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Good day and welcome to the New York State Department of Health Cloverdale start quality improvement program. If anyone should require operator assistance press star then 0. I will out -- I would like introduce your host Christine Steagall.

Good afternoon and welcome to that I Pro action network series presentation. We appreciate you joining us for the conference call presentation this afternoon. On the topic for -- the topic is to provide an overview of the New York State Department of Health COBRA Dale stroke quality initiative and Registry Program. Including points of consider when coordinating patient care transition. Those of you who have registered for today's conference call were forwarded the e-mail a copy of the slides that will be referenced during today's presentation along with the program evaluation form. The presentation slide sent out earlier this week may not exactly match what is being presented on the webinar today but the -- because final revisions were completed this morning. The final presentation will be posted on our IPRO website along with the recording of today's webinar in the past events section at HT TP\\Care Transitions.org. There will be a period of questions at the end of the presentation. There are two ways to ask questions during the presentation. If you think of something -- a question you don't want to forget, you can enter that into the chat area in the lower right-hand corner of the webinar screen. We will be monitoring bat and will be able to answer questions after the presentation. You can also wait until the lines are opened at the end to ask your questions and get them answered. We are pleased today to have our guest speaker, Anna Colello. She serves as a director of regulatory compliance in the Department of Health office of quality and patient safety. Her various roles include serving as administrator of the statewide primary stroke designation program, project director of the COBRA Dale -- Coverdale stroke quality improvement initiative and codirector of the cardiac services program. She is also lead staff to the palliative care education and training Council and is an assistant adjunct professor at the Albany medical College in the Department of medical education. She is a member of the Northeast cerebral vascular consortium AEMS workgroup and conference planning committee. She is a recipient of the American stroke associations community conscientious award for the year 2013 and has received several commissioners recognition awards. She has been in the New York State ever meant -- -- government for over 32 years and has held leadership roles with the division of legal affairs and the office of help systems management. She is a graduate of the University of Albany and New York Law School. At this time I will turn the call over to Anna and thank you.

Thank you Chris. I am so thrilled to be invited to speak to your group and to work with IPRO on another collaborative project. Chris and I have worked together along with Sarah Butterfield and some of you on the call with the discharge planning workgroup. Which really forms some of the basis for why I wanted to talk to a group beyond the acute stroke care that I generally speak to hospitals about. There are lots of things that I am thrilled about this program to report to you and

hopefully you will learn not only about the stroke Coverdale quality initiative and our primary designation program, but also walk away with some quality assurance program information that will help you in other programs that you manage in the hospital that drive quality improvement. It is all about the data. We are going to talk about the data. It's about a systems approach so you are not alone. You are part of a team. Both inside and outside the hospital. You are also focused on patients and their caregivers like what patients need to do. We're at a time in society where this access to a lot of information and patients have more questions than they've ever had before. But you are the leaders in helping them take responsibility for their care so also going to touch on what individuals need to do to prevent a stroke from occurring and if they have a stroke, how to avoid that from occurring again. You will see statistics about the possibilities of having a TAA or a stroke and what the likelihood is of possibly having another stroke. I have a lot of people to think and I want to thank my colleagues Kate rose boxing who is project coordinator for the Coverdale program and our intern [Indiscernible] who helped create this PowerPoint. With that being said we will go to the objectives of this program. What I hope to accomplish today is highlight the importance of stroke care in New York State, review the requirements of the New York State stroke designation program, which forms the quality improvement initiative which is the basis of our further work in Coverdale. Discuss the benefits of designation over non-designation, introduce the CDC funded Coverdell Stroke Quality Improvement and Registry Program, and as I referred to earlier with regard to discharge, talk about the role of long-term care facilities and home care agencies improving outcomes and stroke patients post discharge.

