Portland State Office Building
800 NE Oregon Street
Portland, OR 97232

Stroke Care Committee Minutes
Wednesday, April 7, 2021
9:00 a.m. – 12:00 p.m.

Chair	Barri Stiber
Members present	Barri Stiber; Hormozd Bozorgchami, MD; Vivian Ugalde, MD; Elaine Skalabrin, MD; Ritu Sahni, MD; Anne Tillinghast; Ted Lowenkopf, MD; Shawn Baird, P
Guests present	Kalissa Lee; Stacey Holmes; Natalie Swearingen; Andrea Calarco; Elly Henderson; Ron Loomis; Heather Zink
OHA staff present	Stella Rausch-Scott, EMT; Elizabeth Heckathorn, P; Peter Geissert; John Crabtree, NRP; Dana Selover, MD; Anne Celovsky; David Lehrfeld, MD
Members not present	Noah Jacobson, RN

Agenda Item	*Call to Order – Barri Stiber*
The meeting was called to order and quorum was met.	

Agenda Item	*Review 2021 Quarter1 (Q1) Minutes – Barri Stiber*

Barri Stiber requested the committee review and approve the 2021 Q1 minutes.
Changes to minutes:

- Hormozd Bozorgchami name error.
- Barri Stiber name error

Ritu Sahni motioned to approve the minutes and Ted Lowenkopf seconded the motion. The motion passed.

Agenda Item	*Membership– Stella Scott*

The committee reviewed the membership appointment list.
Current vacant positions are:

- Hospital Administrator or Delegate (Telehealth)
- Rural Health Care Provider involved in Emergency Stroke Care

Oregon Emergency Department Physician – Dr. Christian Smith, Mercy Medical Center, has been appointed to complete the vacant position.

Recommendation to recruit for open positions: Office of Rural Health EMS Licensure list It was decided to send the recruitment for open positions to the above lists for recruitment. Stella shared the link for appointment application to the group through chat: https://www.surveymonkey.com/r/EMSTSCOMMITTEE	
Action	Recruitment for open positions: Stella Scott– Send a recruitment letter with information for interested parties to apply.

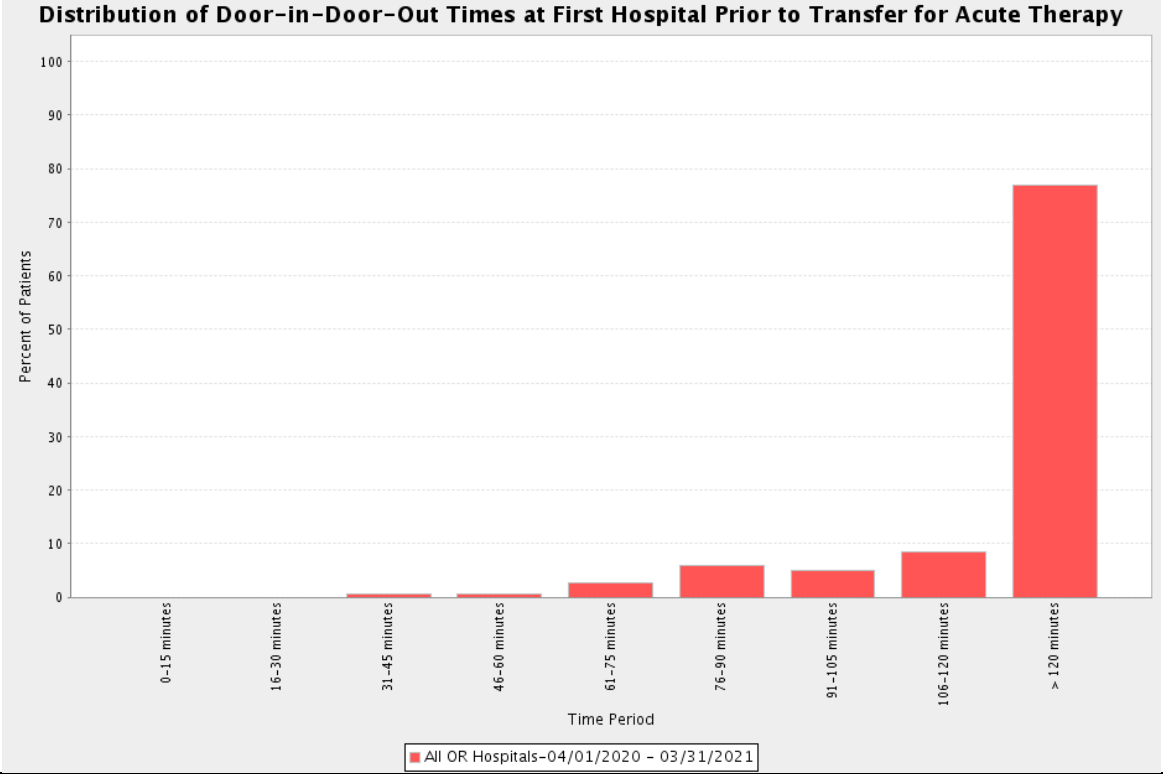
Agenda Item	*American Heart Association Get with The Guidelines Data – Stroke – Peter Geissert*

