Virginia Stroke Systems Task Force

Quarterly Meeting (Virtual Available)

Meeting Location: Virginia College of Osteopathic Medicine, Blacksburg, VA

April 19, 2024 | 10am – 3:00pm

WELCOME

VIRGINIA COLLEGE OF OSTEOPATHIC MEDICINE DEAN

Virtual Housekeeping

- **PLEASE PUT YOUR NAME AND ORGANIZATION OR ROLE IN THE CHAT BOX**
- **Please remain on mute for the duration of the meeting, unless speaking.**
- **Please turn your camera on!** It's always nice for the speaker to be able to see faces instead of talking to a bunch of blank squares.
- **Open the chat box** so you can view the discussion and ask any questions of the speaker. The chat box will be monitored by meeting hosts to ensure the questions are brought to the speakers' attention.
- If you want to speak to contribute to the conversation or ask a question, **please use the "raise hand" feature** found along the bottom of the participant's box.
- If joining the meeting over the phone only, you **can mute and unmute yourself by pressing *6** on your phone's keypad.

Agenda

10:00 – 10:05	Welcome
10:05 -- 10:25	VSSTF Business, co-chairs: Melanie Winningham, MD, Sentara Healthcare and David Long, Tidewater EMS
10:25 -- 10:40	State Stroke Triage Plan Updates, Ashley Camper, OEMS
10:40 -- 11:30	Workgroups Report Out
11:30—12:00	ZODIAC Trial, Stacie Stevens, VCU Healthcare
12:00 -- 12:30	Lunch
12:00 – 12:30	Simulation Center Tour – 2 Groups of 10 (Please Sign up if interested)
12:30 – 1:00	Rethinking Rehabilitation: Intensive Telerehabilitation to Maximize Recovery from Stroke, Kristin Nuckols, Imago Rehab
1:00—1:30	EMS Blood Draw for Stroke Patients-Pros and Cons, Panel Discussion Elizabeth Hart, Sophea Booker, Pat Edwards, David Long, Melanie Winningham
1:30 -- 1:45	VDH Updates, Allie Lundberg, Epidemiologist, VDH
1:45 -- 2:00	Final Remarks and Wrap Up, Melanie Winningham and David Long, co-chairs
2:00 -- 3:00	Virginia Stroke Coordinators Consortium Meeting, Elizabeth Hart, LewisGale, Co-Chairs, Mary Jobson-Oliver, incoming co-chair

VSSTF
Virginia Stroke Systems Task Force

Special thanks to Imago for sponsoring today's meeting!

CEUs will not be provided for the industry sponsored speaker on **Rethinking Rehabilitation: Intensive Telerehabilitation to Maximize Recovery from Stroke**

In the spirit of Collegiality and Professionalism, please be mindful of any information obtained and shared in this meeting that could be sensitive to an individual or an institution

VSSTF Business

- Approval of meeting minutes from January 19th meeting.
- New Voting Member Introductions
  - Daniel Linkins, EMS Representative
  - Dr. John Daniel, III, PCP Representative

- Voting Members Introductions
- Co-Chair Nominee Introductions
- New Co-Chair Voting

VSSTF
Virginia Stroke Systems Task Force

Welcome and Introductions

Welcome from VCOM

Introductions of

VSSTF Voting Members

Name, Title, Organization/Hospital, City/County

For those joining virtually, introduce yourselves using the chat box to let your colleagues know you are here

VSSTF

Virginia Stroke Systems Task Force

VSSTF Co-Chair Nominations for April 2024 Voting (Nomination Information to come via email to VSSTF Voting Members)

Reminder: VSSTF Structure

- Co-chairs
  - Two-year term; staggered
  - Elected by VSSTF voting members
- Voting members
  - Listed positions are based on 2014 VSSTF Guidance Document with noted modifications
  - Two-year term; staggered
  - Open nomination, except organizational representatives
  - Selected by VSSTF co-chairs
  - Member may be reappointed for additional two-year terms
- Nonvoting members

Co-Chair Nominees

- **Dr. Sherita Chapman**
  - Stroke Section Chief, Central Virginia VA Medical Center
    Associate Professor, UVA Department of Neurology

- **John Gaughen, MD**
  - Stroke Medical Director, Centra Health
    Neurointerventional Medical Director, Centra Health

OFFICE OF EMS STROKE PLAN UPDATES

Ashley Camper

Trauma and Critical Care Manager

Virginia Office of Emergency Medical Services

- Hospitals are accredited, and stroke programs are certified via multiple bodies
  - Joint Commission (TJC), Det Norske Veritas (DNV), and Accreditation Commission for Health Care (ACHC).
- 24-hour window of witnessed onset or last known baseline
- Replacing “first” step with “critical steps”
- Recognition of BEFAST/FAST
- Use of “facility” instead of “hospital” to recognize those that can deliver stroke care.

CLARIFYING BETWEEN ASSESSMENT AND SEVERITY TOOLS

- There is a difference between Stroke Assessment Tools such as CPSS and BEFAST and stroke Severity Tools such as RACE and VAN. The Stroke Severity Tools are not designed to replace a basic Stroke Assessment tool but to guide destination decisions for potential LVOs.

ADDITIONS

PREHOSPITAL STROKE RECOGNITION SECTION

PRE-HOSPITAL DESTINATION DECISION MAKING AND INTER-FACILITY TRANSPORT HAS UNDERGONE A TOTAL REWRITE

CONSIDERATION FOR PARALLEL ACTIVATIONS FOR STROKE AND TRAUMA ACCORDING TO INDEX OF SUSPICION

CONSIDERATIONS FOR PEDIATRIC STROKE

- Currently the following have been assigned for complete rewrites:
  - Acute Field Stroke Triage Decision Scheme
  - EMS Thrombolytic Candidate Checklist
  - Post Thrombolytic EMS/inter-facility Transfer sheet

These documents were largely found to be out of date or difficult to navigate in a timely manner.

FINE TUNING

VETTING FOR EASE OF USE FROM INTENDED AUDIENCE

ONE SHEET ALGORITHMS FOR EMS PROVIDERS

CLEANING UP LANGUAGE, INCONSISTENCIES AND ABSOLUTE STATEMENTS

SPECIAL THANK YOU!!!

- Dr. George Lindbeck
- Kathryn Funk
- Mary Jobson-Oliver
- Stacie Stevens

Work Group
Reports
April 2024

Current Workgroups

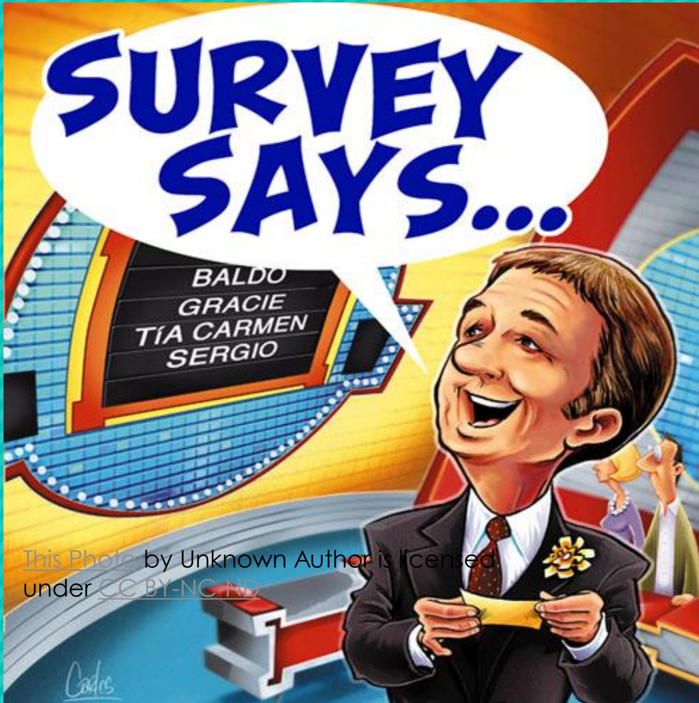
1. **EMS Destination Protocols**, Daniel Linkins, Central Shenandoah EMS
2. **May Day for Stroke Awareness**, Melanie Winningham, Sentara Healthcare
3. **Messaging to Address Social Disparities**, Kristie Burnette, Mary Brandenburg, VHHA
4. **Post-Acute Discharge Disposition**, Chad Aldridge, UVA
5. **Teleneurology**, Branden Robinson, Sevaro
6. **Stroke Smart**, Alan Stillman, Kwikpoint

EMS Destinations Workgroup

February Meeting:

- Overview:
- 1. Need to gather data to identify where in Virginia patient are mistriaged and why.
- 2. Identify tools being used across the state (of 4 regions represented on the workgroup, 3 different scales being used).
- 3. Gather hospital preferences and pros/cons of each
- 4. Address implementation barriers

