

NC Stroke Advisory Council
Report of
Year-IV Findings and Recommendations
for an NC Stroke System of Care
to the
Justus-Warren Heart Disease and Stroke
Prevention Task Force

April 21, 2010

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**Justus-Warren Heart Disease and Stroke Prevention Task Force
April 21, 2010**

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Highlights of 2009-10 Stroke Advisory Council Meetings

December 7, 2009

- Presentation of NC Hospital Survey on Stroke Capability by Larry Goldstein, M.D.
 - tPA administration is higher in hospitals with Primary Stroke Center (PSC) designation and otherwise organized for stroke care.
 - The effectiveness of tPA is dependent on receiving this treatment as early as possible (3hr window).
 - Critical time factor in treating patients makes transporting a stroke patient to another hospital less than ideal. The closer patients are to a hospital that can treat stroke, the better.
 - Therefore, improving all hospitals' capacity to treat stroke is preferable.
 - NC Data highlights:
 - 41% of the population lives within reach of a PSC
 - 5% of the population lives nowhere near a PSC
 - 45% of the population lives within reach of a Joint Commission certified hospital or one that is ready for J/C certification
 - 36% of hospitals have a remote support or transport plan
 - Focus should be on the 45% and 36% above.
- Presentation regarding NC Chapter of the National Consortium of Stroke Coordinators
- Stroke Rehabilitation Resource Directory is complete and information is available through the state's NCcareLINK website

January 11, 2010

- AHA presentation of information on what other states are doing regarding hospital readiness for stroke
- Calling 911: results of focus group interviews
- NC awarded ASTHO grant for a Stroke System of Care Plan

March 15, 2010

- Stroke Advisory Council (SAC) heard a presentation regarding ordering trends for *Activase* (an acute ischemic stroke therapeutic) purchase, and concept of affecting behavior change
- Success stories from the regional stroke networks
- Report of the responses to questions sent out to hospital CEOs in the Southeastern portion of the state that are currently not enrolled in a Stroke QI program. While some of the hospitals are beginning to participate in a program, some indicated that they are not currently participating in a stroke QI program nor have immediate plans to do so
- A new stroke network forming in the Charlotte area
- Improper coding for stroke is a national problem. Center for Medicare & Medicaid Services (CMS) needs accurate data to adjust reimbursement rates
- AHA is working on developing the definition of and criteria for “stroke capable” hospital designation
- NC hospitals should be recognized in their early efforts to become certified, and assisted with resources
- Hospitals need to be able to code and bill accurately
- CMS will be publishing a hospital report card based on stroke indicators
- SAC should facilitate a process to help hospitals position themselves to perform well when CMS begins reporting on stroke indicators
- SAC should support stroke coordinators’ role in high stroke mortality regions
- Addressed importance of addressing the high rate of re-hospitalizations for stroke
- Partner with others to help address the issue of falls among stroke patients
- Many recovering stroke patients do not have a primary care physician
- Patient education is another issue that relates to recurrent stroke, and full recovery
- “*Beyond the Hospital*” NCSA product that helps with stroke patients’ discharge planning and post-hospital care
- 10% stroke re-hospitalization rate based on national data. Rate is higher in stroke belt states, including NC

April 5, 2010

- Meeting devoted to arriving at consensus for the recommendations to be reported to the Justus-Warren HDSP Task Force

Findings and Recommendations

Based on meeting presentations and Stroke Advisory Council (SAC) discussions, the following findings and recommendations were developed and are presented to the Justus-Warren Heart Disease and Stroke Prevention Task Force (JWTF) at its April 21, 2010 meeting.

The SAC recommendations are divided into two categories. Section I are those recommendations that require legislative action for the NC General Assembly Short Session that will convene on May 12, 2010. Section II contains recommendations for actions to be taken by SAC, JWTF and their partners in order to bring about systems and policy changes conducive to a sustainable system of stroke care for NC.