Peter Geissert presented requested data from GWTG to the committee. Data review was 2020q2 - 2021q1. The GWTG presented were stock reports. He was unable to present a geographical breakout of the data extracted.

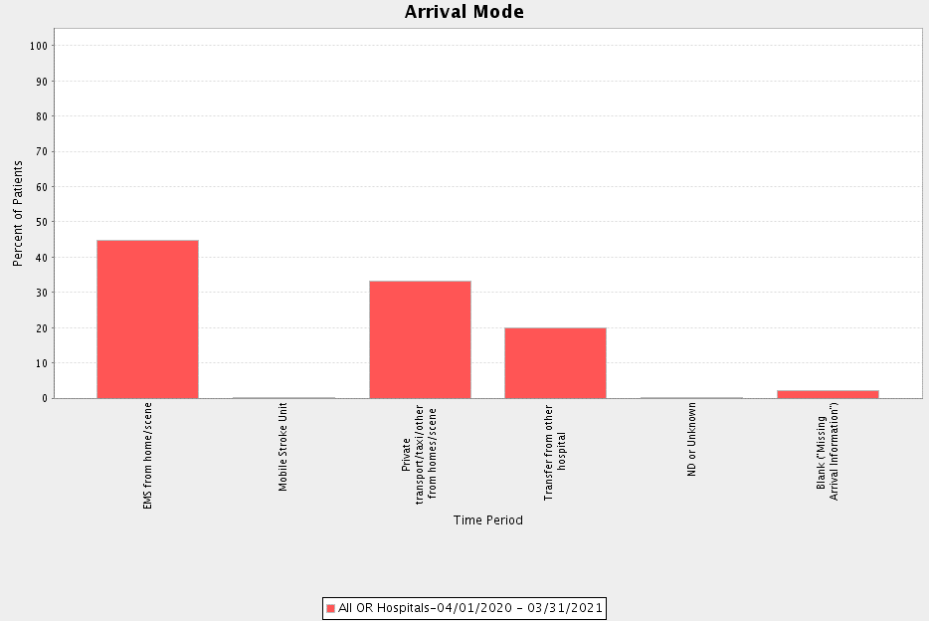
Door-in-Door-Out Time at First Hospital Prior to Transfer for Acute Therapy that is lower than 90 minutes.

Door-in-Door-Out Time at First Hospital Prior to Transfer for Acute Therapy

Benchmark Group	Time Period	Numerator	Denominator	Exception
All OR Hospitals	04/01/2020 - 03/31/2021	51	526	9