10 of the 11 Regional EMS Councils Responded



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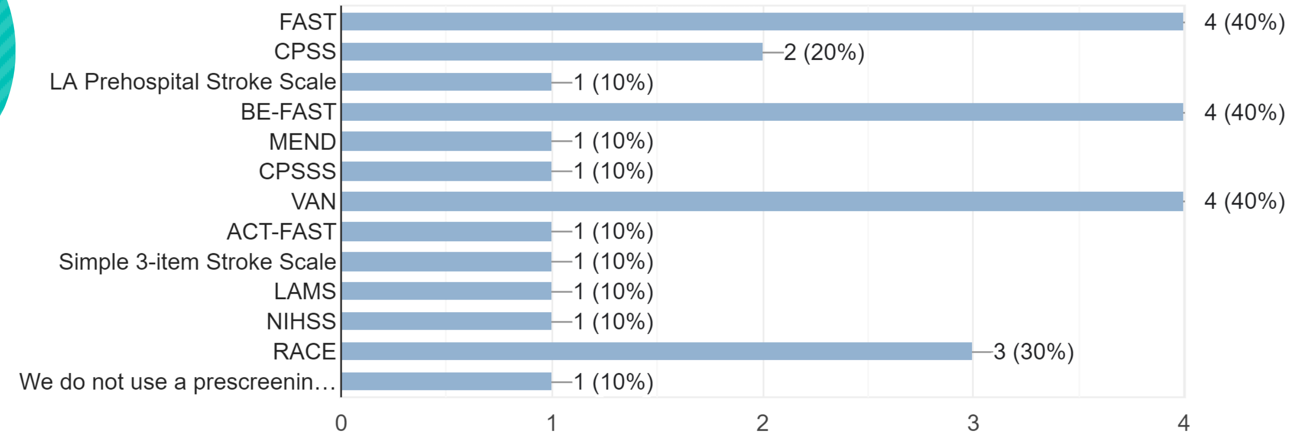
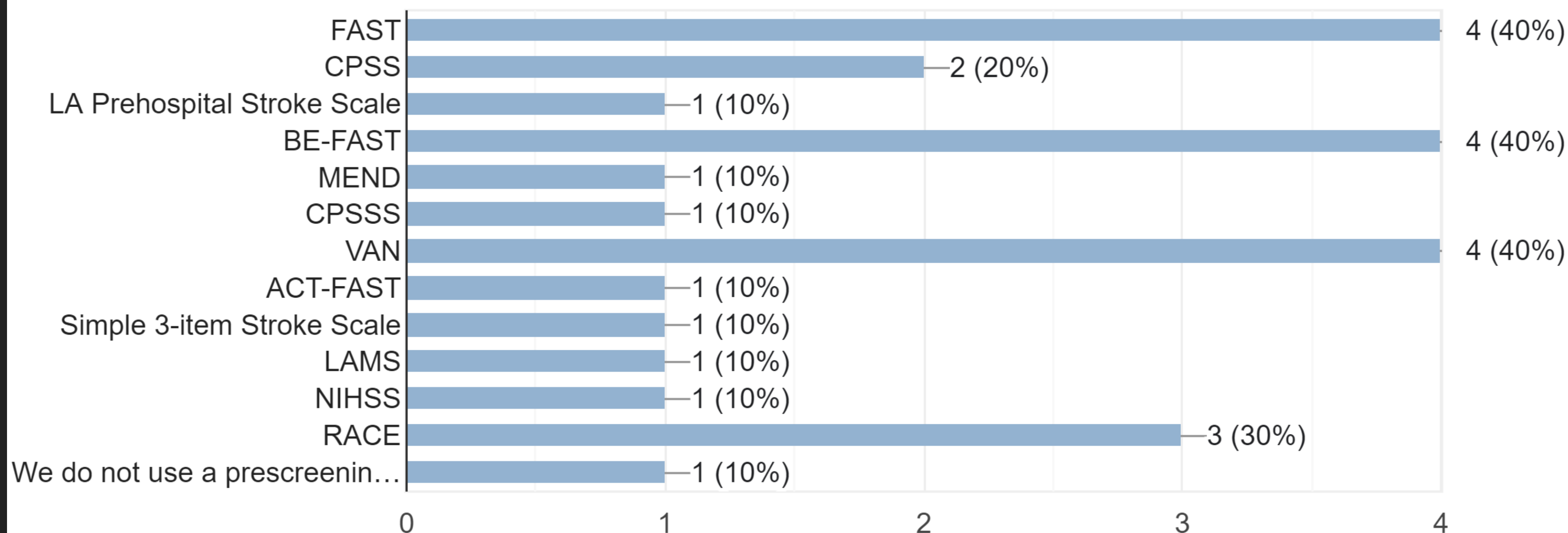
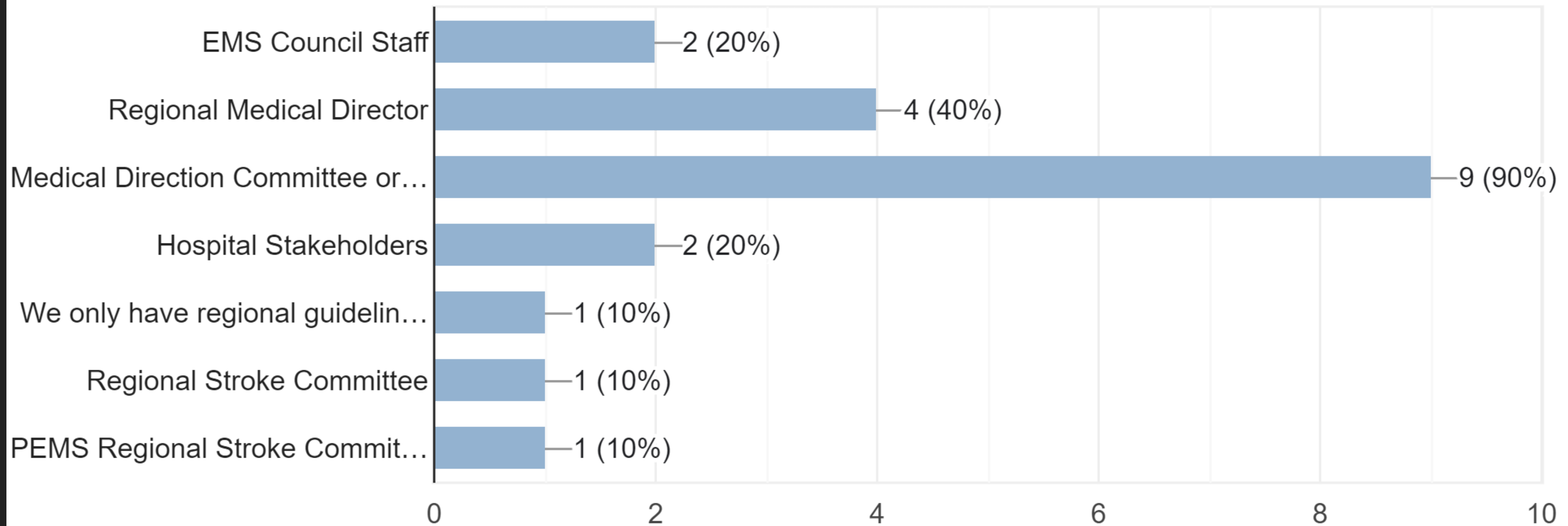
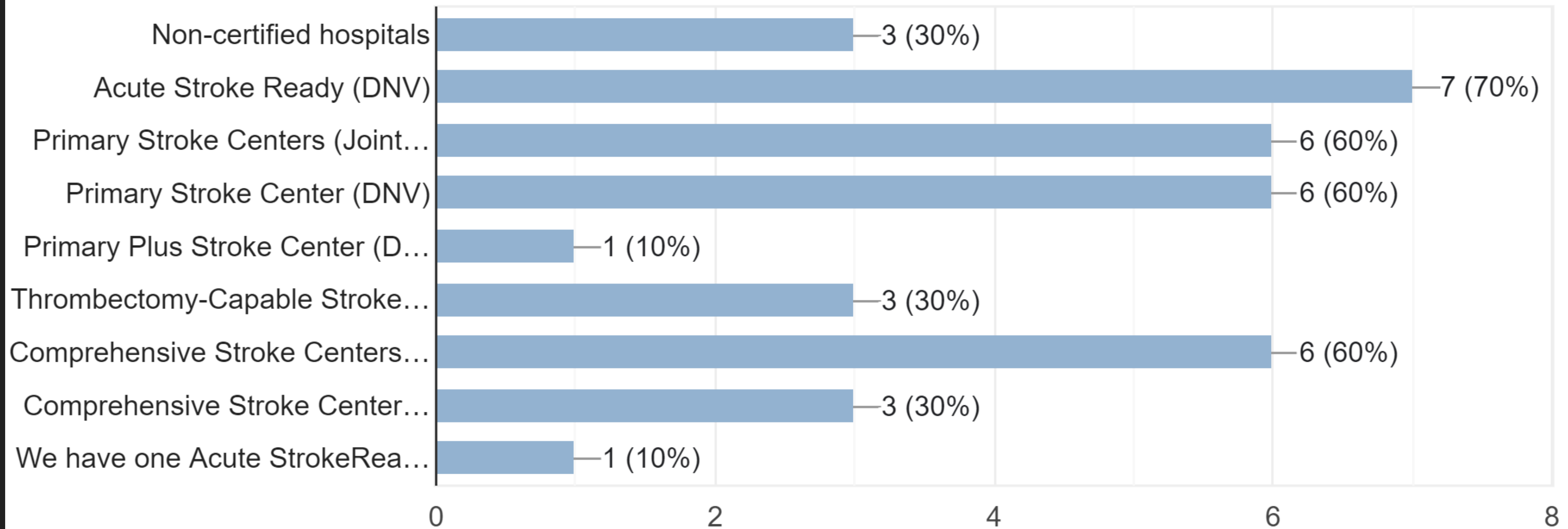



What initial stroke screening tools are used in your region to determine transport destination? Select all that apply, if you also perform a Large-Vessel-Occlusion Screening or others.
10 responses
FAST
4 (40%)
CPSS
2 (20%)
LA Prehospital Stroke Scale
1 (10%)
BE-FAST
4 (40%)
MEND
1 (10%)
CPSSS
1 (10%)
VAN
4 (40%)
ACT-FAST
1 (10%)
Simple 3-item Stroke Scale
1 (10%)
LAMS
1 (10%)
NIHSS
1 (10%)
RACE
3 (30%)
We do not use a prescreenin…
1 (10%)
0
1
2
3
4

How are stroke screening tools determined/adopted by your region?

