

# Oregon Stroke Care Committee

<b>Meeting Date:</b>	Thursday, February 26, 2015
<b>Meeting Time:</b>	7:00 a.m-8:30 a.m.
<b>Meeting Location:</b>	Portland State Office Building, room 1D 800 NE Oregon Street, Portland, OR 97232 <b>Conference Call line: 1-877-336-1831</b> <b>Participant Code: 559758</b> Host Code (State): 643563
<b>Meeting Purpose:</b>	The Stroke Care Committee was established under the Oregon Health Authority as a result of SB 375. For the purpose of achieving continuous quality improvement in the quality of stroke care the committee shall: <ul style="list-style-type: none"> <li>Analyze data related to the prevention and treatment of strokes; and</li> <li>Identify potential interventions to improve stroke care; and</li> <li>Advise the authority on meeting the objectives of the authority, including but not limited to the objectives of the emergency medical services and trauma systems related to stroke care.</li> </ul>
<b>Regular Attendees:</b>	Appointed members: <i>Shawn Baird, Mark Brauner, M.D., Karen Ellmers, RN, Charity Gillette, RN, Trece Gurrad, RN, Sarah Higginbotham, Theodore Lowenkopf, MD, Lori Morgan, M., MBA, Elaine Skalabrin, M.D., Viviane Ugalde, MD</i>  Oregon Health Authority-Public Health Division Staff: <i>Kirsten Aird, MPH, Scott Montegna, MA, Todd Beran, MS</i>

Updates	Contact
1. The Oregon Health Authority submitted a brief memo type report to the Oregon Legislature on February 4, 2015 regarding the initiation of the Oregon Stroke Care Committee. The report is required of the Oregon Health Authority.	Kirsten Aird

Agenda Item, objective and background information	Time
<b>Item 1: Welcome and Introductions – Dr. Ted Lowenkopf</b> <ul style="list-style-type: none"> <li>Approve December meeting minutes</li> </ul>	7:10-7:15 a.m.
Committee Attendees: Shawn Baird, Karen Ellmers, RN, Charity Gillette, RN, Sarah Higginbotham, Theodore Lowenkopf, MD, Lori Morgan, MD, MBA, Elaine Skalabrin, MD  OHA Staff: Kirsten Aird, MPH, Scott Montegna, MA, Todd Beran, MS	
<b>Item 2: Discussion: Hospital Self-Identification Regarding Level of Acute Stroke Treatment Service – Dr. Ted Lowenkopf</b>  <b>Background:</b> At the December 2014 Stroke Care Committee meeting, Dr. Elaine Skalabrin presented on Utah's experience with voluntary identification for stroke ready hospitals – see previous meeting minutes to view a copy of this presentation.  <b>Objective:</b> Discuss options for how this may or may not work in Oregon's hospitals – i.e. would identifying hospitals as stroke-care ready improve stroke care for Oregonians. Identify a working group to come up with key strategies and next steps for the Stroke Care Committee to consider for recommendation to OHA.	7:15-8:15 a.m.
<b>Discussion:</b> Lowenkopf asked the EMS representatives if a triage system based on identified hospitals would be helpful. Baird stated that from the EMS perspective, credentialed and verified hospitals are essential. This would allow EMS to defend a decision to bypass a hospital. He stated that health systems and insurers	

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pressure EMS providers to keep patients with their health system and PCP. EMS would be in a better position if a recognized credential framework were in place. Dr. Ritu Sahni stated that one expectation of such a system is accountability. EMS should be expected to appropriately triage the patients, and hospitals need to know what it means to be stroke ready. He stated that transparency was another expectation. Was the appropriate care provided? EMS needs regularly communicated feedback for quality improvement.

Lowenkopf asked whether or not a rationale triage system with transparent, verifiable standards to identify hospitals as acute-stroke ready care would benefit Oregonians. The Committee generally agreed such a system would be beneficial, but members raised many issues for consideration. Baird stated that in essence there are two worlds in Oregon, Portland and the rest of the state. LeeAnn Hastings provided the example of rural hospitals and how bypassing may not be a viable option in most cases. She stated that all hospitals need to be acute care ready. Skalabrin agreed to the need for accountability and transparency, but she reiterated that all hospitals need to be brought up to appropriate stroke care levels. She stated that Oregon needs a triage system and hospitals need to be identified to understand which may be in need of intervention. Both goals are important. Skalabrin added that in Utah there was a fear that patients would be transported to big centers, but this did not happen. Patients were still treated locally. The focus in Utah was putting patient care first.

