

# STATE OF COLORADO

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Dedicated to protecting and improving the health and environment of the people of Colorado

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Colorado Department  
of Public Health  
and Environment

## Stroke Advisory Board Meeting Minutes March 18, 2014

**CDPHE Staff:** Crystal Cortes, Eileen Shelby, Grace Sandeno, Margaret Mohan, Matt Concialdi and Scott Beckley

**Guests in Person:** Anwai Ali, Hidajah Almuhaishi, Julie Blakie, Marwah Alabbad, Maura Proser, Susanna Morris

**Roll Call/Call to Order:** 1:05 PM

Members	Serving as:	In Person	By Phone	Absent
Kevin Burgess	EMS Provider			Excused
Coral Cosway	Rep. National Association			X
Nancy Griffith	Statewide Hospital Association	X		
Christina Johnson	Statewide Chap. Emerg. Physician	X		
William Jones	Physician Vascular Neurology		X	
Michelle Joy	Admin at Rural Hospital			X
Julia Cowan	Rep. Stroke Rehab Facility	X		
Mary Ann Orr	Person/Caregiver Stroke Survivor		X	
Michelle Reese	Representing CDPHE		X	
David Ross	Statewide Assoc. of Physicians		X	
Karin Schumacher	Phys/Occup Therapist	X		
Richard Smith	Rep. National Stroke Assoc.	X		
Michelle Whaley	RN in Stroke Care	X		
Mary White	Admin at Urban Hospital		X	
Chris Wright	Expert Stroke Database	X		
Donald Frei	Physician Interventional Neuroradiology		X	
Unfilled	Primary Care Physician			
John Hudson	Neurosurgeon			X
Tim Bernard	Neurologist Serving Rural Area	X		

### Organizational Issues:

- After review of the January 21, 2013 minutes, Griffith motioned to approve the minutes; seconded by Richard Smith. The minutes were unanimously approved.

### Discussion:

- New Member Introductions:**  
The Stroke Advisory Board welcomed three new members. Julia Cowan replaces Cynthia Kreutz as a representative from a rehabilitation facility and Dr. Tim Bernard fills the position of a neurologist

serving patients in a rural area of the state. Dr. John Hudson who completes the role of a physician actively involved in stroke care in neurosurgery was not in attendance.

- **Meeting Schedules**

Stroke board meetings will continue to meet every other month but an additional mid-term call-in meeting was discussed to combat the loss of momentum between meetings. Those mid-meetings will begin in April for the work groups in consecutive thirty minute intervals with member and public call-in availability. Members and the public can attend any or all sessions. Staff will send out a meeting invite with date options for member response.

- **Stroke Update from American Heart Association**

Julie Blakie with the American Heart Association (AHA) stated Colorado received the Lee Shwamm award for tPA administration in 60 minutes or less by 87.5% of eligible hospitals (those participating in Get With The Guidelines stroke registry) in Colorado. Colorado is expected to continue improvement and is more saturated with GWTG stroke registry compared with other states. The question was asked if Colorado has the best door-to-needle times in the nation. Blakie explained AHA does not track door-to-needle times but individual facilities do have the capability to track that. Dr. Shwamm may include door-to-needle times next year.

- **Stroke Data Presentation**

Beckley, with the department, presented stroke data from the hospital discharge data set from 2012 representing one-hundred hospitals. The data was filtered to include only the primary diagnosis as ischemic or hemorrhagic stroke. Some discussion continued in interpreting tPA administration. It appears that roughly 8.5% of ischemic stroke patients receive tPA, which is above the national average but the group consents there is room for improvement through education.

Sandeno, with the department, shared the fact that the discharge categories are not clearly defined or consistent among hospitals. Patients discharged to home, self-care or routine are considered as going to where they were pre-hospital which may be a myriad of facilities such as skilled nursing or home health agencies.

The data review increased interest in gathering information on how many stroke patients receive rehabilitative services and to what extent. A glaring concern is the lack of coverage for rehabilitative services by private insurances, Medicare and Medicaid.

- **Stroke Recognition Update**

Part of Senate Bill 13-225 instructs the department to recognize STEMI and stroke facilities in the state of Colorado that are certified, accredited or designated by a nationally recognized accrediting body.

The department requested feedback from the board if the accrediting agencies, criteria and process seemed acceptable as described. After confusion with defining nationally accrediting bodies, Griffith contributed that the term accrediting body is used by CMS (Centers for Medicaid and Medicare Services) who endorses accrediting bodies. CIHQ is to be added to the accrediting bodies list which is expected to begin certifying stroke centers in the future. The department was asked about active auditing of the certification claims. Reese, with the department, shared that in the trauma system enforcement is passive in that complaints are researched and stroke will likely be the same. The competitive nature of the trauma system aids in self-regulation. The board did request updates on the process of recognition as it matures.

