Oregon Time-Sensitive Medical Emergencies Advisory Committee: Stroke Subcommittee Meeting Summary
2025 Quarter 2 | May 7, 2025

Slides and recording available upon request.

Appointed Subcommittee Members		
Name	**Position**	**Attendance**
Adrienne Duke	Rehabilitation specialist	Present
Tracy Holliday	Nurse	Present
Jeff Mathia	EMS provider	Present
Desi McCue	Hospital administrator	Present
Christian Smith	Emergency medicine physician	Absent w/o notice
Natalie Swearingen	Nurse	Present
Anudeep Yelam	Stroke neurologist – comprehensive stroke center	Present (virtual)

1. **Call to Order and Introductions (Rebecca Long, Oregon Health Authority Emergency Medical Services Program) (Recording timestamp 00:00:44)**
   a. Roll call was conducted.
   b. OHA-EMS staff introduced themselves.
   c. Subcommittee members introduced themselves.
   d. The group went over expectations and norms for participation.
   e. The meeting agenda was reviewed; no changes were requested.

2. **Bylaws and Subcommittee Structure (Rebecca Long) (Recording timestamp 00:17:47)**
   a. Rebecca introduced members to the bylaws of the Time-Sensitive Medical Emergencies Advisory Committee (TSMEAC). The stroke, cardiac, and trauma subcommittees are embedded within the TSMEAC.
   b. Anudeep Yelam and Tracy Holliday will serve as the liaisons from this subcommittee. They are also voting members of the TSMEAC.
   c. Because the subcommittees provide recommendations to the TSMEAC, quorum is not required for decision-making within the subcommittee.

3. **Handoff from Previous Stroke Care Committee (Nicole Perkins, OHA EMS Program) (Recording timestamp 00:28:34)**
   a. The previous Oregon Stroke Care Committee was established under the direction of Oregon Senate Bill 375 (2013), which became Oregon Revised Statutes 431A.525 and 431A.530. The 2024 EMS Modernization Act repealed these statutes and incorporated the committee into a greater system of time-sensitive medical emergencies.
   b. Three projects were discussed from the Stroke Care Committee's final sunsetting meeting in fall 2024.
      - First, improving documentation of prehospital stroke assessment in electronic patient care reports. The goal was to improve compliance with National EMS Quality Alliance measures. Training was developed for EMS agencies on best practices for charting stroke assessment. A letter was drafted to EMS agency leadership; State EMS Committee and Stroke Care Committee leadership agreed to sign it.

- Second, development of the biennial legislative report required by Senate Bill 375. A draft report was prepared in 2024 and submitted for review by OHA leadership.
- Third, a transition survey was conducted of Stroke Care Committee members on topics relevant to this subcommittee's future decision-making. Four out of ten members responded. Responses were mixed on use of the American Heart Association's Get With The Guidelines (GWTG) registry as the state data system, acknowledging that it is labor-intensive and expensive. Most respondents preferred the optionality of combining national standards with state surveys.

c. Member discussion and questions followed.
- Subcommittee members requested to view the legislative report. Nicole will check on the report's status, as it was in the process of review and approval.
- An online stroke dashboard is available.
- Several members offered perspectives and experiences regarding the challenges of prehospital stroke assessment and documentation, appreciating the potential for multiple factors to impact compliance. Nicole noted that root causes were not explored by the previous committee.
- The work of this subcommittee in developing a stroke system is directed by statute. Hospital accreditation systems are built into EMS Modernization. This subcommittee will determine which national standards to recommend, acceptable tiers of care, and standards for quality improvement.

4. Regional Roundtable Updates (Recording timestamp 00:56:50)

a. Anudeep Yelam shared that he started at Peace Health RiverBend in Springfield in July 2024. The C-STAT scale used in his region has high specificity but low sensitivity, especially for longer EMS transports. The screening scale is missing patients who may benefit from care at a primary stroke center. Primary centers are sometimes being bypassed in the effort to get a patient to a comprehensive stroke center, but then patients end up being out of the time window for intervention.

