**Tufts Medicine Comments Regarding the Massachusetts Department of Public Health’s Proposed Regulations 105 CMR 130.000, Hospital Licensure**

**October 28, 2024**

Tufts Medicine appreciates this opportunity to comment on the Department of Public Health’s proposed regulations for 105 CMR 130.000, *Hospital Licensure.* These rules replace the current designation for hospitals that provide stroke services with a tiered model reflecting hospitals’ capabilities to care for patients with stroke requiring different levels of treatment intensity.

We are grateful to the Department of Public Health (DPH), the Executive Office of Health and Human Services and the Healey-Driscoll Administration for its commitment to improving the health and well-being of residents across the Commonwealth and its close partnership with hospitals and health systems to help meet our patients’ needs. Stroke care is one of the most vital services for keeping our communities healthy and saving lives.

At Tufts Medicine, our hospitals provide 24/7 emergency diagnostic services and treatments to patients with acute stroke within a **hub-and-spoke stroke network**, including our Comprehensive Stroke Center at Tufts Medical Center in Boston, which brings together multidisciplinary teams that provide treatments for patients with severe stroke and complex cerebrovascular disorders. At the same time, our community hospitals in Lowell and Melrose provide rapid, high-quality care for patients with less severe strokes and quick triage-and-transport of patients with more severe strokes directly into the operative suites and intensive care units at Tufts Medical Center. We appreciate the DPH for considering ways to expand access to such services according to patients’ acuity levels and look forward to providing input on its proposed updates. We respectfully offer suggestions below to help ground the regulations in the realities of the healthcare landscape in Massachusetts.

**Proposal to amend the tiered system**

We urge DPH to add a designation modifier, “**stroke network integrated**,” to the first and second tiers (Acute Stroke Ready Service and Primary Stroke Service) to indicate a hospital’s integration into a hub-and-spoke stroke network. This level of stroke network integration would require a **formalized transfer agreement with at least one Endovascular Capable Stroke Service hospital** with a **guarantee of acceptance at the destination hospital** (within the bounds of bed availability and clinical appropriateness) and a **plan for continued performance improvement to reduce door-in-door-out (DIDO) times**, filed with DPH on an ongoing basis. Understanding that field assessment tools (such as FAST-ED) have limited predictive value for large vessel occlusion ischemic strokes and pose a risk for over-triage to Endovascular Capable Stroke Service hospitals, this designation would **allow Emergency Medical Services to bring patients to the closest, highest level, stroke network integrated hospital as an option alongside direct transport to an Endovascular Capable Stroke Service hospital**. Creating such a designation would add value to patient care for all patients with stroke by encouraging national certification as Acute Stroke Ready hospitals and Primary Stroke Center hospitals, which in turn would foster continued performance improvement in thrombolysis treatment and other tenets of stroke care.

The current proposed rule is limited in its ability to improve the care of patients with stroke. First, the language as written does not provide a clear delineation or purpose for seeking an Acute Stroke Ready Service or Primary Stroke Service designation, which underrepresents the capability of hospitals that can provide care for a large volume of patients hospitalized with stroke. Second, it does not account for the capacity of Endovascular Capable Stroke Service hospitals to accommodate an increase in volume of patients transported directly to their Emergency Departments. Third, it does not address limitations in Emergency Medical Services availability, particularly in municipalities relying on fire paramedic services with few ambulances. These limitations may be further exacerbated by long distance transports. Finally, it does not address continuity of care that can be disrupted by transporting a patient to an Endovascular Capable Stroke Service outside of a healthcare network in which a patient receives most of their care, potentially resulting in treatment decisions based on inaccurate or incomplete information and subsequent disjointed post-acute care.

For patients with acute stroke symptoms, every minute counts. We assert that **the best scenario for our patients in our communities is to present to the closest stroke network integrated center**, such as Lowell General Hospital or MelroseWakefield Hospital. Our patients with acute stroke are brought by Emergency Medical Services directly into the CT scanner for rapid identification of hemorrhagic strokes, assessment of thrombolysis eligibility for ischemic strokes, and rapid identification of large vessel occlusions by CT angiography. All brain and blood vessel imaging studies are immediately available via mobile device and artificial intelligence-supported large vessel occlusion identification to the Acute Stroke Team at Tufts Medical Center, allowing rapid care coordination between the Emergency Medicine and Neurology teams between our stroke network integrated hospitals and the Comprehensive Stroke Center. Patients with large vessel occlusion strokes can then be transported rapidly to the Neurointerventional suite at Tufts Medical Center, omitting delays that may occur with transfers between Emergency Departments. Quality assurance and performance improvement within the Tufts Medicine network occurs continuously at both the local and hospital network levels.

Without changes, the proposed rule will confine patients with acute stroke symptoms to ambulances for more time, sacrificing crucial minutes in transit rather than connecting patients to stroke care for their immediate needs. It will also risk exacerbating the growing pressure on ambulance capacity in Massachusetts. We expect this trend will compound if ambulances must make extended trips under the proposed rule. Our recommended update to allow EMS the option to transport patients with acute stroke symptoms to nearby stroke network integrated hospitals for initial care is a small change but one that would have an outsized impact on their lives.

**Timeline for Implementation**

We respectfully ask DPH to amend the regulations to allow a grace period of at least one year after implementation. The proposed timeframe would be difficult for us to meet as we need to commit significant time and resources to apply for credentials, recruit staff, expand education and quality programs, and more. This update will position hospitals and health systems to best serve the needs of our patients as the rules take effect.

**Further Follow-Up**

Thank you for your time and consideration of our recommendations. If you have questions or need further input, please do not hesitate to contact Beth Riportella, Vice President for Government Affairs at Tufts Medicine, at 978-877-2377 or [Bethany.Riportella@tuftsmedicine.org](mailto:Bethany.Riportella@tuftsmedicine.org) and Jessica O’Neil, Vice President of Neurosciences Service Line at Tufts Medicine, at 603-943-0741 or [jessica.oneil@tuftsmedicine.org](mailto:jessica.oneil@tuftsmedicine.org).

With warm regards,

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