Illinois Stroke Task Force
Summary of Meeting Minutes
July 20, 2007
11:00a.m. – 2:30p.m.

I. Call to Order and Welcome

Michael Gaines welcomed Illinois Stroke Task Force members and public guests.

II. Roll Call of Members

Members in Attendance

William Adair, MD – Represents Illinois Hospital Association
Mark J. Alberts, MD – Represents Medical doctor at a research university
Barbara Bollenberg, Ph.D., RN – Represents the Illinois Nurses Association
Brian Churchill – Represents emergency medical technicians
Michele M. Clancy – Represents the general public
Joseph M. Harrington – Represents minorities
Richard L. Harvey, MD – Represents Illinois Association of Rehabilitation Facilities
Christina Kavelman – Represents stroke survivors
Edmund G. Lawler – Represents the IL Chpt. of American Assn. of Retired Persons
Sylvia Mahone, MD – Represents the Illinois Academy of Family Physicians
Dilip K. Pandey, M.D., Ph.D., M.S. – Represents the Illinois CAPTURE Stroke Registry
Rosanne Thomas, MS, PT, PhD – Represents the Illinois Physical Therapy Assoc.
David Z. Wang, D.O. – Represents the American Stroke Association

Members Absent

H. Hunt Batjer, MD – Represents the American Association of Neurological Surgeons
E. Bradshaw Bunney, MD, FACEP – Represents the IL College of Emerg. Physicians
Carolyn Brown Hodge – Represents the IL Rural Health Association
Kristine Coryell, Ph.D. – Represents the Pharm. Manufacturers Assn. of America
Philip Gorelick, MD, MPH – Represents the National Stroke Association
Gregory J. Mishkel, MD – Represents the Illinois State Medical Society
Michael R. Murphy – Represents the Illinois Life Insurance Council
James R. Nelson – Represents the Illinois Public Health Association
Eric E. Whitaker, MD, MPH – Illinois Department of Public Health

Ex-Officio Members Absent

Representative Mary E. Flowers – Chicago, Illinois
Representative JoAnn Osmond – Antioch, Illinois
Senator Dale A. Righter – Mattoon, Illinois
Senator Carol Ronen – Chicago, Illinois

American Heart Association- Greater Midwest Affiliate/American Stroke Association
Peggy Jones, Senior Director, State Health Alliances and Cultural Health Initiatives

Illinois Department of Public Health Staff
Chandana Nandi, MS, RD, LDN – Division Chief
Michael Gaines, MPA –Program Manager
Lynette E. Shaw, MSEd, CHES – Health Educator
Julie Doetsch, MA – Chronic Disease Data Manager

III. Approval of March 9, 2007 Meeting Minutes
Minutes for the March 9, 2007 meeting were approved by a vote and consensus of the group.

IV. *Grant Application Updates*
Michael Gaines, Program Manager
Update on grant funding:

Capacity – CDC – competitive new application - $345,091
Optional Funding – CDC – Not funded
Stroke Network Funding – CDC - $195,700
Illinois CAPTURE Stroke Registry Funding – CDC – Approved but not funded.

V. Illinois CAPTURE Stroke Registry – Update
Dilip K. Pandey, MD, PhD, MS – Director, Neuroepidemiology & Clinical Trial unit
Dr. Pandey provided update on the Illinois CAPTURE Stroke Registry. The Registry is a quality improvement project for acute care in Illinois. There are 45 acute care registry hospitals, which reported 9,000 cases in the data base. The process of quality was improvement initiated: real time feedback, quality improvement committee, mentoring, and quality improvement workshops. The Registry data show that 85% have a Stroke QI Team which meets on a regular basis, 92% of the hospitals use stroke order set, protocol or care map, and 62% of the hospitals use transient ischemic attack order set, protocol or care map.

VI. Hospital Inventory
Julie Doetsch, MA – Chronic Disease Data Manager
Julie provided an update on the hospital assessment to measure the capacity and limitations for treating acute stroke, the approach to sub-acute care and current stroke quality improvement activities. The following is the findings from the stroke survey administered to hospitals during December 2006. The Stroke Task force members and provided input on the survey content. The survey purpose was to collect information to develop a more thorough understanding of stroke care provided in Illinois hospitals. The survey included the following categories: general hospital information, acute stroke care, emergency medical service (EMS) integration, support services, quality improvement, and educational programs.