b. Adrienne Duke shared that at Legacy, admission timelines to stroke rehabilitation average 5-7 days. All six hospitals are experiencing increasing patient arrivals by private vehicle with decreasing EMS arrivals. The Legacy team is trying to improve EMS utilization and spread community awareness of the value of EMS for stroke care. Legacy uses the Get With the Guidelines (GWTG) data system, but its data standards center on diagnosis, not necessarily on EMS performance and prehospital screening.

c. Natalie Swearingen shared that Providence also uses GWTG, though only patients with primary diagnosis of stroke are included due to patient volume (secondary and tertiary diagnoses are excluded). Providence piloted a program to reduce delays for intervention: ambulance crews would place a sticker on the patient with witness contact information, allowing the stroke neurologist to speak with the witness as soon as the patient arrived at the hospital. Unfortunately, uptake of the stickers was low.

d. Tracy Holliday shared that St. Anthony Hospital uses GWTG as well. The hospital works with three prehospital agencies. Last year, the emergency department had 57 stroke patients; their best door-to-needle time was 24 minutes. People weren't calling or coming to the hospital for stroke, but calls were rather for falls, dizziness, or other non-typical symptoms. The hospital faces challenges with transfers and direct acceptance of stroke patients, including limited EMS transport availability overnight. Stroke aftercare is not available in Tracy's area of rural Eastern Oregon.

e. Jeff Mathia shared that his region also experiences challenges with public education and stroke recognition. Jeff believes that paramedic education can improve teaching of non-traditional stroke presentations and technologies that are changing the paradigm of care.
f. Desi McCue shared that as a hospital administrator, she sees challenges with long-term care and obstacles in pre-authorization processes. Insurers are making navigation more complicated. Patient transfers also present challenges: when patients are moved to comprehensive centers despite needing palliative care, the higher level of care will not change outcomes and the complexity of discharges increases for patients who live far away. Turnover in EMS is bringing in new providers with less experience and less nuanced understanding of stroke recognition and triage.

5. **Regional Boundaries and Referral Patterns (Nicole Perkins)** **(Recording timestamp 01:35:25)**
   a. A map of the area trauma advisory boards (ATABs) will serve as the starting point for discussions of stroke regionalization. Subcommittee members were asked to consider whether the current geographic regions for the ATABs are a good fit for stroke care.
   b. Subcommittee members asked for an interactive map with hospital locations. Nicole responded that there is an older Geographic Information Systems version that the EMS Program can work on updating.

6. **Building an Integrated Statewide Stroke System (David Lehrfeld, OHA EMS Program)** **(Recording timestamp 01:40:35)**
   a. The Oregon trauma system was established in the 1980s and will be the foundation for building a systems framework for stroke and cardiac emergencies.
   b. The activities and scope of the OHA EMS Program include regulatory functions, systems-building, and systems support. Oregon House Bill 4081 (2024) tasked the EMS Program with developing regionalized systems of care and specifically setting standards for emergency medical care, patient transfers, and data systems. It also requires setting and monitoring performance and equity indicators.
   c. The regionalized systems of care will focus on six domains: capability, capacity and access; recognition and diagnosis; resource matching and use; medical care; coordination of care; and outcomes.
   d. State processes for developing these systems will include the development of rules from standards, building regional plans, setting criteria and processes for facility categorization, regional implementation, system monitoring, and ongoing improvement.
   e. The subcommittee will consider oversight options for the stroke system and make recommendations to the TSMEAC. The landscape of national standards for stroke are similar to those for the trauma system: accreditation, facility types (designation/recognition), screening standards, and patient definitions.
   f. There are 58 hospitals in Oregon with emergency departments. Of those, 17 have some kind of stroke certification and at least 25 report stroke data.
   g. Subcommittee members asked about next steps for system development. David advised that the initial work is to consider available national standards. Recommendations do not have to be immediate nor all-inclusive.

7. **Key Takeaways (Rebecca Long)** **(Recording timestamp 02:30:45)**
    a. Rebecca reviewed the subcommittee's vacancies and geographic needs for representation.
    b. The subcommittee's next meeting will be held August 13, 2025, 0900-1200, in person at the Portland State Office Building.

8. **Public Comment** **(Recording timestamp 02:31:38)**
    a. No public comments were requested.

Meeting adjourned at 1157.

Next meeting:
August 13, 2025, 0900-1200
Portland State Office Building, Room 1D
800 NE Oregon Street, Portland, OR, 97232