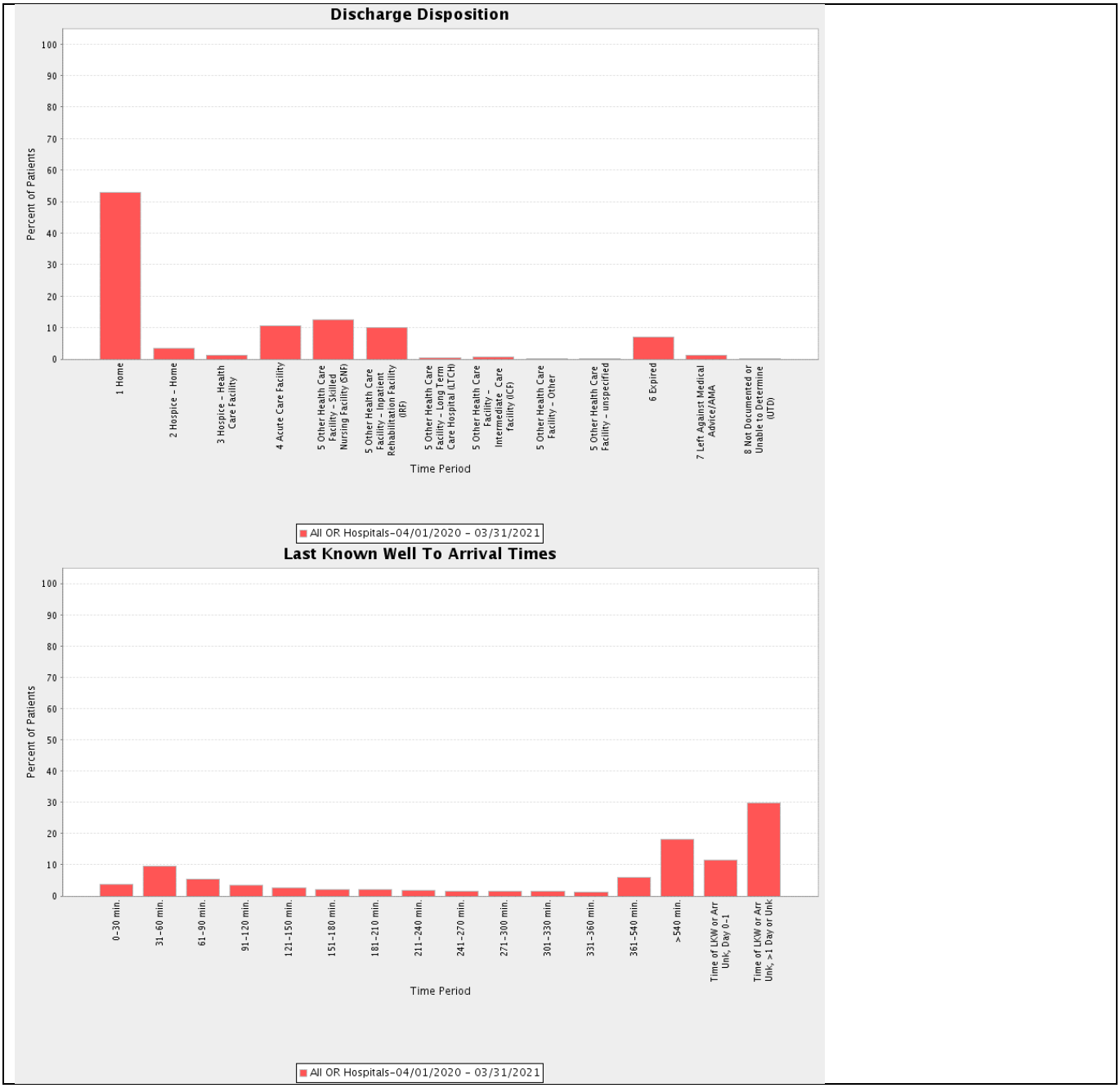
This measure reviews Door-In-Door-Out (DIDO) times at first hospital prior to transfer for acute therapy percentage of confirmed patients with great than 90 minute spent at the ED prior to transfer from ED to a higher level of stroke care. Elly, AHA, will send Peter the logic data and how they get to the data extraction.
T. Lowenkopf stated that reviewing the data it gives the committee a good example of the way the DIDO times are so long.
Q - Why is the DIDO time so long? Is it delay in initiation of transfer/ waiting for EMS/ Someone getting an infusion waiting for completion before transfer begins?
With the question posted it was recommended that the reconvening of the Portland EMS Taskforce review data and bring to the SCC analysis of data and possible policy changes.