Here are some things from the American heart association which those vital statistics that really emphasize this area of disease. It is the fourth leading cause of death. This is behind heart disease and cancer. COPD recently beats stroke out to take over the third spot. It is one of the leading causes of lung -- long-term disability. If we think of death as the ultimate bad outcome that for many of us we think about living with a disability for a long period of time as very burdensome as well. When talking to patients and educating them what you're really trying to do is to give them hope for how they can try to regain the functionality they had before. There is a lot that has been -- research has shown that can be done to improve patient outcomes and it's not the disease of long ago where if you had a stroke you didn't have any hope of recovery. So I wanted to emphasize those two points from this slide. The next slide is showing the significance of time is brain. There are lots of conditions where you do want to act fast but in this condition, just like in heart disease and care, time is crucial to save functionality. This diagram illustrates the importance of looking at the clock and having a system in place that does everything that can be done to reduce wasted time and drive towards the 16 minute timeframe for the best outcomes for treatment for a particular ischemic patients. In a stroke 1.9 million [Indiscernible] are lost per minute. Stroke victims was an average of one to point to -- 1.2 billion neurons per stroke.

In establishing a standard of care it was back in 2000 that the brain attacked coalition made randomization based on clinical trials and observational studies that suggested there were several elements of a stroke center that would improve patient care. Here are listed what they believe were the key elements of a primary stroke center. It was important to have an acute stroke team. Those members specifically trained to understand and deal with the issues that were necessary in that 60 minute time frame. To have dedicated stroke units where there were trained professionals that understood outside of the immediate acute stroke period what would be important in monitoring the patient particularly ones receiving TPA. To be guided by written care protocols

and have integrated emergency response system. The availability of CD scans on a 24/7 basis. There are time targets on Windows scans should be taken. Rapid laboratory testing. Administrative support. Strong leadership with champion both in terms of stroke medical director and stroke coordinator, and emphasizing continuing education.

The main goals of designation was to monitor the care delivered to stroke patients within this system of care. Improve the quality of care and move patients through the initial acute care phase in a timely fashion. Both prehospital assessment and care with EMS and in the emergency room. Ensure that those who care for the patient while they remain at the hospital are trained to execute that proper care.

These are the requirements for stroke designation in New York State. They are based on the brain attacked coalition guidelines and recommendations. One I would like to emphasize is this is a voluntary program and it's not based in regulation or statute. It is based on guidelines. It's been in place since 2004 and 2005 and opened up to the entire state. It emphasizes the need to have certain things in place on a 24/7 basis that keep the focus on the patient and update educational requirements for staff so that they keep abreast of the latest research to make sure that care for patients is in keeping with the guidelines. On this slide, I would like to emphasize the quality assurance and data peace. Going back to what I said in the opening that the importance of data collection. We are fortunate that the majority of hospitals that are designated in New York are entering their data into the get with the guidelines systems. It's an easy system to use. Promoted by the American Heart Association. It allows hospitals to review their own data in an easy way. It generates reports in a way that you can target improvement. There are performance measures and time targets that are within the program that help you to monitor your self against the state and against the nation because it is a national program. Here I am emphasizing the time targets. We talked about the 60 minute window which more recently actually there is a move to get those times down even further. There are several initials -- initiatives to help hospitals do that. The impact of TPA clotbusting medication actually works best when it is given as close as possible to the time of the symptom onset. The inclusion and exclusion criteria for that drag requires or FDA approval of the three-hour window. We are looking at within two hours of symptom onset it should be tried to be given as close in time as possible to that onset time. Although there are uses that allow it to be [Indiscernible] to the 4.5 our window. Some hospitals may be getting it into that greater window of time but the best outcomes are for when it's given at the earlier time.

Here are the performance measures. As I said if using the get with the guidelines system, these are in some ways tailored specifically to New York. There are a number of measures that are part of what I will later talk about, the Coverdale quality measures. There are CMS for measures that many of you in the quality improvement part of the hospital might be most familiar with. The core measures. We work with our stroke advisory group to have included some additional measures that we believe help monitor how the patient is seen on admission and what their functionality is when they are discharged from the hospital as a measure of performance while the patient is in that hospital stay. I want to emphasize the modified rank and discharge because previously we had collected the NIH stroke scale on discharge as a way to look at admission and discharge that modified rank and -- ranking became the national measure. Some of you might be familiar with modified rank being used as a scale of functionality post discharge. And it has been

validated within the hospitals stay as well. But certainly modified rank and after discharge particularly at 90 days is something to follow as well.