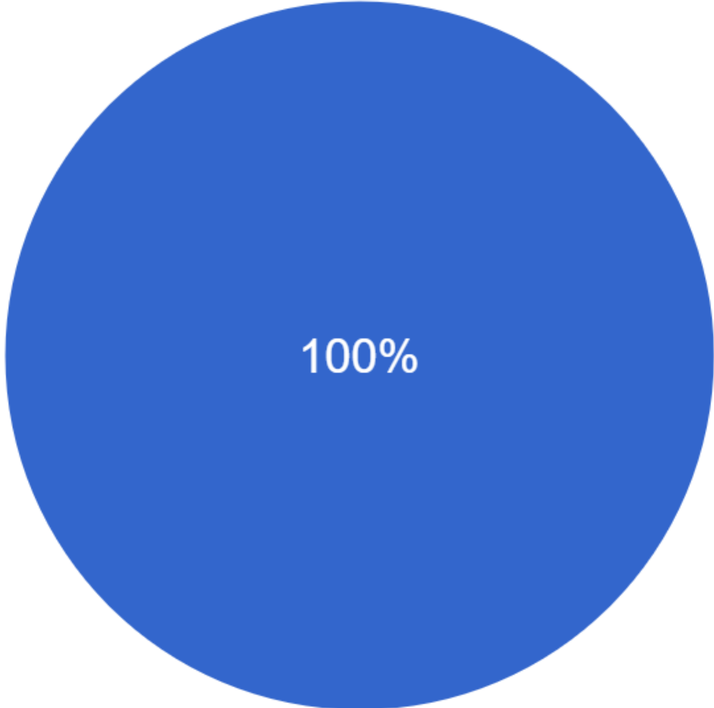
10 responses




What destination facilities are available in your region (select all that apply)?
10 responses
Non-certified hospitals
3 (30%)
Acute Stroke Ready (DNV)
7 (70%)
Primary Stroke Centers (Joint…
6 (60%)
Primary Stroke Center (DNV)
6 (60%)
Primary Plus Stroke Center (D…
1 (10%)
Thrombectomy-Capable Stroke…
3 (30%)
Comprehensive Stroke Centers…
6 (60%)
Comprehensive Stroke Center…
3 (30%)
We have one Acute StrokeRea…
1 (10%)
0
2
4
6
8

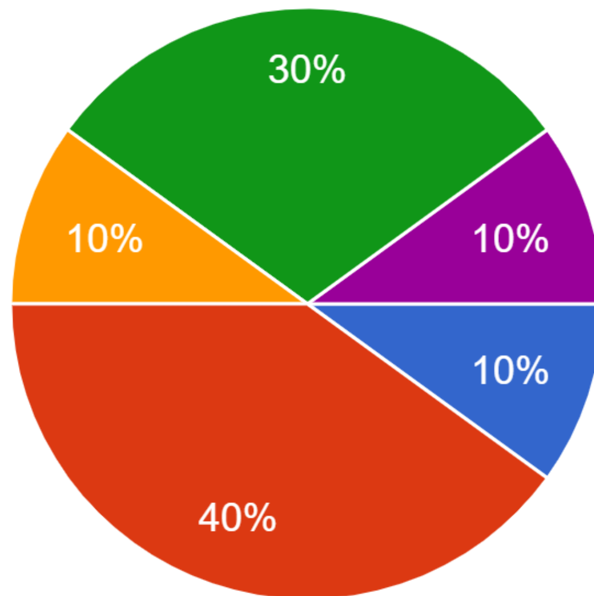
Are EMS providers permitted to call stroke alerts in the field?

10 responses



How do receiving facilities respond to field-called stroke alerts?

10 responses



- Hospitals do not normally change their actions
- Hospitals act with urgency and decisiveness
- Hospital response is inconsistent from day to day
- Some hospitals respond with urgency and others do not
- Most act with urgency and decisiveness, while some do not

Comment Summary:

The state should agree on a standard screening tool and severity tool for stroke alerts, and EMS should call stroke alerts in the field based on stroke screening. Geographically large regions benefit from transport to local facilities for scans, TELESTROKE consults, thrombolytics, and referral to stroke centers. Providers should be aware of stroke centers and their differences, and provide thorough stroke assessments. A meeting is planned to discuss consistency with stroke patients, protocols, assessment tools, best-practice, and continuity among EMS and hospitals. Patients with a RACE score of 5 or greater are presumed to have an LVO, bypassing primary stroke centers.

Next Steps:

- Workgroup Follow-up to discuss survey findings
- Request Data regarding stroke outcomes, correlated with tools used
- Request Data regarding stroke outcomes, correlated with destination type
- Develop common nomenclature for EMS protocols in determining destinations
- Develop best practices recommendations in collaboration with Regional EMS Councils

What we need from others?

- Stroke Coordinators Consortium:
  - Provide preferred scales and the benefits of each in prehospital environment.
  - If stroke alerts are called in the field, how does your hospital respond? Are they acknowledged/accepted resulting in immediate action?
    - By policy?
    - In practice?

Questions, Comments and Suggestions?

vsstf-destinations@g.vaems.org

Daniel W. Linkins, MPH, NRP, NCEE
CSEMS Regional Director
Office of Emergency Medical Services
Virginia Department of Health
Daniel.Linkins@vdh.virginia.gov

VSSTF: Messaging to Address Social Disparities Workgroup

April 19, 2024

Members

Mary Brandenburg, VHHA Foundation (Co-Chair)

Kristie Burnette, VHHA (Co-Chair)

Karen Bonham, HQI / Twin County Regional Healthcare

Tanya Claiborne, Riverside Health System

Beth Cottone, Survivor

Sarah Fowler

Alecia Hamm, Thomas Jefferson EMS Council

Beth Hundt, Centra Health

Keri Johnson, UVA Health

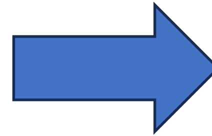
Alan Stillman, Kwikpoint

Scope of Work & Goals

Scope of Work

The Messaging to Address Social Disparities workgroup will:

- Review available stroke data, stratified by race/ethnicity, payor, zip code, and other socio-demographic factors
- Provide education to partners along the continuum of care about the impact of SDoH on health outcomes, how to identify health-related social needs, and how best to connect patients and their families to resources that address social needs
- Identify practices and frameworks that promote community collaboration on initiatives to address SDoH



Goals

- Review available data and literature to identify disparities in Stroke treatment and outcomes; share findings with the VSSTF
- Create a multi-modal communication plan to educate partners about the impact of SDoH on health outcomes, the importance of standardized screening for health-related social needs, and how to connect patients and their families to social care resources in the community.
- Initiate innovative strategies to make available "best-practice" education and resources to foster collaboration and support statewide, regional, and community-level efforts to address the social drivers of health impacting Stroke patients and their families.

Strategy Development

1/5/24 Meeting

- Approval of Charter & Goals
- Literature Review
- VHHA Analytics Data Overview

2/2/24 Meeting

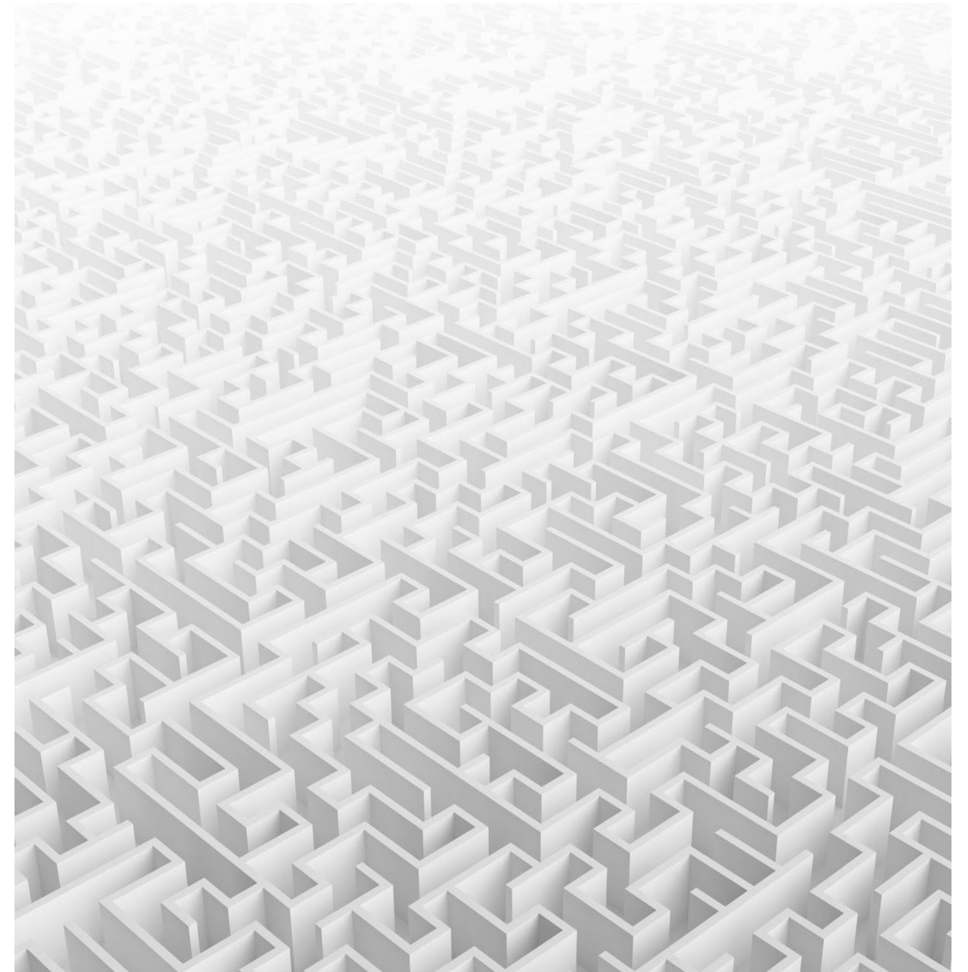
- VHHA & VDH Disparity Analysis

3/8/24 Meeting

- Communication / Education Strategy Discussion -> Provider Assessment & Pilot Test

4/12/24 Meeting

- VDH Stroke Burden by Locality
- Pilot Site Selection Criteria
- Two-Pronged Approach: Community & Provider Outreach