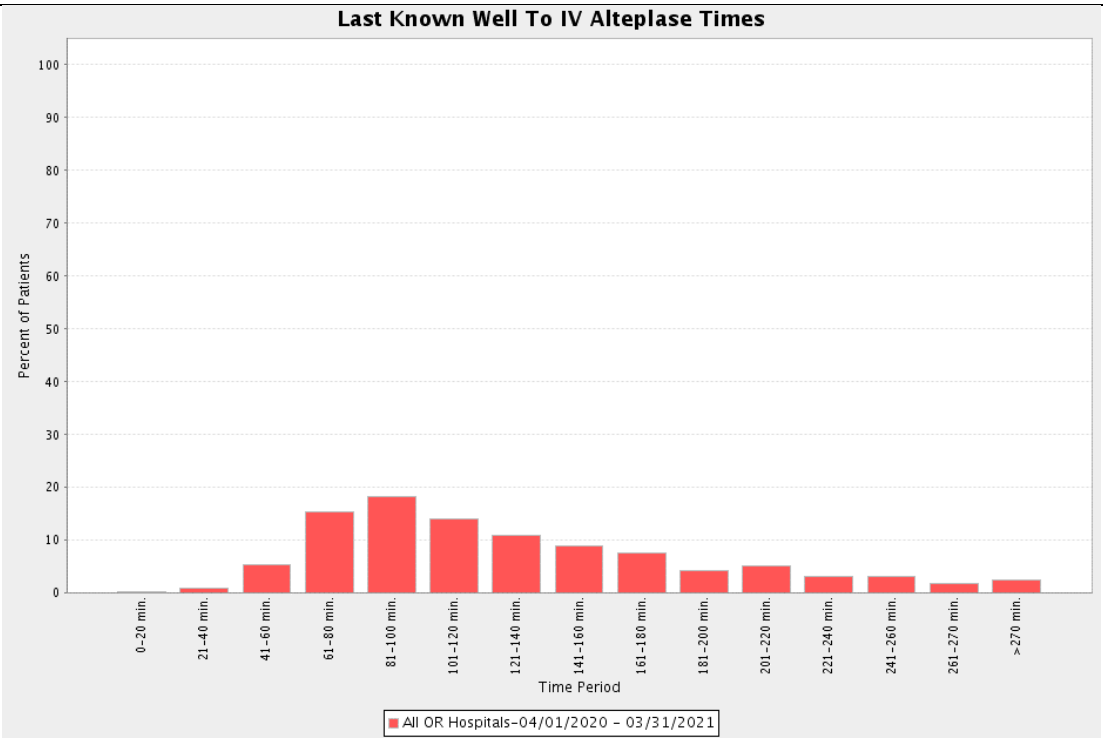


Pre-notification

Benchmark Group	Time Period	Numerator	Denominator
All OR Hospitals	04/01/2020 - 03/31/2021	1986	2990

Peter requested confirmation that the data presented seem accurate or is there a filter he should apply. The SCC members stated that the data seemed accurate. Hospitals do confirm with EMS documentation that these numbers are accurate.


Discharge Disposition
Percent of Patients
100
90
80
70
60
50
40
30
20
10
0
1 Home
2 Hospice - Home
3 Hospice - Health Care Facility
4 Acute Care Facility
5 Other Health Care Facility - Skilled Nursing Facility (SNF)
5 Other Health Care Facility - Inpatient Rehabilitation Facility (IRF)
5 Other Health Care Facility - Long Term Care Hospital (LTCH)
5 Other Health Care Facility - Intermediate Care facility (ICF)
5 Other Health Care Facility - Other
5 Other Health Care Facility - unspecified
6 Expired
7 Left Against Medical Advice/AMA
8 Not Documented or Unable to Determine (UTD)
Time Period
All OR Hospitals-04/01/2020 - 03/31/2021
Last Known Well To Arrival Times
Percent of Patients
0-30 min.
31-60 min.
61-90 min.
91-120 min.
121-150 min.
151-180 min.
181-210 min.
211-240 min.
241-270 min.
271-300 min.
301-330 min.
331-360 min.
361-540 min.
>540 min.
Time of LKW or Arr Unk, Day 0-1
Time of LKW or Arr Unk, >1 Day or Unk
Time Period
All OR Hospitals-04/01/2020 - 03/31/2021



It was requested to review a break-out of times by:
Last known well to arrival times should be broken out by hours 0-3/ 3-4.5 / 4.5-24/ greater than 24 hours. These breakouts are clinically relevant to response for patient care.

