facility transfers (arrival-to-departure) exceeds > 60 minutes more than 35% of the time the facility will create and implement an internal plan of correction; and

(5) Agreements and policies:

(A) A Level IV Stroke Center shall develop and implement a written plan for transfer of patients to a Level I, II or III Stroke Center. The written plan shall establish medical conditions and circumstances to determine:

(i) Which patients may be retained or referred for palliative or end-of-life care

(ii) Which patients shall require stabilizing treatment; and

(iii) Which patients shall require transfer to a Level I, II or III Stroke Center;

(B) Development and implementation of policy and transfer agreements directing transfer of acute stroke patients to the closest appropriate higher level facility. Patient preference may be taken into consideration when making this decision; and

An Act

ENROLLED HOUSE

BILL NO. 1641

By: Jordan, Coody and Dorman of
the House

and

David of the Senate

An Act relating to public health and safety; amending 63 O.S. 2011, Section 1-502.1, which relates to transmission of communicable diseases; directing State Board of Health to promulgate certain rules and guidelines; updating certain reference; and providing an effective date.

SUBJECT: Communicable diseases

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 63 O.S. 2011, Section 1-502.1, is amended to read as follows:

Section 1-502.1 A. All agencies and organizations that regularly employ emergency medical technicians, paramedics, fire fighters, peace officers, as defined in Section 648 of Title 21 of the Oklahoma Statutes, correctional officers and employees, or health care workers, all mental health or mentally retarded treatment or evaluation programs that employ persons involved with providing care for patients, the J.D. McCarty Center for Children with Developmental Disabilities, and all juvenile institutions of the Department of Human Services shall implement the universal precautions for the prevention of the transmission of communicable diseases published by the Centers for Disease Control, U.S. Public Health Service, in the Morbidity and Mortality Weekly Report, Volume 36, Number 25 or as subsequently amended.

B. The State Board of Health shall promulgate rules and guidelines that will implement a system of notification of emergency medical technicians, paramedics, fire fighters, health care workers, funeral directors, and peace officers, and any person who in good faith renders aid in accordance with the Good Samaritan Act relating to risk exposures during health care activities, emergency response activities or funeral preparations. Risk exposure shall be defined by the State Board of Health to be exposure that is epidemiologically demonstrated to have the potential for transmitting a communicable disease.

C. The ~~Mental Health Board~~ of Mental Health and Substance Abuse Services, Commission for Department of Human Services, Oklahoma Cerebral Palsy Commission, and State Board of Corrections shall each promulgate rules, guidelines or policies to provide for such notification of risk exposures to persons employed by such agencies.

SECTION 2. This act shall become effective November 1, 2013.

Passed the House of Representatives the 6th day of May, 2013.

Jan W. Murphy

Presiding Officer of the House
of Representatives

Passed the Senate the 17th day of April, 2013.

G. Shiffin

Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this 7th

day of May, 20 13, at 2:44 o'clock P M.

By: Kandi C. Batts

Approved by the Governor of the State of Oklahoma this 13th

day of May, 20 13, at 3:29 o'clock P M.

Mary Fallin

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this 13th

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SUBCHAPTER 13. INFECTION CONTROL

310:667-13-1. Infection control program

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310:667-13-1. Infection control program

Each hospital shall establish an infection control program to provide a sanitary environment and avoid sources and transmission of infections. The program shall include written policies and procedures for identifying, reporting, evaluating and maintaining records of infections among patients and personnel, for ongoing review and evaluation of all aseptic, isolation and sanitation techniques employed in the hospital, and development and coordination of training programs in infection control for all hospital personnel.

[Source: Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

310:667-13-2. Infection control committee

The infection control committee (or its equivalent) shall meet at least quarterly. If central services are discussed such as the dietary service, employee health, engineering or maintenance, housekeeping, laundry, material management, surgical services, pharmacy, or laboratory, at least one individual with appropriate background who can speak for the relevant department(s) attends the meeting or is consulted.

[Source: Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

310:667-13-3. Policies and procedures review

(a) The infection control committee shall evaluate, revise as necessary, and approve the type and scope of surveillance activities utilized at least annually.

(b) Infection control policies and procedures shall be reviewed periodically and revised as necessary, based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.

[Source: Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]OAC 310:667 OKLAHOMA STATE DEPARTMENT OF HEALTH 36 July 25, 2013]

310:667-13-4. Policies and procedures content

The policies and procedures outlined by the infection control program shall be approved by the infection control committee and contain at least the following:

(1) A requirement that a record of all reported infections generated by surveillance activities include the identification and location of the patient, the date of admission, onset of infection, the type of infection, the cultures taken, the results when known, any antibiotics administered and the physicians and practitioners responsible for care of the patient.

(2) Specific policies related to the handling and disposal of biomedical waste.

(3) Specific policies and procedures related to admixture and drug reconstitution, and to the manufacture of intravenous and irrigating fluids.

(4) Specific policies regarding the indications for and types of isolation to be used for each infectious disease. These policies shall incorporate the concepts of Standard Precautions and utilize the recommended transmission-based categories of Contact, Airborne, and Droplet isolation procedures where deemed appropriate by the medical staff.

(5) A definition of nosocomial infection.

(6) Designation of an infection control officer, who coordinates the infection control program.

(7) A program of orientation of new employees and other workers, including physicians, and a program of continuing education for previously employed personnel concerning infection control. Written documentation shall be maintained indicating new employees have completed the program and that previously employed have attended continuing education.

[Source: Added at 12 Ok Reg 1560, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 20 Ok Reg 1664, eff 6-12-2003]

310:667-13-5. Universal birth dose hepatitis B vaccination

All Oklahoma birthing hospitals shall implement a procedure to ensure that the hepatitis B vaccination is administered to all live infants within twelve hours of birth and recorded in the Oklahoma State Immunization Information System. A parent or guardian may refuse hepatitis B vaccination of their newborn on the grounds of medical reasons or that such vaccination conflicts with their religious tenets or personal beliefs. A refusal based on medical reasons shall include a statement in the medical record by a physician stating that the physical condition of the newborn is such that the vaccination would endanger the life or health of the child and that the child should be exempt from the vaccination requirement. A refusal based on the parent's or guardian's religious tenets or personal beliefs shall be documented in the newborn's medical record.

[Source: Added at 29 Ok Reg 1603, eff 7-12-2012]

Title 310:667-13-6 [NEW]

All Oklahoma licensed hospitals shall establish a written policy and procedure for notifying any person who in good faith renders aid in accordance with the Good Samaritan Act and are known to have been exposed to a patient with an infectious disease while transporting or treating an ill or injured patient to that licensed facility. Each licensed facility shall designate a person or persons to notify the Good Samaritan of the potential exposure. These procedures shall include at a minimum the following:

- 1) Notification of exposure to an infectious disease, either verbal or in writing, must take place within 4 hours of a confirmed diagnosis.
- 2) Verbal notification of such exposure to a selected infectious disease must be followed by written notification within 24 hours of a confirmed diagnosis.
- 3) Identification of the Good Samaritan known to have been in contact with the patient during treatment or transport, if notification is made to the EMS provider.
- 4) Both written and verbal notification shall contain at a minimum:
 - a. Name of disease;
 - b. Signs and symptoms of clinical disease;
 - c. Date of exposure to the selected infectious disease;
 - d. Incubation period of disease;
 - e. Mode of spread of the disease;
 - f. Advisement of appropriate diagnosis, prophylaxis, and treatment, if any.
- 5) Confidentiality of patient information must be maintained. The name of the patient shall not be disclosed.

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