Stroke Advisory Council Meeting Minutes

Thursday, May 1, 2014
Division of Public Health Campus – Cardinal Room
5605 Six Forks Road, Raleigh
1:00pm – 4:00pm

Members: Karen McCall, Peg O'Connell, Andrew Asimos (phone), David Huang, Pamela Duncan, Robin Jones

Guests/Partners: Betsy Vetter, Abby Fairbank, Kimberly Elks, Sheila DeBastiani, Terry Congleton, Marie Welch, Valerie Gatlin, Jo Malfitano, April Reese, Donna Beaman, Sharon Rhyne, Ron Cromartie, Sarah Myer, Kimberly Leathers, Rayetta Johnson, Erica Nelson, Angie Wester, and by phone: Debbie Lambert, Amy Jones, Birtha Shaw, Maureen Driscoll.

Staff: Anita Holmes, Cathy Thomas, Sarah Myer, Sylvia Coleman, Tosha Boyd, Laurie Mettam, Alicia Clark

I. Welcome, Introductions, Approval of Minutes

Karen McCall, Chairperson, called the meeting to order, welcomed all and asked everyone present and on the phone to introduce him/herself.

A motion to approve the March 6, 2014 minutes was made by David Huang and seconded by Peg O'Connell. The motion passed.

II. Overview of Justus-Warren Heart Disease and Stroke Prevention Task Force meeting of April 16, 2014 and Stroke Advisory Council (SAC) Recommendations

Anita Holmes, Task Force Executive Director, provided highlights of the April meeting led by Task Force Co-Chair Senator Louis Pate.

- The Southeastern Stroke Belt Consortium was held in Florida February 28-March 1, 2014.
- The Eastern NC Stroke Network has been revived and recently sponsored a Network meeting.
- Application for continued funding of the North Carolina Stroke Care Collaborative (NCSCC) through the Centers for Disease Control and Prevention (CDC) has been submitted.
- NCSCC is holding regional workshops, titled "Strengthening EMS and Hospital Partnerships for Improved Stroke Care."
- NCSCC awarded five member hospitals with Innovative Quality Improvement Grants.
- Defect-free care for Collaborative hospitals increased from 49% in 2005 to 74% in 2013.
- NCSCC website was rebuilt and updated.
- Fire Chief Jeff Cash and Thomas White, MD, presented on "Firefighters and Cardiovascular Disease." The number one cause of a firefighter fatality is an

acute cardiovascular event. Due to funding issues, only 25% of firefighters have a medical check-up in a 24 month period. When funds are available, career firefighters receive the benefits. Only 25% of firefighters are career vs 75% being volunteers. Firefighters suffer from higher levels of hypertension than the general public.

- The 50th Anniversary Surgeon General's report on Smoking and Health was presented by Sally Herndon, Tobacco Prevention and Control Branch, DPH. Evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and increased risk (estimated 20-30%) of stroke. Evidence is suggestive but not sufficient to infer a causal relationship between the implementation of a smoke free law or policy and a reduction in cerebrovascular events and other heart disease outcomes, including angina and out of hospital sudden coronary death. Smoking is now known to cause13 types of cancer, with liver and colorectal cancer being recently added to the list. CDC recommends investing $10.53 per person on tobacco prevention and control. Currently, NC spends $.41 per person. The national average is $1.50 per person.
- Vondell Clark, MD, chair of the Eat Smart, Move More NC, presented NC's plan to address obesity: *Healthy Weight and Healthy Communities, 2013-2020*. The Eat Smart, Move More NC – state obesity plan was released in January of 2013. NC's plan is aligned with the Healthy NC 2020 Objectives and is based on the most recent evidence base of what works for obesity prevention.
- Pam Seamans shared the NC Alliance for Health report. The Report supports restoring funding for tobacco prevention and control programs, clarification of smoke free law and promoting the elimination of food deserts.

III. Overview of SAC Recommendations to the Task Force.

Karen McCall reported on the SAC report and recommendations made to the Task Force at the April 16th meeting.