This seems to be a busy slide that I wanted to give you an idea of how the measures for the hospitals in New York play out. What I'm emphasizing here is that there are a number of measures where some hospitals are at 100% compliance and that is certainly noteworthy. There are others where within the 80% compliance would certainly be impressive. What we are looking at is if you are a hospital that is in the last them -- less than optimal range for that particular measure most hospitals are doing extremely well. It would cause you to believe that there is something you can do to be better. It may be simply a data quality issue and certainly that is something you should be looking at fixing. If you are doing something but it's not documented correctly you certainly don't want that to hold you up from being in compliance. It may actually be a system problem that you need to work on. We will hopefully help you through this process and see how you can help target areas for improvement.

Here is another representation of that particular performance measures that are out that 100% compliance and smoking cessation appears to be one which most hospitals are doing the best in.

Here is an article from JAMA from 2011. The benefits of designation. Doctor [Indiscernible] had reviewed New York State data looking at spark information and found that hospitals that were designated did do better on stroke mortality and also had increased TPA administration leading to better outcomes which we would like to say is attributed to the system of care approach that designation requires.

In New York I applaud all of you who are so dedicated to the work that you do. We are never satisfied with just being good enough. We are always striving to do better. That is represented by this additional quality improvement initiative that many of the hospitals were happy to join the department in. It is the Paul Coverdale national acute stroke registry. The mission is to measure the -- measure, track and improve quality of care and access to care for stroke patients from onset of stroke symptoms through rehabilitation and recovery. Eliminate disparities and support development of stroke systems of care. In this particular webinar, I'm emphasizing improving access to rehabilitation and opportunities for recovery after stroke. Hopefully as part of this system we are reaching out beyond the walls of the hospital to the community to those of you who are providing care for the stroke patient as they recover from the acute episode.

To give a little history of the registry, in 2001 Congress from the state of Georgia did suffer a stroke and die and the legislature decided to charge CDC with developing a state-based registry system that measured and tracked stroke care. It was named in his honor and it is still going strong today. The original hospitals that were funded during that initial stage were Georgia, Illinois, Massachusetts and North Carolina. It was a three-year funding period. In 2007 there was an additional five years. In 2012 is when New York joined 10 other states to become part of this national quality improvement and Registry Program. Here are the states.

We were funded for the acute care episode but there are additional opportunities for finding both in the prehospital and post hospital care. We hope to apply for the additional pieces of this event in the next year.

The overall goal of the New York State program are to strengthen and expand existing quality improvement program and the designation program at, meet certain CDC performance standards related to data quality and data quality collection assurance and partnership, and develop and implement and evaluate a focus the queue I initiative that requires 10% improvement in selected indicated during in-hospital care.

Earlier I mentioned that we work with a stroke position advisory group who are our leadership team for the specific Coverdale project. We met with them and they helped us to select the focus measures that through the Coverdale program we would work with a small cohort of hospitals for these specific 10% improvement project. There was one time target and for performance measures. TPA is the miracle drug for the ischemic patients. Certain patients. There are clearly inclusion and exclusion criteria for when that particular treatment is appropriate. It has been demonstrated to improve outcome focusing on this measurable to have the TBA given within the 60 minutes or less from their arrival at the hospital. As a performance measure to get patients to understand the importance of calling 911 right away so that within the two hours of symptom onset they can be treated during that golden hour in the hospital. Screening and improving stroke education were also selected. The way we chose these measures with meeting with that group but focusing not only on those performance measures where there clearly was a need to improve but it wasn't just that Doctor. -- That factor. We wanted to choose measures where there were known or strategies for improving stroke care. Which measures reflect aspects of care that have the greatest impact on stroke and outcomes but are also and areas -- in areas where CMS and other national quality bodies are encouraging hospital improvements. So preventing complication, readmission, disability, mortality and other areas which we are focusing on. What we did in this past year during the Coverdale project was to engage in a learning collaborative. We hosted for learning sessions working for the two hospital associations and here is a list of the webinars that we held that I believe can still be found on the hospital association sites. There were also biweekly conference calls and monthly tracking reports which I would like to say is a way in which you can form a quality improvement program for other areas in your hospital where the team approach is emphasized and where you use and in our case we were using IH I tracking reports to focus on a specific intervention and identify who on the team would be the lead and have other team members also be responsible so it's not left to just one person but emphasize the team approach. By tacking and seeing improvement at the 30 and 60 and 90 day mark.