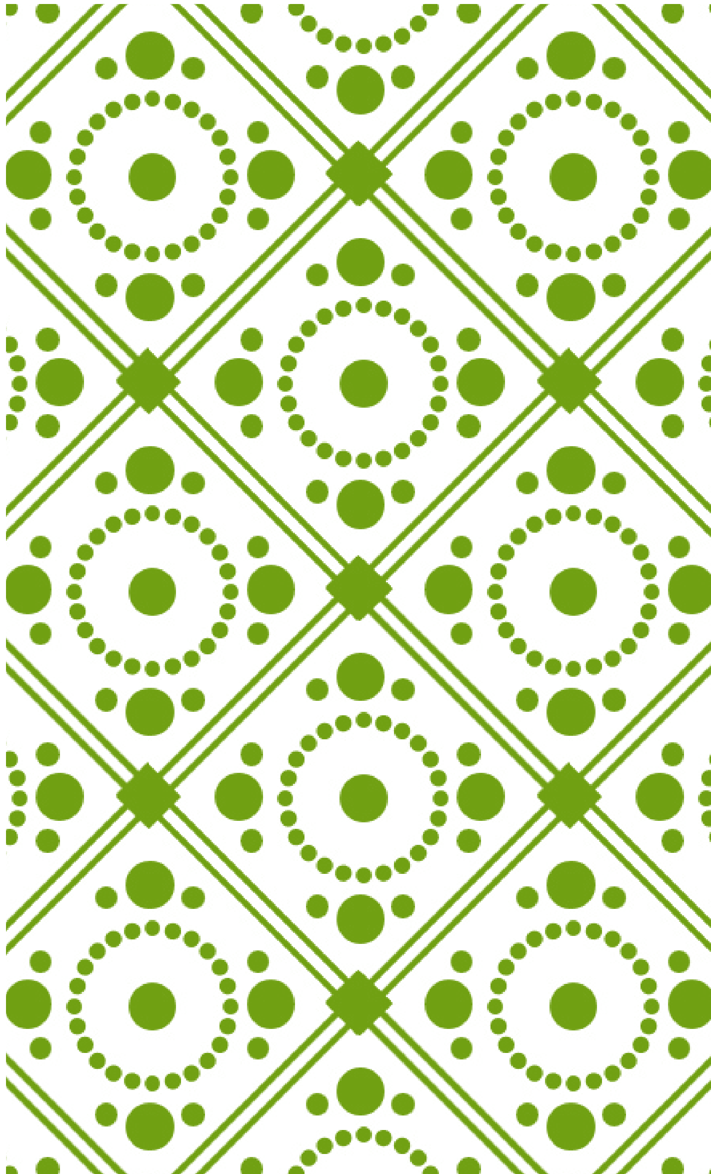


Next Steps

Provider Assessment Survey

Unite Us Resource Review

Pilot Site Selection



MAY DAY!
A COMMUNITY FIELD DAY TO RAISE STROKE AWARENESS

Melanie Winningham, MD
Vascular Neurologist
Sevaro Health / Sentara

MAY DAY 5.2025

Now planning for 2025 event.

Time to gather team with experience in fundraising, corporate sponsorship, and event planning.

First work group meeting to come.

Location pending – likely in Charlottesville or Richmond region initially.

Planning for a reproducible annual event akin to Relay for Life or Heart Walk.

Need strong marketing approach for success – news outlets/ social media.

PROPOSED MAY DAY ACTIVITIES

- Plan to include invited speakers (stroke survivors) and/or "ask the Neurologist" panel.
- Live music?
- Health screenings (blood pressure / risk factors for stroke).
- Stroke Smart presence? Selfie poster with QR code?
- Classic field day activities – would like recommendations to make these events accessible for all participants (including our stroke survivors).
- Activities for kids (face painting, focused education about stroke).
- Food trucks.
- Event t-shirts.

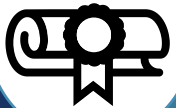
VSST 4/19/2024

WORKGROUP MEMBERS

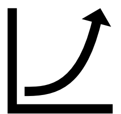
- Carla Gunter, RN
  - Nursing Educator / Stroke Coordinator, Twin County Regional Hospital
- Kim Warren, DNP
  - CNO, Bon Secours Southampton Medical Center
- Laurie Mayer, MBA, BSN
  - Quality Program Specialist, Telespecialists
- Laith Altaweel, MD
  - System Stroke and Acute Care Neurology Medical Director, Inova Health System
- Branden Robinson
  - Chief Growth Officer, Sevaro Health

TELENEUROLOGY WORKGROUP GOALS

Establish accepted metrics and processes for telestroke and standardization of the process



Educate hospitals that use telestroke and educate non-telestroke programs on the benefits of setting up a telestroke program



Improve outcomes by using telestroke to increase the use of thrombolytics in appropriate patients and route patients quickly for endovascular thrombectomies.

METRICS

- Stroke alert to telestroke activation within 10 min.
- Telestroke activation to telestroke response within 10 min (total time 20 mins)
- Telestroke imaging interpretation(wet read) w/in 10min notification of imaging completion (total time 30 mins)
- Telestroke imaging interpretation to communicating treatment decision : (total time 40 mins)
  - EVT - 10 minutes
    - Notify onsite staff
    - Calling IR
    - Calling transfer center
  - Intravenous thrombolytic-10 minutes
  - ICH/SAH - 10 minutes
- % of stroke alerts presenting within 4.5 hrs LKW that receive thrombolytics 10%
- Reason thrombolytics was not given.
- Reason video not used
- Track proportion of stroke alerts that are assessed by video.

  *all times are median
- Patient outcomes (Mortality Rates, Functional Outcomes, etc)
- Patient Satisfaction (NPS or other Scales)

BEST PRACTICES

- One-step notification from facility to teleneuro provider (CG)
- Teleneuro Provider Back-up Process (CG)
- Teleneuro Provider Etiquette (CG)
  - Introduction
  - Confirm Identification (Name and Date of Birth)
  - Identify staff and family in room
  - Inclusion/Exclusion Criteria
  - Risks/benefits and alternative conversation with patient or surrogate, and if none available, emergency policy consent.
- ED Provider in room at end of consult to facilitate care (CG)
- Acute Stroke Ready through CSC should expect the same level of care and response from telestroke
- Quick Access to Imaging Studies- Ensure rapid access to imaging studies (CT scans, MRIs) for remote neurologists.
- Utilize advanced imaging interpretation tools(AI) (Brainomix, Rapid, Viz)
- Establish a direct to CT and tele-cart setup protocol.
- Establish a process for telestroke neurologist to contact receiving facility/NIR MD.

BEST PRACTICES CONT…

- Establish one process when on-site and teleneurology vendor cover different shifts.
- Televideo provider must document in the EHR
- Wifi Connectivity Mapping - designate areas for video evaluation
- NIHSS Certified RNs
- Telepresenter training for bedside staff Imaging shared with receiving hospital within 10 min of transfer request
- DIDO for acute stroke requiring transfer within 120 min
- Multidisciplinary Collaboration- Establish collaboration between neurologists, emergency room staff, radiologists, and other relevant healthcare professionals to include process and metric data sharing.
- Standardized Protocols and Guidelines- Develop and implement standardized protocols and guidelines for telestroke assessments, diagnosis, and treatment. Consistency in procedures helps ensure quality care.

PHASE II

Education Q2 and Q3:

Current Telestroke Programs

Hospitals not using Telestroke

THANK YOU

BRANDEN@SEVARO.COM

Stroke Smart Workgroup

AMY SWIERCZEWSKI, ASSISTANT DIRECTOR OF PROGRAMS, MSVF
KATHRYN FUNK, AGACNP-BC, MSN-RN, SCRN, CNRN, STROKE REGISTRY COORDINATOR, VDH

Stroke Smart Workgroup Members

Kwikpoint | Stroke Smart Virginia

Alan Stillman

Medical Society of Virginia Foundation

Jennifer Joss

Amy Swierczewski

Virginia Department of Health

Kathryn Funk

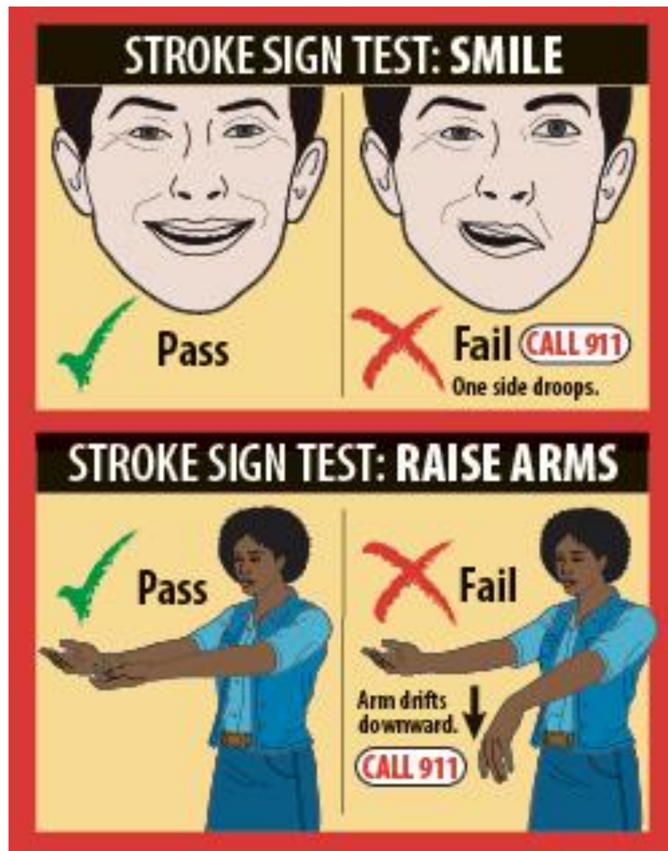
Bethany McCunn

Anne McMillan

Virginia Hospital and Healthcare Association

Kristie Burnette

Stroke Smart – Objective



Reduce pre-hospital delay and increase timely treatment of strokes

Stroke Smart Workgroup: Focus Areas

Facilitate implementation of Stroke Smart Medical Practice (SSMP) through collecting and sharing resources

Update the VDH Stroke Smart website and use it as the central repository for materials that can be used in implementation

Create a way to recognize practices who have implemented some or all of the (5) SSMP actions

Collect data of <u>who</u> has implemented SSMP and <u>how</u>

(Publicly) Recognize practices who have implemented; motivate further action

Identify "best practices"– collect what "works"

Share and Inform to those who want to adopt

Sneak Peek: Updated VDH Stroke Smart Website

Resources

Data

Virginia Stroke Systems Task Force

Virginia Stroke Care Quality Initiative Advisory Group

Virginia Stroke Coordinators Consortium

VDH Stroke Team

Contact Us

Email this page

How to Spot a Stroke- 3-Minute Video

Magnets & Wallet Cards

Coming Soon!