Data Definitions should be defined in a Data Dictionary to have all data points entered with the same understanding.
Is there a sense of a denominator of how many stroke care patients are captured? It is unknown and needs to be considered what hospitals are not participating. Need to identify who is included and who needs support to be included. It is estimated that roughly 80% of stroke patients are captured for data and a majority of the rural/frontier patients are not included.
Providence Hospitals system has purchased GWTG for telehealth hospitals to participate but the hospitals must provide their own data abstractors. Providence does support these abstractors with training. That is a local cost to the hospitals. Some states have supported the rural/frontier hospitals with hiring a data abstractor that cover hospitals for submitting data to GWTG.

It would be beneficial to receive support from the local hospital's stroke data registrars. Dr. Ted Lowenkopf and Barri Stiber offered their data team to help support OHA with review of the GWTG Stroke data.

Question – What is the committee's recommendations for collection of GWTG data? The state has been asked to clarify what data points are required. There is no standard data set for optional versus required.

The recommendation of the committee is to enter all bold data elements. The committee recommends that adhering to the national standard should be the minimum requirements.

ImageTrend has a feature for GWTG that will automatically upload the ImageTrend prehospital chart into GWTG data collection. Not all hospitals were aware of the feature. If any hospital is interested in this feature they should contact the EMS and Trauma System office. Ems.trauma@dhsoha.state.or.us

Action Item	Ted Lowenkopf and Ritu Sahni - Portland EMS Taskforce review data and bring to the SCC analysis of data and possible policy changes. Further data review at the July meeting • Review the First door to treatment time • IV Thrombolytic • First Door to Endovascular treatment time • Door to imaging

Agenda Item	*Rehabilitation Workgroup – Vivian Ugalde*

It has been difficult to receive responses. 10 completed surveys had representation of both rural and frontier hospitals. Therapies appear to be available for patients, but support groups are not in all areas of the state.
The largest issue documented was getting access for patient services based on transportation, co-pays for patient out care, authorization procedures, under or uninsured, Medicare reimbursements share rehab funding and patients must choose.
Next steps:

- Survey for patients
- Enough response could publish outcomes
- Recommend policy choices to remove barriers
- Request formal analysis of survey

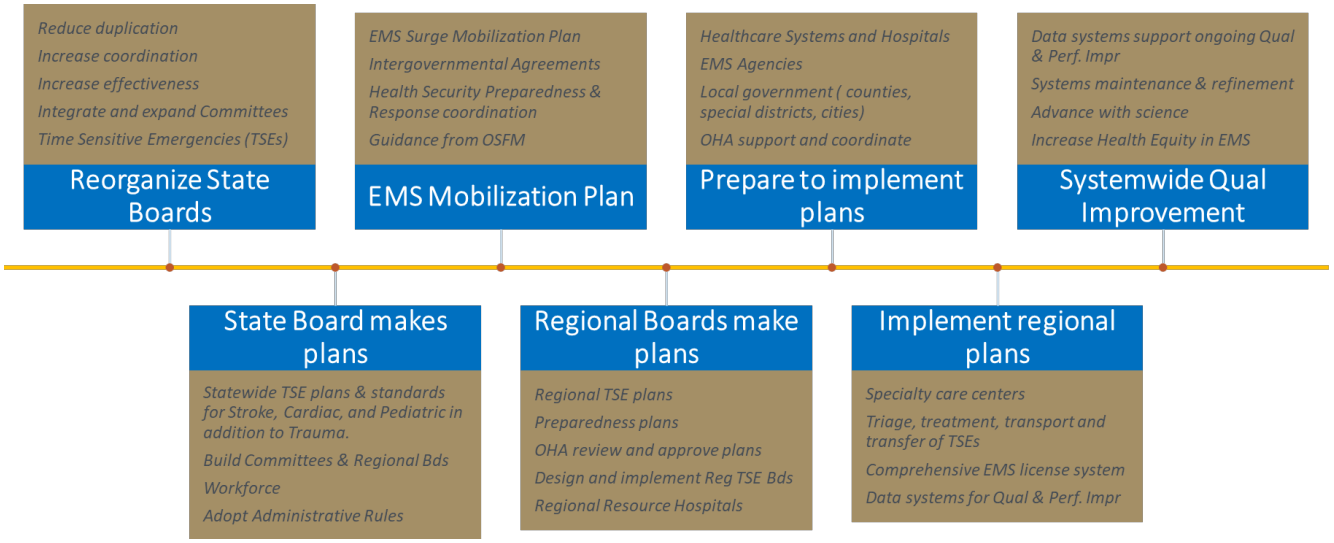
Cardiovascular program at OHA to review the survey and analyze the data.