The Director of Public Health invited hospital administrators, via e-mail, to participate in the survey. An explanation of the purpose and a hyperlink to the on-line survey

administration systems were included in the e-mail. The survey took approximately 15 minutes to complete. The survey population was all 202 eligible hospitals (i.e., excluded eight psychiatric care and two rehabilitation-only hospitals). A total of 74 responded to the survey for a response rate of 36.6 percent. The results should be viewed with caution given this low response rate. However, as a baseline for programmatic development, these data are important to begin understanding stroke care in Illinois. The results are essential for the Heart Disease Stroke Prevention to determine needed technical assistance and to support improvements in care provided.

The General Information survey section gleaned background information about hospital type, stroke center director title, if available, and other characteristics of the responding hospitals. Based on county name, hospitals were stratified into rural, urban (rural with one city of over 50,000 population), collar (counties contiguous to Cook County), and Cook County. Most responding hospitals were located in rural counties, and hospitals in urban counties and Cook County were evenly represented. Hospitals in collar counties were least likely to respond.

Of the 74 hospitals responding, 45 (61.6%) were publicly owned, 22 (30.1%) were privately owned and 6 (8.2%) were university affiliated. A minority of hospitals had a designated coordinator or director of the stroke care center (28.4%, n=21).

Among hospitals with a stroke care center coordinator/director, by hospital type, university affiliated hospitals were most likely to have such a position (100%, n=6), while private hospitals (27.3%, n=6) and public hospitals (20.0%, n=9) were less likely to have such a position. By staff specialty, neurologists (50.0%) were most likely to be the designated stroke center coordinator/director, followed by nurse (20.0%), other (15.0%), neurosurgeon (5.0%), emergency department (ED) physician (5.0%), and radiologist (5.0%). Stroke care center coordinators/directors designated in the other category were: cardiologist, physiatrist/physical therapist and quality director.

A total of 38 hospitals provided Tissue Plasminogen Activator to one or more patients during the past 12 months. Among these hospitals, 23 (60.5%) were hospitals without a stroke care team and 15 (39.5%) were hospitals with a stroke care team. Of the total number of patients treated with t-PA in the past 12 months (n=213), 132 (62.0%) patients were provided t-PA by a hospital with a stroke care team and 81 (38.0%) were provided t-PA by a hospital without a stroke care team.

Hospitals were asked whether they have an intensive care unit (ICU) to provide stroke care and, if yes, the type of ICU stroke care provided. The majority of responding hospitals (78.4%, n=58) have an ICU. Among the 58 hospitals with an ICU, the majority (91.4%) provided stroke care in a general ICU, 13.8% provided stroke care in a dedicated neuro-ICU, and 10.3% provided stroke care using a neuro-intensivist in a general care ICU

The majority of responding hospitals have an emergency department (ED) (98.7%, n=73). Hospitals with an ED were asked “Beyond stabilization during acute phase in the

for stroke does your hospital provide the following?" Responses were based on a five-point Likert scale (1 = Never, 2 = Seldom, 3 = Sometimes, 4= usually, 5 = Always). The grouped mean response for all services was 3.4, as indicated by the horizontal line in

Figure 6. The most frequently reported services beyond stabilization were ED care only and admission (mean 3.9 and 3.8, respectively). Observation unit care was least likely to occur with a mean frequency of 2.7.

VII. MOCK Stroke Event Update

Lynette E. Shaw, MSEd, CHES – Health Educator

The Mock Stroke Event took place on May 8, 2007 in Chicago. A total of 250 magnets with the warning signs of Heart Attack and Stroke were distributed. The Chicago Fire Department participated with the event. The event was well attended and pictures were taken.

VIII. JCAHO Certification

Mark J. Alberts, MD

JCAHO continues to certify primary stroke centers, with about 400 being certified already. Some centers that were certified initially 2 years ago are now completing their recertification cycle. It is currently unclear, if JCAHO will begin a certification program for Comprehensive Stroke Centers (CSC). Any such program would likely be a 'low-volume, high-cost type of effort. Estimates for a per-hospital cost for CSC certification are in the range of $15,000 per facility, although this is simply a rough estimate and could change. Some state governments are looking at CSC certification programs through a state health department type of format.

The Brain Attack Coalition (BAC) is working on revisions for Primary Stroke Centers (PSC) criteria. Such revisions are timely now since the initial guidelines are 6-7 years old, and there have been significant advances in stroke care and related guidelines during that time period. The BAC hopes to have the revised PSC recommendations published in the next 6-8 months.