Coming Soon!

Stroke Smart Medical Practice Recognition

Purpose:

1) **Collect data** from medical practices who implemented SSMP (what and how)
2) **(Publicly) Recognize** practices who have implemented; motivate further action
3) **Identify "best practices"**– collect information on what is working, and good practices/tools used
4) **Share and Inform** to assist interested practices in adopting initiative

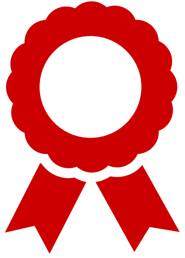
Stroke Smart Medical Practice Actions*

Goals: Don't schedule appointments for people having a stroke and provide effective education on stroke signs and importance of calling 911

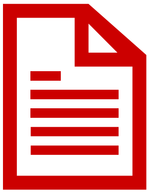
1. Train office staff to spot strokes and follow practice protocol if a stroke is suspected
2. Ensure Stroke Smart education and materials are accessible to all patients
3. Identify high risk patients and provide targeted Stroke Smart education
4. Incorporate Stroke Smart script in phone system recordings
5. Track metrics on Stroke Smart program activities

** Approved by VSSTF January, 2023*

SSMP Recognition – Overall (Proposed) Process



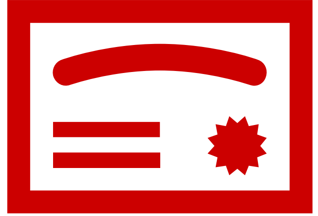
1) (4) Levels of Recognition are available:
    a. Champion (implemented 1 action)
    b. Silver (implemented 2 actions)
    c. Gold (implemented 3 actions)
    d. Platinum (implemented 4 or more actions)



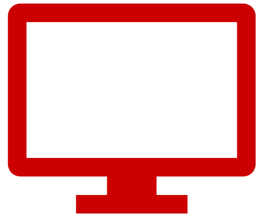
2) Online application for practice to select level, self-report which of (5) actions they have taken and provide information on "how"

3) Working team reviews submissions: 1x/month
    a. Determine if criteria was met
    b. Provide any feedback

Recognition Proposed Process Cont'd :



4) Issue certificate (electronically)



5) Recognize practices on VDH Stroke Smart website

6) Provide debrief of activity to VSSTF (minimum 1x per year)

Online Application:

Stroke Smart Medical Practice Recognition Submission Form

Thank you for your interest in receiving Stroke Smart Medical Practice Recognition.

There are four (4) levels of Stroke Smart Recognition:

Stroke Smart Champion

Participant has implemented and consistently practices (1) element of the Stroke Smart Medical Practice criteriaSilver Level

Participant has implemented and consistently practices (2) elements of the Stroke Smart Medical Practice criteriaGold Level

Participant has Implemented and consistently practices (3) elements of the Stroke Smart Medical Practice criteriaPlatinum Level

Participant has Implemented and consistently practices (4) or more elements of the Stroke Smart Medical Practice criteriaThe elements of the Stroke Smart Medical Practice Criteria are:

Train office staff to spot strokes and follow the practice protocol if a stroke is suspected (suggested: annually).Ensure Stroke Smart education and materials are accessible to all patients (i.e., wallet cards, magnets, posters, videos)Identify high risk patients and provide (intentional) education and materialsIncorporate Stroke Smart script in phone system recordingsTrack metrics on Stroke Smart program activitiesPlease complete the survey to submit your site for recognition.

Our practice would like to apply for the following level of Stroke Smart Medical Practice Recognition:

- ○ Stroke Smart Champion (one element)
- ○ Stroke Smart Silver Level (two elements)
- ○ Stroke Smart Gold Level (three elements)
- ○ Stroke Smart Platinum Level (four or more elemen

Check the element(s) of the Stroke Smart Medical

- ☐ 1. Train office staff to spot strokes and follow

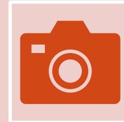
Recognition Application Process:

1. Radio Button link to be on VDH Stroke Smart Medical Practice Page

Recognize Your Stroke Smart Medical Practice

2. Practice would select level they are applying for (Champion, Silver, Gold, Platinum) based on # of criteria implemented

3. Basic information on implementation asked (i.e. type of staff trained, total #, what materials did you distribute, how did you distribute materials, etc.)



4. Practice can upload photos or samples of materials

5. Feedback requested on what worked well, needs improvement, general comments

6. Practice invited to share a "success story"

Team Review:

Workgroup would assess application and make determination if practice met criteria (subjective) and award a level

Feedback given on application and certificate sent via email

Updates to website (listing practice and level) would be requested

Future: share “success stories”

Stroke Smart VIRGINIA

2024

Virginia Stroke Smart Medical Practice
CHAMPION ACHIEVEMENT

____

In recognition of your efforts to stop strokes and save lives.

Signature____________________

Stroke Smart VIRGINIA

2024

Virginia Stroke Smart Medical Practice
SILVER ACHIEVEMENT

____

In recognition of your efforts to stop strokes and save lives.

Signature______________________

2024

Stroke Smart VIRGINIA

Virginia Stroke Smart Medical Practice
GOLD ACHIEVEMENT

____

In recognition of your efforts to stop strokes and save lives.

Signature______________________

Stroke Smart VIRGINIA

2024

Virginia Stroke Smart Medical Practice
PLATINUM ACHIEVEMENT

____

In recognition of your efforts to stop strokes and save lives.

Signature______________________

Discussion/Questions Recognition?

- Award Levels and Basic Criteria
- Application Form
- Certificates
- Overall Process

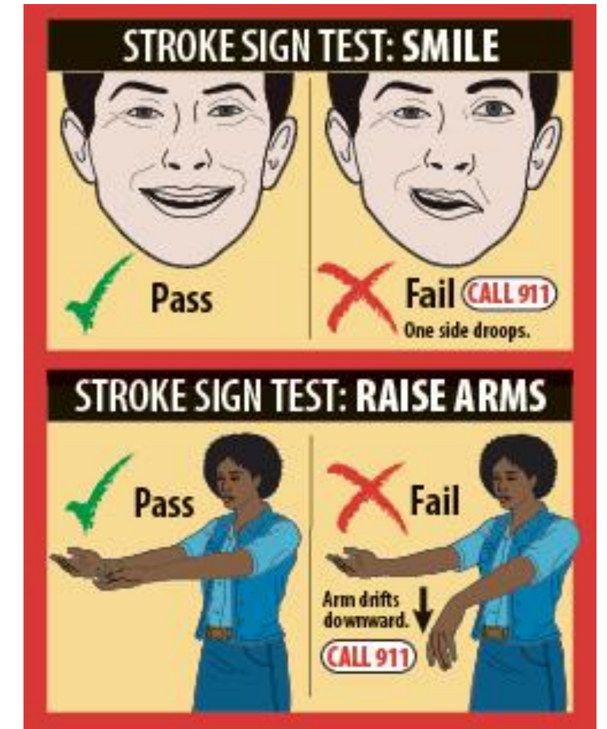
Vote for Approval:

- Award Levels and Basic Criteria
- Application Form
- Certificates
- Overall Process

Spot a Stroke-Stop a Stroke-Save a Life

Stroke Smart Medical Practice – Elements*

1. Train all office staff to spot strokes and follow the practice protocol if a stroke is suspected (suggested: annually)
2. Ensure *Stroke Smart* education and materials are accessible to all patients (i.e., wallet cards, magnets, posters, videos)
3. Identify high risk patients and provide (intentional) education and materials
4. Incorporate *Stroke Smart* script in phone system recordings (Suggested Element)
5. Track metrics on *Stroke Smart* program activities



*Approved by Virginia Stroke System Task Force: Jan 2023

Suggested Levels for Recognition:

Stroke Smart Champion

- Participant has implemented and consistently practices **(1) element** of the Stroke Smart Medical Practice criteria

Silver Level:

- Participant has implemented and consistently practices **(2) elements** of the Stroke Smart Medical Practice criteria

Gold Level:

- Participant has implemented and consistently practices **(3) elements** of the Stroke Smart Medical Practice criteria

Platinum:

- Participant has implemented and consistently practices **(4) or more elements** of the Stroke Smart Medical Practice criteria

ZODIAC TRIAL

Stacie Stevens, VCU

Lunch
and Simulation Tours

Rethinking Rehabilitation: Intensive Telerehabilitation to Maximize Recovery from Stroke

Kristin Nuckols, Imago Rehab

EMS Blood Draw for Stroke Patients- Pros and Cons, Panel Discussion

Elizabeth Hart, Moderator

Sophea Booker, Pat Edwards, David Long, Melanie Winningham, Speakers

EMS Blood Draw for Stroke Patients

Performance Improvement Background

- Bon Secours Maryview Medical Center (MMC) is a 346-bed Primary Stroke Center located in Portsmouth, VA.
- MMC serves a community of 280,000 and has approximately 400 stroke patients each year.
- 70% of the acute stroke patients seen in the ED arrive via Portsmouth Fire, Rescue, and Emergency Services (PFRES).
- Maryview had an average DTN time of 70 minutes in 2014.
- Process gaps found in the ED included delays in care when transferring patients to ED beds and drawing blood in a timely manner.