Action Item	Advise Cardiovascular program at OHA to review the survey and analyze the data. Stella will send Vivian Ugalde a contact in the cardiovascular program at OHA and help facilitate the meeting.

Agenda Item	*EMS & Trauma System Program update – Dr. David Lehrfeld, Dr. Dana Selover, Elizabeth Heckathorn, NRP*

EMS Modernization update
Purpose: Create a comprehensive integrated Emergency Healthcare System that recognizes problems, determines which services are needed and then delivers the patient to those resources.

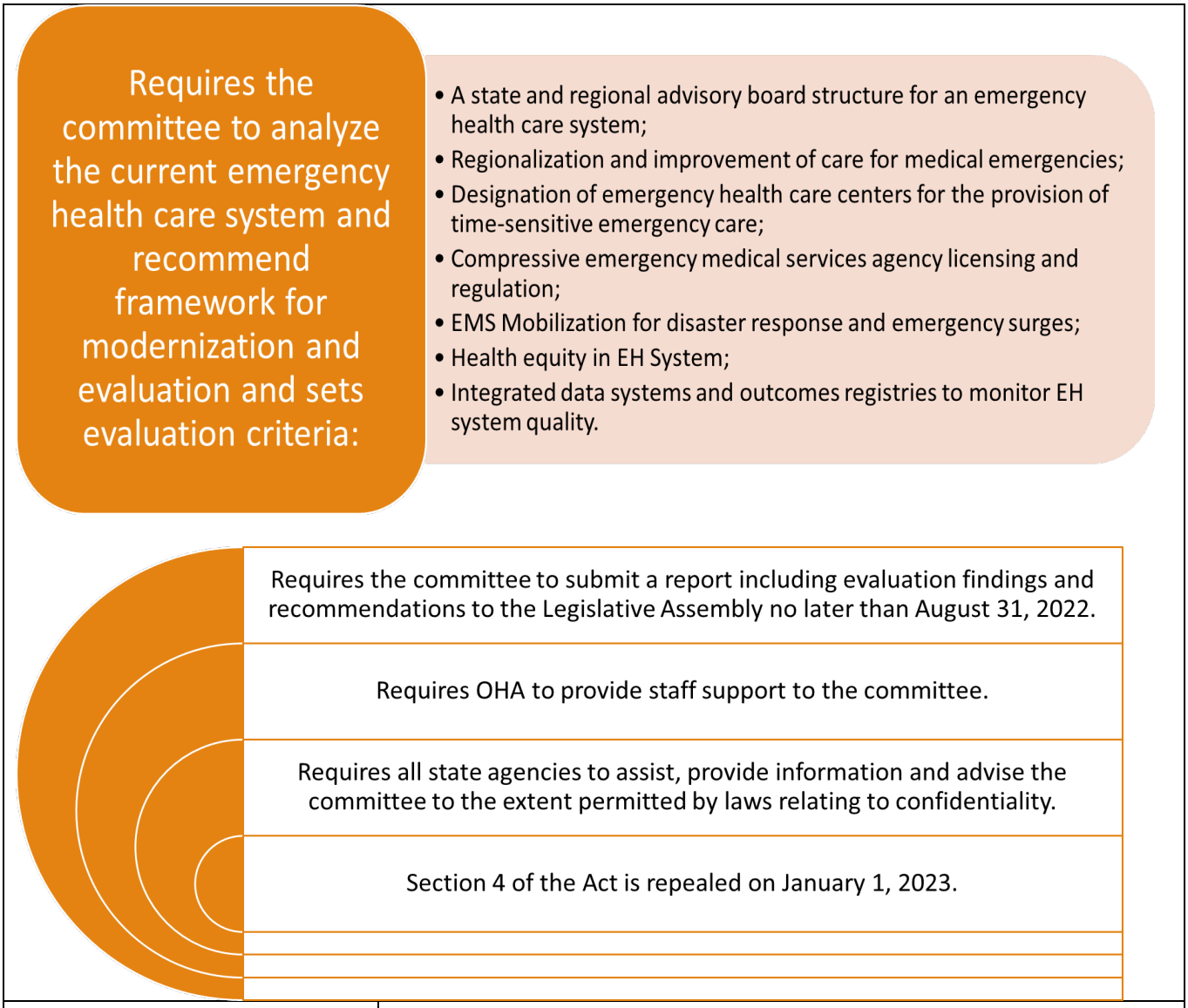
Proposed timeline:



History: Emergency Health Care Taskforce 2010, SB 234 and SB 106
Recent planning: worked with our advisory boards, stakeholders and partners, national and state models, NASEMSO, other state agencies, Health Security Preparedness and Response, and others to develop HB 2076
Feedback on the bill through Public Hearing:

- Support for emergency health care system concepts and continuing work from 2010, improvement is still relevant, important for health equity in EMS, essential for disaster readiness.
- Concern about membership on boards, authority of boards, hospital designations and unintended consequences of regionalization and county Ambulance Service Area work.

Work Session scheduled to review -3 amendments
-3 amendments: ambulance agency fee increase and temporary advisory committee to make recommendations to create a comprehensive integrated state-wide emergency health care system identifying incidents requiring emergency services and delivers individuals to those services.
Timing can be accelerated if workgroup clarifies more details of the system.



Action Item	

Agenda Item	*Committee Legislative Report – Stella Rausch-Scott*

The Stroke Care Committee is required to present a Legislative Report. The Legislative report is a maximum of two pages and includes updates to Legislation on the work that is taking place through the Stroke Care Committee.

A draft of the committee report has already been created. The state has requested a workgroup to support and help with the 2021 Legislative Report.

- Ted Lowenkopf
- Noah Jacobson
- Ritu Sahni
- Hormozd Bozorchami
- Barri Stiber

Stella Scott will send the drafted report to the workgroup.

Action Item	Workgroup email to include next step and the drafted legislation report.

Agenda Item	*2021 Committee work – Barri Stiber*

2021 committee work identified were:

- Supporting the OHA EMS/TS Legislative concept
- Rehabilitation workgroup
  - Continue to support and identify work that can be
- Report to Legislature
  - Committee members identified to review the drafted report
- Bypass regional care policy
  - Discuss this at the July meeting. A paper with best practices was published for Stroke Care. Have the committee review before the 3rd quarter meeting and then discuss what recommendations would be applicable to Oregon. Identify a workgroup to review and present possibly best practices to the committee.

Would there be other groups that have already started working on the below listed tasks and should we request collaborating with their resources?

- Consider virtual support groups
- OHA Stroke navigation. What to expect when you have a stroke.
- Assessment of Telehealth and Telemedicine

Oregon Stroke Network (OSN) can create templates to hospitals on helping stroke patients navigating the rehabilitation portion of care. Anything at a higher level of collaboration would better sit with the state committee.
OSN is a great resource to identify regional hospital stroke coordinators and offer them opportunities to participate in regional care and beset practice policies for their region.
Collaborate with Health Prevention and Chronic Disease Promotion to identify gaps of stroke health care. OSN may be able to give an update for a “state of the state”. Identifies different data sets quarterly and consider creating a data dashboard.

Action Item	Action item – Bypass regional care policy workgroup. Discuss at Q3 meeting regional care policy. Present an overview of the paper best practices. Identify needed resources and those available for stroke care.

Agenda Item	*Public Comment*
No comments	