- As Senator Pate is very interested in the work of the SAC, Karen McCall shared the history of the SAC and highlights of *The North Carolina Plan for the Prevention and Management of Heart Disease and Stroke 2012-2017*, which includes goals for stroke prevention, pre-hospital care, acute care, rehabilitation and transitions of care, and Telestroke.
- Worked with the Governor's office to produce a proclamation declaring May 21, 2014 as Hypertension Awareness Day. With the support of Representative Carney and Senator Pate, the need for awareness of the importance of blood pressure and the urgency of treatment for stroke has been introduced in draft legislation for this session and is supported by many partners.
- A recurring appropriation to continue previous SAC funding in the amount of $50,000 has been proposed.
- An ad hoc hypertension committee has been established and will meet May 15, 2014. Members include NC Area Health Education Center, Community Care of NC, Blue Cross Blue Shield NC and Blue Cross Blue Shield SC.

IV. Stroke Center Designation Rules Draft

Donnie Sides, Operations Manager, Office of Emergency Medical Services (OEMS), presented the drafted rules to administer Senate Bill 456, Designate Primary Stroke Centers, which was passed in 2013.

- The process for establishing rules, written to carry out the intent of the legislation was shared. Members were provided a handout which included the ratified Bill and the drafted rules. The goal is to complete the process, which includes a public comment period, by mid to late fall.
- Additional work regarding administrative procedures and a fiscal impact report are needed. The OEMS Triage and Destination Plan will need to be updated. Hospitals are grouped by level of care and certification through the OEMS webpage.
- With respect to a fiscal package, the only fiscal component is for Department of Health and Human Services (DHHS) to create a website.

Discussion:

- Robin Jones, Ron Cromartie, Sharon Rhyne, Peg O'Connell and Anita Holmes shared questions, suggestions and responses.
- Certification of hospitals is based on the Joint Commission and American Heart Association/American Stroke Association (AHA/ASA) standards.
- Hospitals are required to report their certification and de-certification directly to OEMS for the Triage Destination Plan updates.
- Hospitals in bordering states are included and transportation to those hospitals, as needed, is allowed and practiced by OEMS.
- Ron Cromartie spoke to the process used by the Joint Commission and AHA/ASA to certify hospitals.
- Peg O'Connell suggested the list of programs, in the drafted rules, be placed in quotes to help readers differentiate between them.
- Highway signage was discussed and Sharon Rhyne suggested that the DHHS and the Department of Transportation work together to generate signs and not leave the work up to hospitals.
- Anita Holmes shared that Larry Goldstein and others had provided input on the current draft of the rules. Any questions after this meeting should be sent to Anita Holmes for follow-up.

V. Examination of Stroke Rehabilitation & Transitions of Care Needs in NC.

Pamela Duncan, Wake Forest Baptist Hospital and Chair of the SAC Post-Acute and Transitions of Care Work Group, spoke to the need for follow up with patients no later than seven days post hospital discharge and rehabilitation.

- An opportunity to keep post-acute stroke care moving forward is now available. Pamela Duncan, Cheryl Bushnell, Wayne Rosamond and other partners are working on a proposal for a pragmatic research project to be funded by the Patient Centered Outcomes Research Institute (PCORI). Forty of the over 240 letters of intent submitted were approved to go forward with

the development of an application. NCSCC data indicates that 49% of stroke patients are discharged home following four days of hospitalization. Once home, many challenges persist. Janet Bettger, Duke University, commented on the importance of transition of care for all patients. There is a need to bridge the chasm of care once patients are discharged. Increased risk of repeat events, falls in particular, and medication non-compliance are factors in hospital readmission.