Goal

1. Improve overall care of Code S/stroke patients through a streamlined process change
2. Decrease the time Door to Lab to reduce Door to tPA/intervention times
3. Improve treatment times and overall experience/outcome for the acute stroke patient

2015 Pilot Program Process

- Planning meeting in February 2015
- Worked with Lab/POC to have MEDIC ID# assigned
- Process Algorithm developed for EMS pre-hospital screen and lab draws
  - Placed in all PFRES ambulances
- Training will be provided to Super-Users who will train others
- Lab draw packets will be provided to PFRES EMS and restocked as needed
- Feedback will be provided to PFRES by MMC Stroke Coordinator
- Feedback will be provided by Lab for any problems with blood draw
- Go Live Blood Draws set for April 1, 2015

Pre-Hospital Stroke Pilot Program

EMS on scene with possible CVA with last seen normal ≤ 8 hours

EMS protocol based CVA evaluation and stabilization with IV access

Prior to starting IV fluids draw 5 tubes of blood in this order

- Red, orange, blue, green, then purple
- Each tube needs to be filled at least ¾ full
- Place a pre printed label with tech code **5130** on each tube
- Write the patient's name, drawer's initials, date, and time of the draw then place the blood back in the biohazard bag with the green label

ED Notification of **Code "S"** with rapid transport. STAT assessment by ED Physician, RN, Tech upon arrival to the door

- EMS Provider **2** validates the blood with the ED Tech/RN
- ED Tech hand delivers the blood to the lab

- EMS Provider **2** arrives the patient with the unit secretary
- Unit Secretary activates tele neurology consultation
- ED RN and Physician place CT and lab orders

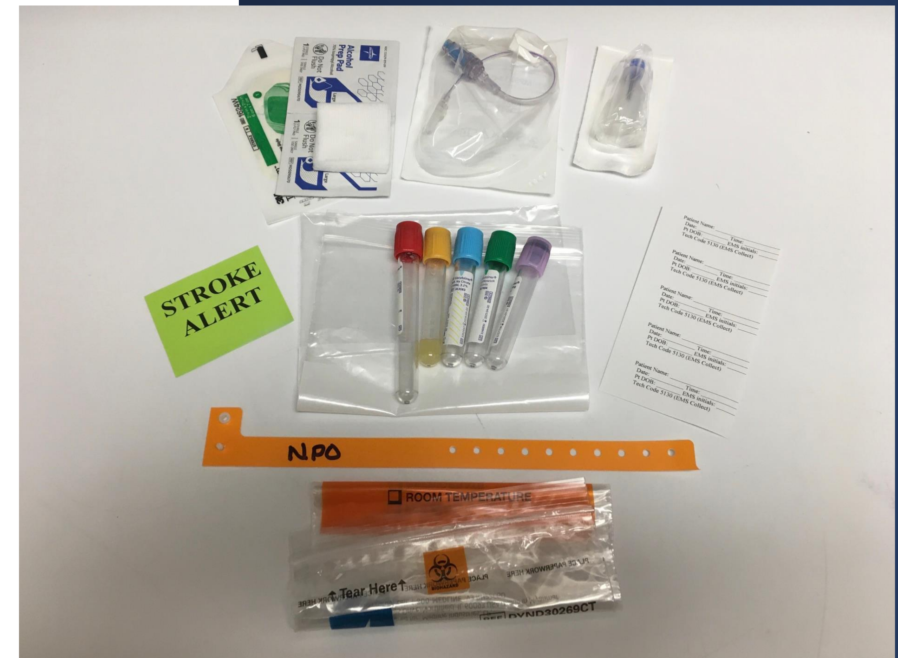
- EMS Provider **1** transports the patient to CT with RN on the EMS monitor
- 2nd ED RN follows with ED stretcher and weighs the patient after CT

Transport to ED room and proceed with standard Code "S" care

3/12/15

Training & Support

- PFRES asked for Volunteers for Super Users
  - Hoped for 5 but 15 EMS Super-users volunteered
  - Had 3 training sessions in March 2015
- EMS Super-users trained additional 200 PFRES personnel



Alcohol Prep Pad
Do Not Flush
Large

STROKE ALERT
Patient Name:
Date: Time:
Pt DOB: EMS initials:
Tech Code 5130 (EMS Collect)
Patient Name:
Date: Time:
Pt DOB: EMS initials:
Tech Code 5130 (EMS Collect)
Patient Name:
Date: Time:
Pt DOB: EMS initials:
Tech Code 5130 (EMS Collect)
Patient Name:
Date: Time:
Pt DOB: EMS initials:
Tech Code 5130 (EMS Collect)
Patient Name:
Date: Time:
Pt DOB: EMS initials:
Tech Code 5130 (EMS Collect)
NPO

ROOM TEMPERATURE
Tear Here
PLACE PAPERWORK HERE
BIOHAZARD
DYND30269CT

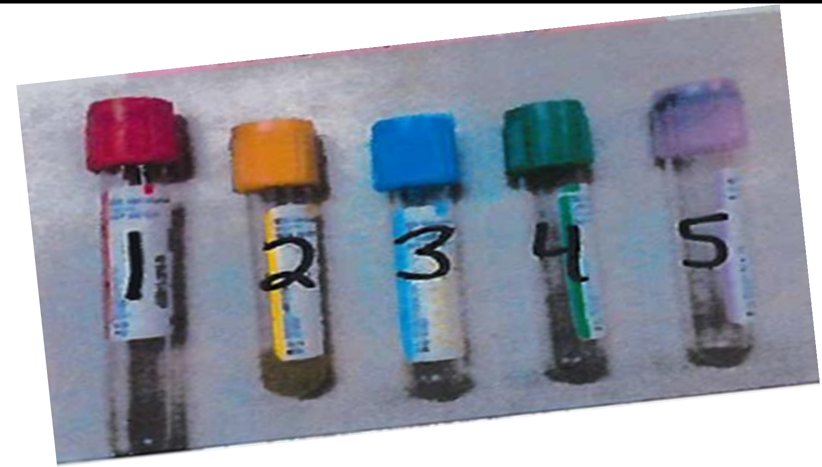
STAT
SENTARA
STROKE
CardinalHealth
STAT

01-2214F
IV START KIT
For Single Use Only
CardinalHealth

2015 Results for Lab Times

Average blood arrival in Lab times									
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Avg Lab Received	0:19	0:23	:20						
With EMS	n/a	n/a	n/a	0:10	0:10	0:07	0:07	0:11	0:12
Without EMS				0:19	0:14	0:19	0:20	0:21	0:23
Difference				0:09	0:04	0:12	0:13	0:10	0:11
% of difference				47%	29%	63%	65%	48%	48%

6 Month Average:
With EMS: 9 min
Without EMS: 19 min



Bon Secours Maryview Medical Center 2022-2023 EMS Blood Draw and CT Data

With EMS Blood Draw

Door to CT	Average – 14.63 minutes
Door to Decision	Average – 24.27 minutes
Arrival to Result	Average – **26.24 minutes**

Without EMS Blood Draw

Door to CT	Average – 31.72 minutes
Door to Decision	Average – 33.39 minutes
Arrival to Result	Average – **58.96 minutes**

Questions?

VDH VIRGINIA DEPARTMENT OF HEALTH

Coverdell Re-Abstraction Process & Results

Allie Lundberg, MPH - Stroke Epidemiologist

allie.lundberg@vdh.virginia.gov
stroke@vdh.virginia.gov

Purpose

Re-abstraction of patient medical records or charts assists in the assessment of data coding quality and completeness.

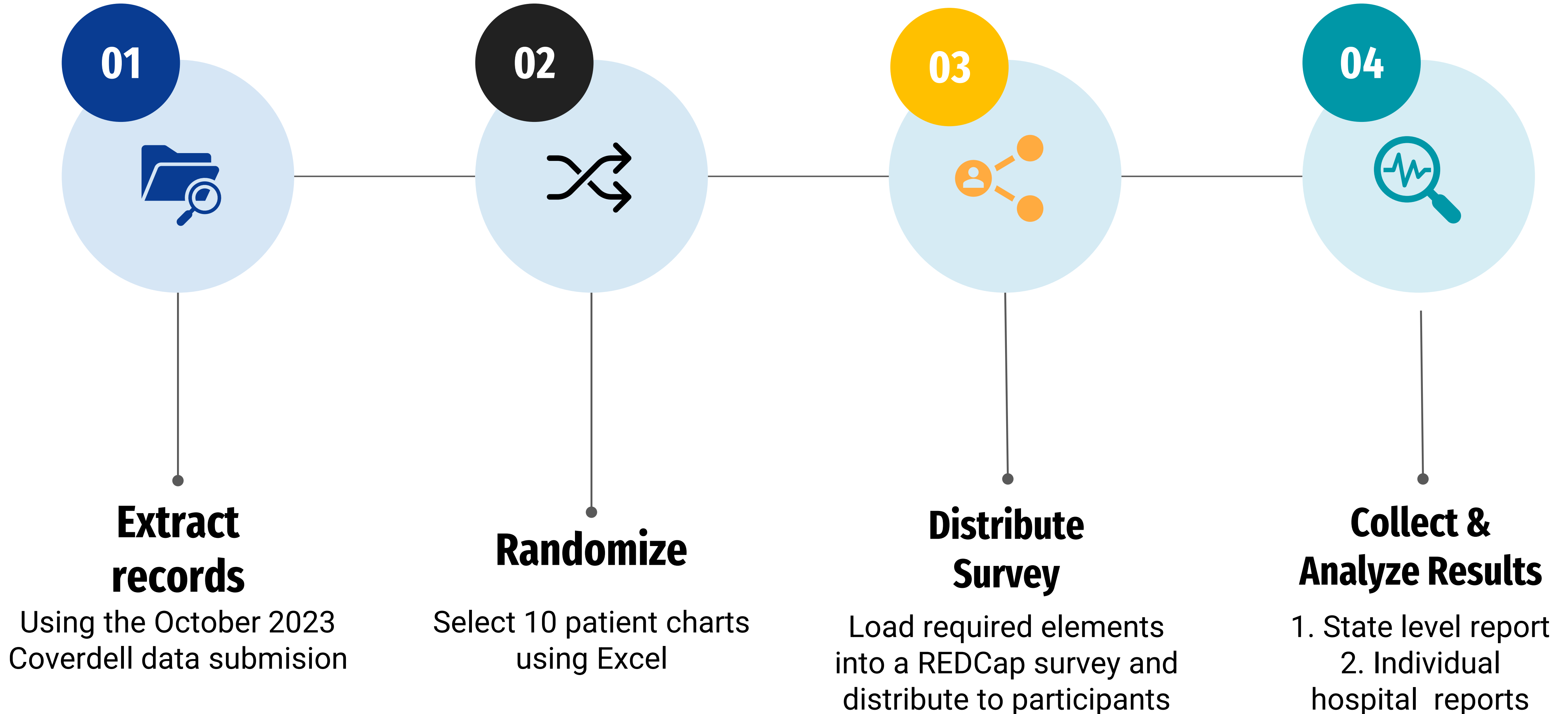
This project included hospitals who have submitted data through Virginia's current Coverdell Stroke project.