Lowenkopf stated that the Committee needs to define what a triage system should look like in Oregon. He asked what it means when a hospital identifies itself as acute stroke care ready. How do we know that self-declaring systems can provide the quality of care claimed? Morgan stated that the challenge is defining what “triage” and “stroke ready” are. In rural areas the challenge is getting the hospital up to speed. She stated that hospitals generally do not have the money to ramp up. Morgan stated that there is a need to understand the pitfalls for setting up a triage system while ensuring inclusiveness, appropriate care, and affordable cost. She used the trauma system as an example with rural Level II hospitals dropping to Level III. How can patient care be best supported considering each of these elements? Do you bypass a secondary stroke center to get to a primary stroke center just down the road?

The Committee agreed that inclusiveness is a key issue. Lowenkopf asked how a triage system can be developed and rolled out to include every hospital that can provide acute stroke care services. Baird reiterated that a triage system needs to include feedback for EMS and hospitals. What was done well? Where can hospitals improve? He stated that in order for inclusion to occur, systems and services need feedback on how to improve patient outcomes. Lowenkopf stated that a significant number of hospitals are not participating in Get with the Guidelines (GWTG), so there are gaps in the data. He stated that it would be helpful to know which hospitals are providing acute care. Aird stated that the OHA can disclose de-identified data only from the stroke care database. Committee members raised additional questions related to stroke care data and reporting. What hospital data are available to help with assessment? Is the minimum dataset being used with GWTG? Could money be used to implement GWTG to improve reporting?

## Next Steps:

1. Generate a map of participating hospitals – Who is participating, who is not? (OHA task – see Action Items below)
2. Define verification process (Committee to develop a proposal – see Action items below)
3. Provide support to increase hospitals’ capacity for stroke care – How can hospitals be enabled to take the next steps? (Oregon Stroke Network task)
4. Develop clear bypass criteria (Committee task – see Action Items below)
5. Assess minimum dataset quality measures – Do these data align with national reporting systems? (OHA task – see Action Items below)

## Action Items:

A volunteer workgroup was charged with the following tasks:

1. Discuss how the Committee should approach the process of verification and participation.

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<p>2. Discuss how to ensure inclusion. Volunteers for the workgroup include: Ted Lowenkopf (Clinical), Shawn Baird (EMS), LeeAnn Hastings (OAHHS), Sarah Higginbotham, Scott Montegna (OHA), and Ritu Sahni. Note: Others may attend as are interested.</p> <p>OHA will develop the following data oversight processes:</p> <ol style="list-style-type: none"> <li>1. Standardization of data collection</li> <li>2. Data reporting</li> <li>3. Define expectations for OHA to share de-identified data</li> </ol>	
<p><b>Item 3: International Stroke Conference February 2015: Practice Change in Acute stroke Treatment – Dr. Ted Lowenkopf</b></p> <p><b>Objective:</b> Share key information addressed/presented at the conference.</p>	<p>N/A</p>
<p>Discussion: No discussion occurred.</p>	
<p>Action Steps:</p>	
<p><b>Item 4: Stroke Care Committee Meeting Frequency – Kirsten Aird</b></p> <p>Objective: Discuss how frequently the committee should meet.</p>	<p>8:15-8:25 a.m.</p>
<p>Discussion: Aird stated the issue of limited staff resources to support the Committee due to a lack of funding. She asked the Committee to consider this when planning future meetings.</p>	
<p>Action Steps: The Committee decided on the following meetings:</p> <ul style="list-style-type: none"> <li>• Workgroup teleconference meeting on March 12, 2015 – See Action Items for a list of workgroup members. Montega will email teleconference information.</li> <li>• Committee meeting April 9, 2015</li> </ul>	
<p><b>Item 5: Wrap-up and Next Steps – Dr. Ted Lowenkopf</b></p>	<p>8:25-8:30 a.m.</p>
<p>Future Agenda Items:</p> <ul style="list-style-type: none"> <li>• Discuss data oversight (OHA)</li> <li>• Clarify subcommittee charge (Committee)</li> </ul>	