- Readmission rates are under scrutiny and require a broader, deeper continuation of care. Socioeconomic status plays a large role in readmissions. Communities need to be educated about these challenges.
- Moving to value-based care will provide better outcomes with care being integrated. Hospitals need to ensure the best follow up care for the patient. Patients need assurance that a safety net is available in the community and how to access it. They also want to know and have confidence that their post stroke conditions will improve. PCORI will not allow a quality measure that discounts the value of a life because of an individual's disability to establish what type of health care is cost effective or recommended.
- Early Supported Discharge (ESD) is new to America. With ESD, the hospital co-manages with home health care agencies. Inviting Area Agencies on Aging to partner with ESD work is recommended. Hospitals that are not part of the initial clinical trial will participate 12-15 months after the trial begins. A successful grant application will provide support for nurse navigators and train the community on ESD and integrated care pathways.

Discussion:

- David Huang agrees hospitals are working on this, believes true disconnect happens outside the hospital. Says the further patients live away from UNC, the more they are readmitted. Pam explained the need for community coalitions, referring to community based networks as being "admitted to the community" for continued care.
- Ron Cromartie brought up the overwhelming cost of post hospital care.
- Pam commented that there are agencies to help with these costs.
- Andrew Asimos met with Wayne Rosamond last week and received an overview of the project.
- David Huang was very supportive as "boots on the ground" staff wants the results tomorrow as they see how the patient is challenged once discharged. He mentioned the challenge of the larger hospital trying to transition the patient back to the local community where the initial stroke care/admission to the community hospital took place. The systems are faulty and need re-evaluation.
- Robin Jones at Mission Hospital noted that only one-third of patients return to the larger hospital.

VI. NC Stroke Rehabilitation Survey

Sarah Myer, Project Specialist, presented on the NC Stroke Rehabilitation Inventory**.**

- A comprehensive handout of the inventory was provided to attendees.

- There is a growing body of evidence that coordinated stroke rehabilitation programs can reduce mortality and morbidity rates and improve quality of life.
- Coordinated stroke rehabilitation includes input form the stroke survivor as well as providing medical, social, education, vocational, and caregiver support therapies and services.
- The Great Lakes Regional Stroke Network Resource Inventory was used to develop and refine a tool for North Carolina's Inventory.
- Calls to NC hospitals indicated that contacts and participants in the survey hold a variety of job titles from Rehabilitation Director to Stroke Coordinator to Clinical Management Personnel. Overall participation rate of hospitals was 75%.
- Rehabilitation settings, stroke rehabilitation therapies, mental health services, support services, community services and Telehealth services were inventoried in the survey.
- Facility measures and scales, interest in data linkage, limitations to providing stroke services and continuing education topics were also part of the survey/inventory.

Inventory Limitations

- The inventory was limited to hospitals as a comprehensive list of skilled nursing facilities was not obtainable in time to be included.
- 70%% of NC hospitals are accounted for in the survey with 10 hospitals reporting as part of a hospital system.

VII. NC Statewide Telepsychiatry Program

Sheila Davies, NC Statewide Telepsychiatry Program Coordinator, provided an overview of the state's Telepsychiatry program. She was accompanied by Jay Kennedy with the NC Office of Rural Health and Community Care.

- Benefits of Telepsychiatry were reviewed and it was noted that if this can be done with psychiatry, why not with other areas of medical need.
- NC has a shortage of mental health providers. Thirteen counties do not have a psychologist. Emergency Departments (ED) have become primary care providers. Mental health patients can be held for several days in the ED while waiting for psychiatric care.
- Telepsychiatry helps by making mental health services more accessible to those in need, affording consumer convenience.
- Sheila Davies works with a telepsychiatry grant from Duke Endowment with funding to the Albemarle Hospital Foundation.

Discussion:

- Karen McCall and David Huang asked about cost.
- Erica Nelson asked about use of telemedicine for other medical needs.
- Protocols for other medical needs will need to be written.
- Peg O'Connell asked about patient outcome. Valerie Gatlin (Duplin Co.) spoke to the success in her hospital, noting that this line of care reduces repeat ED visits every other day.

- Anita Holmes spoke to the need for outcome measures/results.

VIII. The general meeting was adjourned, with the remainder of the time used for Stroke System of Care Plan Work Group Sessions

The Prevention/Public Awareness, Acute/Subacute and Telestroke Work Groups met and submitted reports following their sessions.

Minutes respectfully submitted by Alicia Clark.