Why is re-abstraction important?

1. Ensure patient data is accurate and reliable
    - Reduce errors and adverse events affecting patient safety
    - Inaccurate data could restrict health data sharing
    - Inaccurate data could complicate clinical research
2. Stay compliant
    - Needed for certification, accreditation, etc.
3. Initiate quality improvement
    - Create improvement projects to monitor and improve performance metrics

Alzu'bi AA, Watzlaf VJM, Sheridan P. Electronic Health Record (EHR) Abstraction. Perspect Health Inf Manag. 2021 Mar 15;18(Spring):1g. PMID: 34035788; PMCID: PMC8120673.

Process



Data Elements Collected

1. Age
2. Gender
3. Race and Ethnicity
4. Date of Arrival at Hospital
5. Time of Arrival at Hospital
6. Date of Hospital Admission
7. Telestroke consultation performance
8. Brain imaging performance
9. Date and Time brain imaging first initiated at your hospital
10. Last known well date and time
11. NIH Stroke Scale performance
12. If performed, first NIH Stroke Scale total score
13. Was IV thrombolytic initiation
17. Was a dysphagia screen performed before administration of any PO medication?
18. Patient discharge date
19. Principal discharge ICD-10-CM code
20. Clinical diagnosis related to stroke that was ultimately responsible for this admission
21. Discharge disposition

Re-Abstraction Survey

Distributed online survey on December 1, 2023 with a targeted completion date of January 31, 2024.

Requested: 44 hospitals

Received: 35 hospitals // 339 total records

VDH VIRGINIA DEPARTMENT OF HEALTH

Resize font:

Coverdell Year 1 Re-abstraction

The Virginia Department of Health (VDH) is requesting your assistance with performing a re-abstraction of your facility's stroke records as a requirement for VDH's awarded CDC Paul Coverdell Acute Stroke Grant and will assist in meeting your certification requirements of inter-rater reliability.

Please use the provided patient ID's (found in a separate email) and re-abstract the following data fields into this survey. Please complete each survey field with the information found in the patient's medical record, not in your stroke logs or *Get With The Guidelines*. All de-identified data entered in this survey will be submitted securely to VDH and will follow all applicable confidentiality policies required by Virginia state agencies.

Please submit your re-abstraction results into this survey by January 31, 2023. We will be providing a report by the end of February comparing your submitted data to the information obtained from this abstraction.

Thank you for your commitment to improving stroke care. If you have any questions, please contact the VDH Stroke Team at: stroke@vdh.virginia.gov.

Hospital Name
* must provide value

Abstractor Name
* must provide value

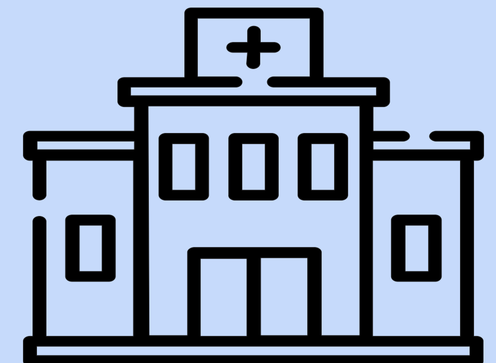
First and Last Name

Participants

(new participants are in **bold**)

Augusta Health
Bon Secours Mary Immaculate
Bon Secours Maryview
Bon Secours Memorial Regional
Bon Secours Rappahannock
Bon Secours Richmond
Bon Secours St. Francis
Bon Secours St. Mary's
Bon Secours Southside
Carillion Roanoke Memorial
Centra Lynchburg
Chesapeake Regional
Fauquier Hospital
HCA Chippenham Johnston Willis
Inova Alexandria
Inova Fair Oaks
Inova Fairfax
Inova Loudoun
Inova Mount Vernon

Riverside Shore
Riverside Walter Reed
Sentara Care Plex
Sentara Halifax
Sentara Leigh
Sentara Martha Jefferson
Sentara Norfolk
Sentara Virginia Beach
UVA Hospital
VCU Community Memorial
VCU Health
Virginia Hospital Center



Comparison from 2023 Re-Abstraction Project

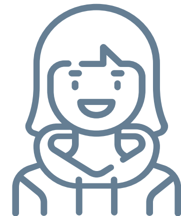
- Number of participating hospitals:
  27 -> **35**
- Number of records re-abstracted:
  240 -> **339**
- Number of discrepancies:
  1094 (14.7%) -> **559 (7.5%)**

Summary Results

Demographics

Total number of records = 339

Age
Number matched: 332
Percent matched: 97.9%



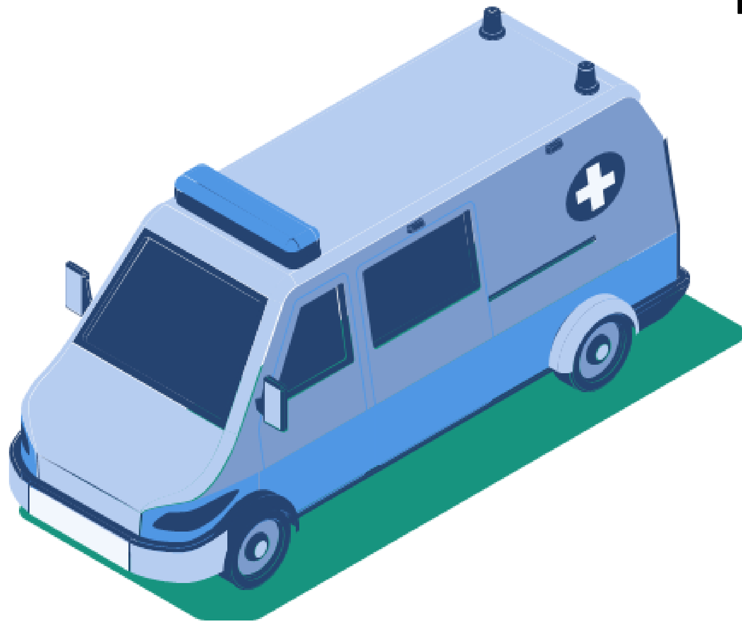
Gender
Number matched: 331
Percent matched: 97.6%

Race and Ethnicity
Number matched: 2,355
Percent matched: 99.2% (**+1.1%**)

Summary Results

Hospital Arrival & Admission

Total number of records = 339

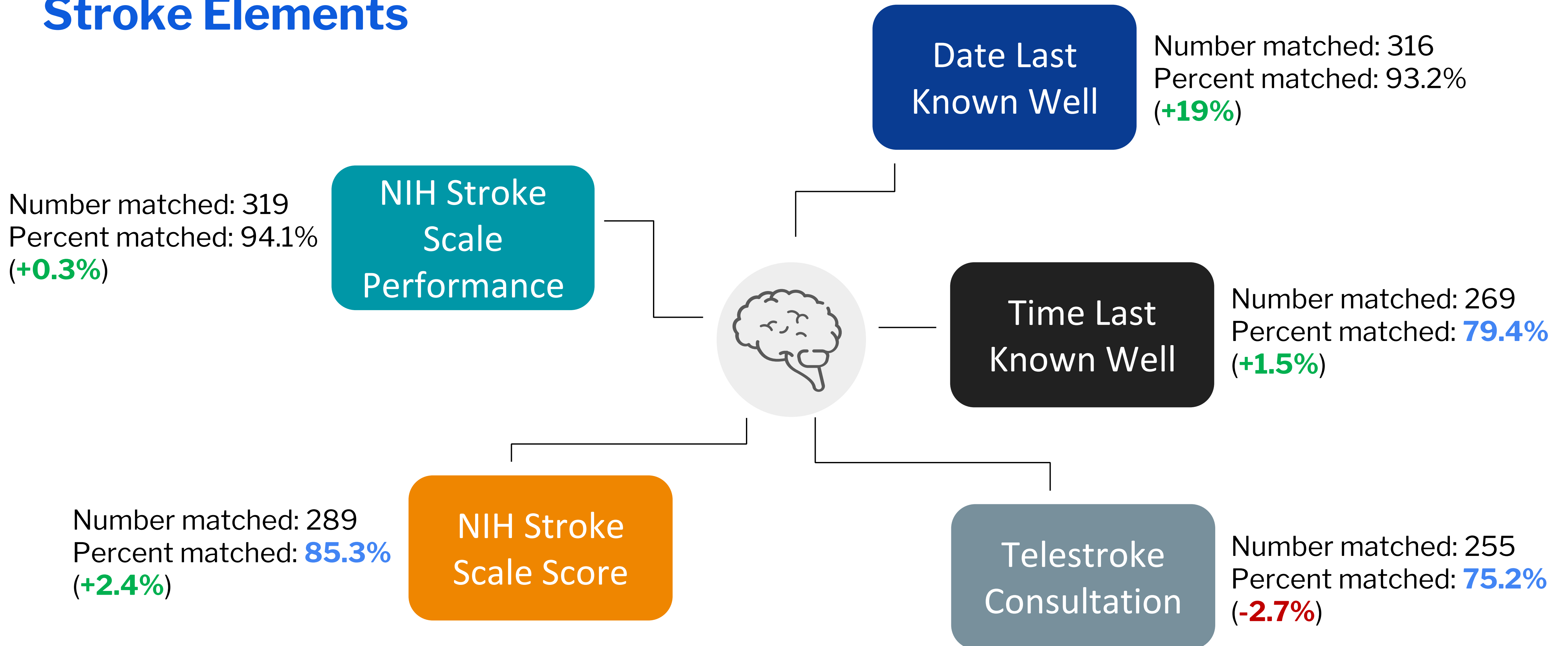


Date of Arrival at Hospital
Number matched: 339
Percent matched: 100% (**+2.9%**)