- **Work Groups**

The board broke into its three work groups to exercise individual objectives.

- **Group One: Data Registry**

**(Participants: Chris Wright-team lead, Mary White, Michelle Reese, Richard Smith, Don Frei, Maura Prouser, Scott Beckley and Nancy Griffith)**

The group defined objectives to collect up to ten relevant data points to most immediately impact stroke care in prevention, treatment, and post-stroke function measures. The group decided to define the desired data points and then adjust requirements based on availability and consideration of capabilities for small or rural facilities.

Limitations:

- Post-hospital data is rarely obtained and difficult even in large facilities

- Rural facilities have limited means for data collection

- Centers for Medicare and Medicaid Services only receive data from facilities with over 25 beds

Four main data points were selected:

- 1)tPA administration

- 2)Anticoagulant medications given at discharge

- 3)Acuity adjusted mortality rates

- 4)90 day quality outcome measure-difficult to collect even in large hospitals

- 5)Discharge disposition (modified ranking is preferable but not collected consistently)

- **Group Two: Treatment and Prevention (Evidence-based Practice)**

**(Participants: William Jones-team lead, Christina Johnson, Kevin Burgess, Cynthia Kreutz, Mary Ann Orr, David Ross, Karin Schumacher)**

Prevention:

- Public education: stroke recognition, treatment availability

- How do we maintain benefits after an educational program ends?

- Provider education

Treatment standards algorithm: access to care, patient transfers, treatment availability, provider education, and tPA availability. Rural facilities will need the freedom to adapt their system to proposed guidelines.

- Minimum requirements include: expertise to recognize stroke, know what test to order, having tests read, getting patient treated or transferred efficiently

- Tools required: physician, CT, tPA, neuro consult capability, neurosurgeon or transfer agreement, interventional neurosurgeon or transfer agreement, primary treatment

- AHA recommended stroke guidelines are 24 min door to scan and 45 min to read

- **Group 3: Rural and Urban Coordinated Care**

**(Participants: Michelle Whaley-team lead, Coral Cosway, Michelle Joy)**

**Karen Schumacher moved to Treatment and Prevention**

Whaley introduced new concepts in care coordination as demonstrated under the RETAC control in California that may show advantageous for Colorado.

The group has reached and hoping to be added to the RETAC agenda for the June meeting in Crested Butte. It would be beneficial to present primary impression of strokes and stroke statistics slides. The goal is to have a biennial plan and address the following (funding may be needed):

- Problems rural hospitals want addressed regarding stroke

- Discuss transport guidelines, assessment scales, treatment guidelines- mainly tPA comfort level

- Regional input on where patients should go
  - Seek RETAC receptiveness to adding algorithms to biennial plans
  - Stroke scale quality improvement
  - EMS training capabilities through hospitals, local hospital bridge building
- Designation
 

In review of Senate Bill 13-225, the Board is to explore without limitation and make recommendations on a statewide database, public access to aggregate data, treatment and prevention, rural and urban care coordination and if state designation is necessary to ensure good quality care based on criteria used by nationally recognized accrediting agencies. Questions include what designation would do for the stroke system. The example of the trauma system was offered to example regulation, auditing and the designation process.

Considerations for state designation:

    - Stroke doesn't fit the trauma model due to specificity and complex assessment and treatment
    - Fiscal and resource impact may not outweigh the benefit. HHS studies showed no difference in sepsis patient outcomes comparing facilities with varying levels of mandated treatment guidelines
    - Phoenix mandates and directs patient transfers. Colorado EMS chooses where to send patients.
    - Florida mandates national accreditation to be a stroke facility
    - Texas designates three levels of stroke care centers using the Joint Commission
    - RETAC level coordination may be an alternative to state designation
    - Trauma designation offers quality improvement processes
    - Designation increases patient resource availability, as in mandated physician response times
    - Legislation could require communication with EMS as hospital staffing changes, divert statuses
    - Legislation can mandate divert protocols when a facility lacks resources to treat stroke patients
    - "Stroke centers" need to have what patients need- first define what is needed for treatment
    - Designation is costly to hospitals, Colorado already has accrediting and reviewing agencies
    - Explore designation only if it proves to have improved care in other states
    - How do we measure quality of life, what does functional mean for stroke patients
  - **Next Meeting Goals**

Staff is to send a meeting invite for the work groups to convene in four weeks. The next agenda will be established from those discussions.

**Next Meeting: April 22 2014, teleconference**  
**Data Registry work group 1:00-1:30**  
**Rural/Urban Care Coordination work group 1:30-2:00**  
**Treatment and Prevention work group 2:00-2:30**  
**Call-in 218-862-6789 Conference code: 914468**