IX. Clinical Volunteers (for pre-stroke risk factor*screening, community education, etc.

Barbara Bollenberg, Ph.D.

Represents the Illinois Nurses Association

Dr. Bollenberg provided updates on the Clinical Volunteers. Clinical Volunteers are developing a public education program for the community on hypertension focusing on issue of prevention, stroke risk assessments and volunteers.

X. ***American Stroke Association plan for using a Stroke Progress***
Peggy L. Jones Director, State Health Alliances
American Heart Association

The State Stroke Systems Planning (SSSP) initiative is progressing and many activities have been implemented to improve the systems of care within the states. SSSP progress markers have been extracted from specific recommendations in the white paper or from the SSSP process to date will be examined to determine progress toward the ideal environment for stroke care. It is understood that there is great variability across the states with available resources, market readiness to change, and ability to achieve these markers.

The following are progress markers from the Ideal Stroke Systems of Care that are recommended for each state to strive to achieve. Markers identified as critical for completion by June 30, 2008, are listed in the right column.

Stroke Markers: What are they? How were they chosen? Initially we used the Likert Scale survey to evaluate where we believed our state stood on implementing Stroke Systems of Care. Using the ASA White Paper on Recommendations for the Establishment of Stroke Systems of Care, a committee worked to develop progress markers. These 26 markers will be utilized to determine progress within each state towards implementing the recommendations for Stroke Systems of Care.

Progress Markers focus will be to maintain focus on the system components and the level of proficiency at the system coordination level rather than at the organization level and patient care level. Progress Marker Evaluation will be completedto identify current conditions. We will need the Task Force members to help procure the survey data. There are 5 survey tools specific to different audiences. Overall State & System Coordination-Stakeholder Survey: EMS Provider Survey, Hospital Survey, Rehabilitation Facility Survey and Aggregate State Data Survey. All survey data will be kept as confidential and reported in aggregate form only.
Survey options include on-line, paper surveys and previous surveys if the data is one year old or less.

The State Task Force role is to help procure data and review the stakeholder survey answers (most of which will be no- we do not meet 100% completion). Identify the markers where we feel we can make the most impact. Shape legislation recommendations around markers that need to be legislated to change or improve. Identify specific plan to move IL toward the 100% completion standard for all markers. Determine how the committee can best work toward implementing a plan.

AHA/ASA role along with IDPH will be to work closely with State Task Force on the Evaluation Process and Survey implementation as well as the planning and prioritizing of next steps. Initiate survey requests and review previous survey data to see if it can be used. Work with our IDPH partners to complete the final survey of the 5- aggregate state data. Work within the AHA/ASA to involve internal partners as needed and using the data from our partners, create a statewide system map of hospitals.

AHA/ASA National Requirement for Implementation is by September 30, 2007, complete Progress Marker surveys and evaluation and submits results to National Center. By June 30, 2008, 100% completion on markers 1, 4, 5, 13, and complete progress on other markers the committee determines to be priorities.

XI. Primary Stroke Centers – Legislation Update Marker
David Z. Wang, D.O. – American Stroke Association Member

Dr. Wang provided an update on legislation about the primary stroke centers. AT time of our meeting, there were only 17 hospitals in the State of Illinois that have been certified by JCAHO to be primary stroke centers. Most of them are located in the Chicago area (two in Peoria and one in Bloomington). There was no JCAHO certified PSC south of Peoria/Bloomington.
The American Stroke Association sent out SB 1585 to all Task Force members. This is a DRAFT bill and is ready to be reviewed by stakeholders (Illinois Hospital Association) and for the stakeholders to make comments. Hospitals to become a mandated primary stroke center or work with a primary stroke center hospital. These would be certified by the State Health Department or Joint Commission on Accreditation. This opportunity provided the Illinois Stroke Task Force with a foundation to build on now for two years. It will serve as a catalyst for discussion and action to move forward in improving the stroke systems of care in our state. American Heart Association/American Stroke Association came out with new national Acute Stroke Guidelines that stated acute stroke patients should be taken to the nearest certified or recognized stroke center. This is the first time that a National organization has stated that, this will be added to the Bill. There was a discussion regarding the bill and guidelines regarding liability with hospitals.

VIII. *Future Meeting Date and Next Steps*
December 14, 2007 via Conference Call at 10:00a.m. CST

IX. Other Business
None

X. Public Comment
None

XIV. Closing Comments and Adjournment
The meeting was adjourned by a vote and consensus of the members at 2:30p.m.