Time of Arrival at Hospital
Number matched: 284
Percent matched: **83.8%** (**-5.4%**)

Date of Hospital Admission
Number matched: 309
Percent matched: 91.2% (**+21.3%**)

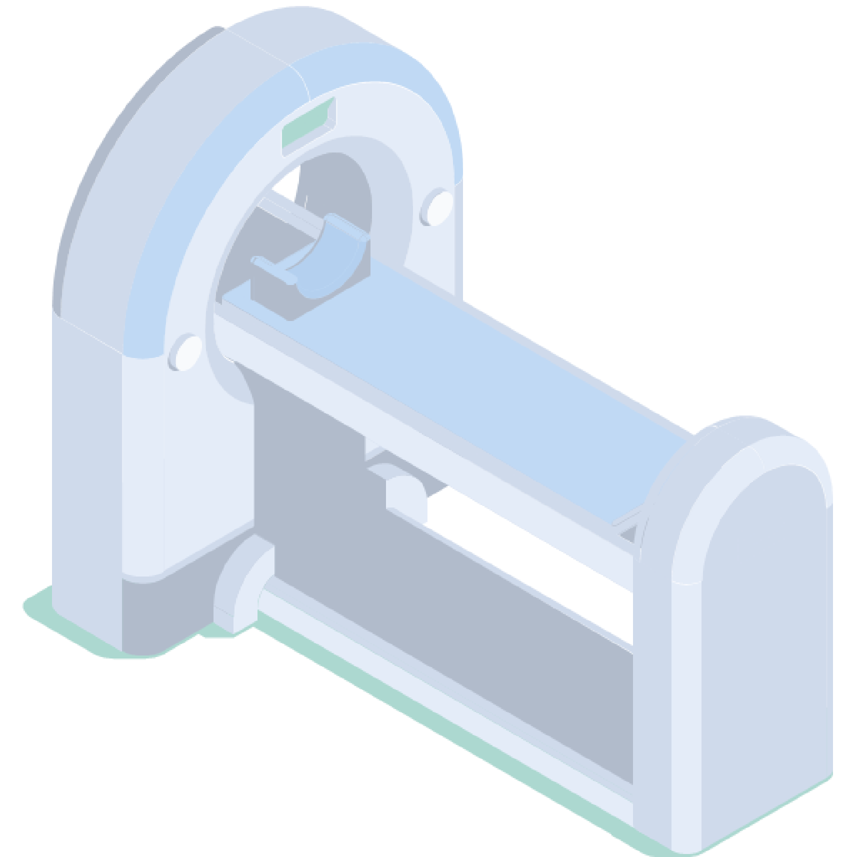
Summary Results
Stroke Elements



Summary Results

Brain Imaging

Total number of records = 339



Was brain imaging done?

Number matched: 304
Percent matched: 89.7% (-5.3%)

Date of Brain Imaging at Hospital

Number matched: 331
Percent matched: 97.6% (+5.5%)

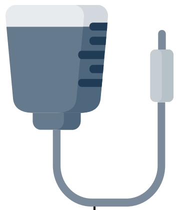
Time of Brain Imaging at Hospital

Number matched: 233
Percent matched: 68.7% (-16.3%)

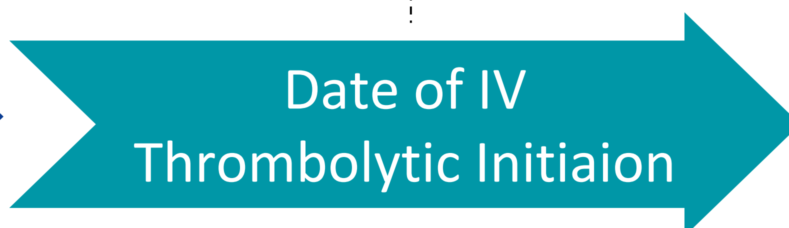
Summary Results

IV Thrombolytic Initiation

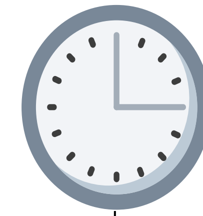
Total number of records = 339

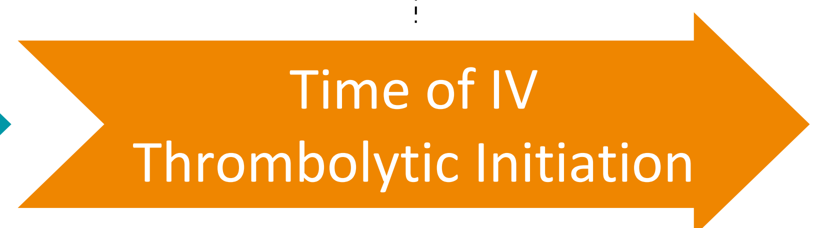


Number matched: 338
Percent matched: 99.7% (**+4.7%**)



Number matched: 338
Percent matched: 99.7% (**+14.7%**)



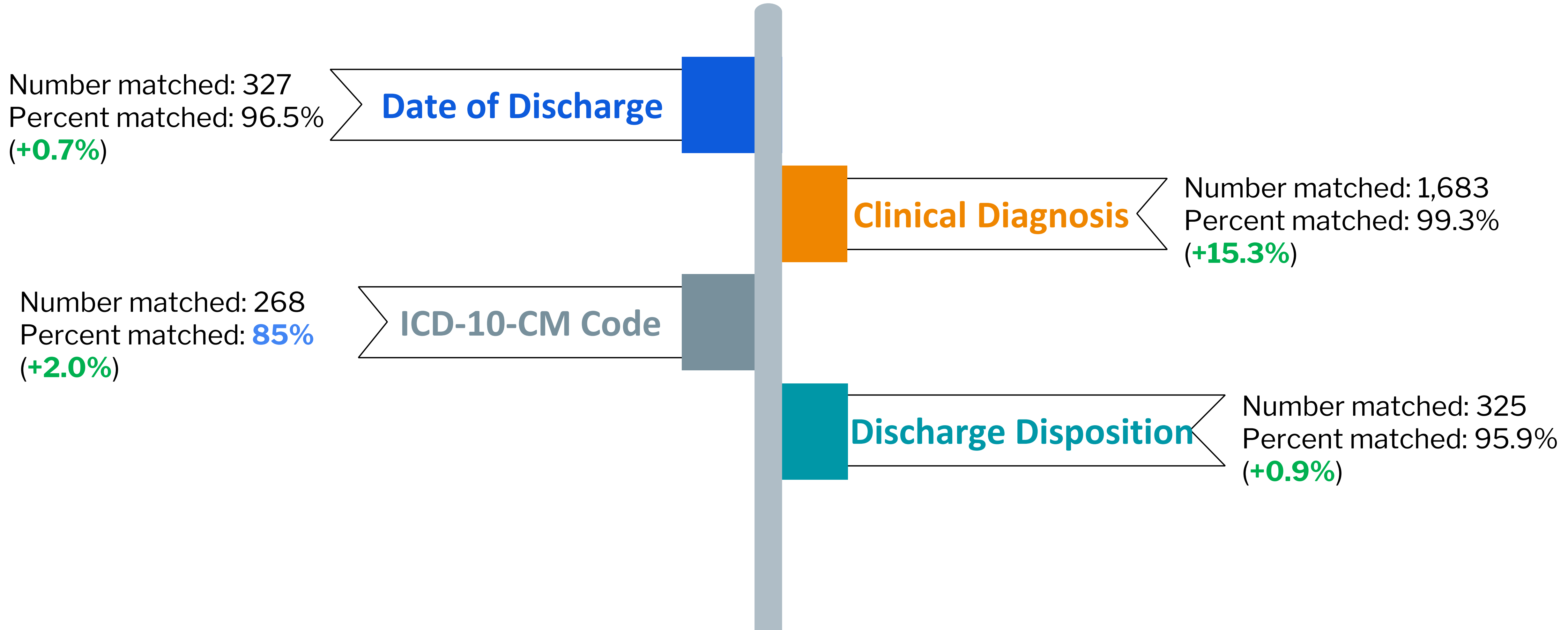


Number matched: 338
Percent matched: 99.7% (**+22.6%**)

Summary Results

Discharge

Total number of records = 339



2024 Hospital Stroke Inventory Survey

- Survey is open and has been sent via email to stroke coordinators 4/16.
- Survey is due and **will close May 10th** (11:59pm).
- Please submit **one** survey for **each** facility and/or free-standing emergency department you oversee. Please allocate 15-20 minutes for completing the survey per site.

Virginia Stroke Registry Update

- Stroke Registry continues to be built and tested through vendor.
- VDH will not have open calls for beta testers. If beta testers are needed, VDH will reach out to select hospitals directly.
- VDH Stroke Team is obtaining GWTG SuperUser access (TBD) – please be on the lookout for data sharing contracts.

Questions?

For further questions, please contact:
Stroke@vdh.virginia.gov

VSSTF Final Remarks and Wrap Up

***VSSTF Co-Chairs**: Melanie Winningham, MD, and David Long, MA, NRP,*

- **Next Meeting Dates Schedule:**
  - July 19, 2024, Maryview Medical Center, Portsmouth, VA
  - October 18, 2024, in Richmond, Site TBD

Virginia Stroke Coordinators Consortium

April19, 2024

Mandi Zemaiduk, Centra Health, Lynchburg

Elizabeth Hart LewisGale Hospital, Salem