I. REQUIRING LEGISLATIVE ACTION

The following recommendations ask for non-recurring appropriations from the NC General Assembly for fiscal year 2010-11.

1.1 SAC Operations

Finding:

Progress continues in developing a system of stroke care for NC. More work is needed to develop and implement a comprehensive plan for a Stroke System of Care for NC.

Recommendation:

Make non-recurring funding of \$50,000 available for continuation of SAC operations, including guiding the development, launching, and implementation of a comprehensive plan for a stroke system of care as outlined in NC's application to the Association of State and Territorial Health Officials.

1.2 Public Awareness Campaign

Finding:

The SAC heard promising evidence that media campaigns are having an impact on the public's knowledge of and actions in response to signs or symptoms of stroke. Resources are required to sustain the effect of past media campaigns so as not to lose progress made, and to extend the media campaign to other areas of the state.

Recommendation:

Make non-recurring funding of \$400,000 available for continuation of public awareness campaign.

II. NOT REQUIRING LEGISLATIVE ACTION

The following recommendations do not require legislative action in the upcoming 2010 short session. The Stroke Advisory Council, its partners and key stakeholders, however, should pursue these recommendations to set the stage for a sustainable system of stroke care for NC.

II.1 Stroke Coding and Reporting

Finding

Appropriate payor (i.e., Center for Medicaid/Medicare Services) reimbursement for treatment of stroke is an essential aspect of a sustainable system of stroke care. In order for CMS to set appropriate reimbursement rates, they must have accurate data on hospitals' stroke treatment events. To this end, the SAC and its partners will assist hospitals in improving coding practices to enhance data collection, which should result in more appropriate reimbursement levels to hospitals for treating patients with stroke.

Recommendation

Identify and support opportunities to train hospital staff on coding in order to maximize reimbursement for stroke, and work with issues associated with reimbursement for transferred patients.

II.2 Stroke Care Quality Improvement

Finding

Hospitals that treat stroke patients should participate in a stroke quality improvement program. Stroke quality improvement programs provide a mechanism to assess and improve acute stroke care performance. Stroke QI programs are also a means of accessing and leveraging limited hospital resources to achieve improved outcomes. The SAC reiterates its strong commitment to work with hospitals to assist them in acute and sub-acute care of stroke patients.

Recommendation

The JWTF, SAC, partners and the state should continue to recruit hospitals into a stroke QI program (i.e., NC Stroke Care Collaborative or GetWithTheGuidelines-Stroke).

II.3 Hospital Recognition

Finding

NC hospitals want to improve stroke care, but are confronted with difficult times and dwindling resources. In addition to working with a stroke QI program, hospitals that commit additional resources towards improving acute and sub-

acute care of their patients should be recognized by the JWTF for their efforts. SAC encourages improvements in the quality of stroke care in all NC hospitals.

Recommendation

Recognize/Reward hospitals for making measureable improvements in stroke care.

II.4 Recognize NC Stroke Coordinators

Finding

The National Consortium of Stroke Coordinators was first established in 2006 in NC. Their stated mission is: "to establish a network for mutual professional support among Stroke Coordinators and provide them with quarterly opportunities to share information and resources related to stroke program development and proficiency across the continuum of care". SAC finds that the stroke coordinators are an integral part of a mature acute stroke care model for hospitals.

Recommendation

Recognize/Reward hospitals for hiring Stroke Coordinators to participate in stroke systems development. Recognize/Reward and support the National Consortium of Stroke Coordinators (NC Chapter) for the work they do in NC.

II.5 Regional Stroke Networks

Finding

The existing stroke networks in the Eastern and Western parts of the state are providing coordination, expertise, and resources towards developing systems of stroke care within their regions of the state. Development of regional stroke networks are essential to the SAC's overarching recommendation that an NC stroke system of care be one that is "regionally based and locally determined". In addition, the regional networks have a critical role to play in ensuring that a regional stroke system achieves sustainability.

