House Health Committee
Proponent Testimony: SB 302
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December 8, 2020

Chairman Lipps, Vice Chair Holmes, Ranking Member Boyd, and members of the House Health Committee, thank you for the opportunity to provide proponent testimony on Senate Bill 302. My name is Ronald Budzik and I am Co-Medical Director of NeuroInterventional Surgery with OhioHealth's Riverside Methodist Hospital, a Comprehensive Stroke Center in Columbus. I am also Chairman of the Department of Radiology, and Co-Medical Director of the Comprehensive Stroke Center. I urge you to please support this legislation to improve outcomes for severe stroke patients. Stroke is the fifth leading cause of death and a leading cause of permanent disability in Ohio.

House Bill 464, passed in the 132nd General Assembly, was an important first step toward improving stroke care in Ohio, and I commend Chairman Lipps for sponsoring this bill, and those of you who supported that legislation. As you may recall, the bill established a three-tiered designation system for hospitals based on their capabilities to treat stroke, factoring in experience, training, and caseload. The designations include: Comprehensive Stroke Centers (Level 1), Primary Stroke Centers (Level 2) and Acute Stroke-Ready Hospitals (Level 3). Senate Bill 302 builds on this progress by requiring the state board of emergency medical, fire, and transportation services to develop statewide guidelines for the assessment, triage and transport of stroke patients. This would be similar to trauma care in Ohio, where patients in critical condition are taken directly to level 1 trauma centers.

This bill is vital to improving the ability of EMS professionals to identify those with suspected emergent large vessel occlusion (or ELVO), the deadliest form of ischemic stroke, and then transporting those patients to the hospital best-equipped to treat them. ELVO is the result of a blood clot in an artery in the brain, restricting the flow of blood and oxygen and killing up to two million brain cells each minute. This type of severe stroke has a low rate of response to intravenous tPA (the clot-busting drug), typically used in treating stroke. Therefore, it is critical that patients with a suspected ELVO be transported directly to an appropriate stroke center for the treatment necessary to save their lives.

Comprehensive (Level 1) Stroke Centers are staffed with highly trained neurointerventional care teams who are available 24/7/365. These teams can perform a minimally invasive catheter-based procedure, called mechanical thrombectomy, in which the clot responsible for the stroke is removed from the patient.

Studies have shown that severe stroke patients who receive this procedure leave the hospital up to four days sooner and are twice as likely to be independent within 90 days. This greatly reduces the need for extensive rehabilitation and long-term care. Unfortunately, despite worldwide acceptance in 2015 that this treatment works, most care systems haven't caught up

with these improvements in treating stroke. Less than 15 percent of patients who would benefit from this procedure receive it.

Similar to trauma, every minute matters when it comes to stroke. The degree to which a patient recovers depends in large part on the amount of time that has elapsed since the artery was blocked. Transporting a severe stroke patient to the nearest hospital, which is often current practice, can lead to significant treatment delays, as this procedure is not available everywhere. Multiple-hour delays are seen when a patient needs to be transferred between hospitals, increasing the chance of death or permanent disability.

This bill is supported by the Ohio Ambulance and Medical Transportation Association. EMS providers I work with will support this policy wholeheartedly. Before this interventional treatment became widely accepted as standard of care, in Columbus where my team was offering this treatment, EMS providers actually asked us to address this issue in the mid 2000's. This is because they were often being asked to re-transport a patient to a thrombectomy capable stroke hospital shortly after they had brought the patient to the closest hospital just an hour or two earlier. They knew that wasn't right and wouldn't lead to the best patient outcomes, so they asked the Central Ohio Trauma Systems/Columbus Medical Association to create a task force to come up with a solution. Now that the mechanical thrombectomy procedure is considered standard of care worldwide, we need a policy for the assessment, triage and transport of stroke patients that ensures patients receive the appropriate care in a safe and timely fashion, which we currently do not have.

Senate Bill 302 recognizes Ohio's geographic diversity and ensures flexibility for local EMS agencies to develop their respective triage and transport protocols accordingly, to align with the statewide guidelines. I believe this bill strikes an appropriate balance in creating standardized guidelines for best practices in stroke triage and transport, without being overly prescriptive and allowing for flexibility when needed.

I was disappointed by an amendment added to the bill that removed reference to EMS training to identify ELVO, instead replacing it with broader training in the assessment in stroke severity. As outlined above, this type of stroke is extremely dangerous, and it is vital that EMS are trained in the latest methods for assessing this type of stroke, so they understand where best to transport the patient according to the available treatments. However, I believe that providing training broadly for stroke severity will include the assessment of ELVO, so I ask that the committee favorably approve this bill for passage. Thank you for the opportunity to provide testimony on this important bill. I am available to answer any questions you may have.