The SAC finds that nurturing the development of additional regional networks in areas of the state not currently covered by one, is imperative to the development of a system of stroke care for the state.

Recommendation

Establish and fund a position within HDSP to foster development of additional Regional Stroke Networks, and promote the role and benefits of Regional Stroke Networks.

II.6 Emergency Medical Service (EMS) Support

Finding

Stroke treatment is time-sensitive. The earlier appropriate stroke treatment occurs from the point of symptom onset, the higher the likelihood of survival and full recovery from stroke. Since the initial acute-care phase of stroke treatment impacts subsequent treatment options, continued investment in supporting the EMS phase of stroke care is essential.

Recommendation

Continue to recognize and support the Office of EMS in its efforts to develop and promote EMS components in the Stroke System of Care. This support is to include the Acute Stroke Care Toolkit, data collection, and support of dispatch and transport protocols for stroke.

II.7 Rehabilitation

Finding

Stroke recovery extends beyond the hospital setting and into the community. Steps in rehabilitation actually begin in the sub-acute care phase of stroke treatment. An NC stroke system of care should incorporate considerations and support for improving access to high quality, comprehensive rehabilitation services to maximize recovery and reduce re-hospitalization. The SAC has developed a database in collaboration with the Office of Citizens Services' NCcareLINK system that provides information to the public about stroke care resources and services throughout the state.

Recommendation

Continue the work of the SAC Rehabilitation Work Group to identify and disseminate information on post-acute stroke care resources.

II.8 Stroke Patient Education/ Counseling

Finding

Based on stroke survivor accounts and the opinions of SAC members, stroke patients and their families generally do not receive adequate information to meaningfully assist them through the post-hospitalization recovery phase of their experience. This transitions of care issue is not an NC specific problem, but one that must be addressed. Rates of re-occurring stroke are alarmingly high. Some of these recurring strokes may be avoided by patient/ caregiver education about the importance of rehabilitation and actions they can take to help prevent a recurrent stroke.

The SAC finds that there is a need to provide hospitals and providers with resources to assist in improving stroke education to reduce the recurrence of stroke, and to assist in coping with life after stroke.

Recommendation

Identify programs/resources, like the NC Stroke Association's *Beyond the Hospital*, to assist hospitals in improving education for patients/caregivers, and transitioning patients back to their communities and physicians' care.

II.9 Identify Primary Stroke Center (PSC) hospitals and "Stroke Capable" or "Stroke Ready" Hospitals

Finding

There is a need to enable persons seeking care to identify hospitals that meet recognized standards of stroke care. Currently, the state links the public, via the Internet, to the Joint Commission's website listing the Primary Stroke Centers. Joint Commission is in the process of developing the criteria for another tier of stroke certification for hospitals which will likely be labeled as Stroke Capable or Stroke Ready. Information about hospitals achieving this tier of certification also needs to be available to persons seeking care.

Recommendation

Assist in NC hospitals' development of qualifications to meet established criteria for designation as "stroke capable", include this new tier of certification in the system devised to provide information to persons seeking care, and increase public awareness of where to find this information.

CONCLUSION

The work of the Stroke Advisory Council and the Regional Stroke Networks is resulting in progress on several critical issues. NC hospitals, EMS systems, state legislators, other officials, and the general public are more aware that stroke is an urgent issue requiring attention. More and more NC hospitals are taking steps to enhance their stroke treatment preparedness and the care that they provide. But many hospitals are not engaged, and need the support and resources that the SAC and its partners can provide.

An intensely focused effort is required to engage hospitals located in areas of the state currently not part of a regional collaboration to address stroke. Alarming, these hospitals are in areas that experience high stroke mortality and morbidity rates, are generally poorer, with hospitals that are struggling financially. Addressing this set of complex circumstances continues to be a priority for the SAC, and should be a priority for the state.