I would like to acknowledge those who are parts this initiative and those in red. Here you see it across the state of those who will be added to our list of participating hospitals moving forward and this last year. Now let's talk about stroke in the post hospital discharge days. I emphasize the importance of discharge planning. There is usually one patient who has many problems that no one solution might fit. Those of you who are discharged planners and those of you who on admission to the various other settings work to identify that only what the condition of the patient is and what medical care is needed but what the social supports our to help the patient, to their optimum functional status. If those other supports are not there, they are less likely to sustain whatever the improvement is that you are trying to make in those early stages. I wanted to emphasize the importance of communication. I will talk about that later. Here we go. Communication exchange. We all know that errors can occur in handoff. With electronic medical records now that might be a very good way to make sure that all the information is there

that is most helpful at the time of the handoff. I'm wanting to talk to you particularly about a stroke patient where if the patient is coming from the nursing home setting, you are providing documentation of medication and how they are at the moment that the stroke may have occurred. But the ED has to also know what the original function status is of the patient so that they are not missing that patient who might be coming from the nursing home who is demented or has Alzheimer's or appears not to be answering questions. If they are thinking in the ED thinking that is the normal state of the percent they might mess that this is something different about this patient that it's not just their baseline. It is a stroke. And we do see when we are reviewing our annual reviews of stroke patients that in the elderly population particularly the stroke is missed because it is mimicking some other condition. I hope through this presentation you recognize the need to alert the hospital that this is different for this patient. When you are receiving a patient who has been not your nursing home patient that has a stroke and is going to you for that subacute rehab base than what you are saying looking at the modified rank on this charge is maybe an improvement from how they enter the hospital with a stroke but what you're going to focus on is where were they before the stroke happened and that is where stroke rehab and recovery are going to take you. A key piece of information that the hospital needs is last known well. In order to give TBA you need to know when the symptom onset occurred because there is that short timeframe. One of the indicators for TBA is that the patient wakes up from sleep with the condition and you can't really attribute it to win it exactly occurred. It seemed to have occurred at the time they were last known well which is the time they went to sleep. If there are any medications particularly Coumadin that the patient is on that that is significant particularly for TPA.

Discharge planning from the hospital -- how can hospitals help us provide information to the next setting nursing homes or in the home with home care. That would allow those who care for the patient post discharge to have as much information as possible in that assessment and planning stage. Hospitals should make sure that what they are documenting for the next setting is an individualized discharge plan that really addresses the patient's level of care needs. Medical -- medically necessary care varies by stroke severity and may impact where the patient is discharged to. That there be active rehab. Often recovering from a stroke the patient is in a weakened state and may not be able to do active rehab but should be encouraged to do as much as possible because studies have shown that the quicker they get back up into doing rehab, the better the outcome. Education is the patient and family secondary stroke prevention. There is certainly materials that the American Heart Association has on their website that might help to focus the patient and caregivers on preventing us -- secondary stroke. Hopefully nursing home staff know the signs and symptoms of strokes and for emphasizing the need for speed and dialing 911 upon recognition of those stroke symptoms. This is most important. In the nursing home train your staff with the very simple past test that are school children are being taught to recognize the signs. Those patients who arrive by ambulance are -- have the best chance as well of triggering and activating the stroke team in the hospital and thereby improving long-term stroke outcomes.

Some complications after stroke. That relate to many of the things that in the post hospital setting you are already paying attention to. These are listed here. You should know that stroke patients might be particularly at risk for these complications.

Finally I talked about the modified rank and scale that is performed at discharge. There are certification requirements for being able to perform this review. Physical therapists are generally the ones who are most familiar with this scale but certainly others can be trained as well to perform this scale. So here we have what the percentages are that both TIA and strokes are at risk for. Another occurrence both at 30 days and one year and it carries forward even at the five-year mark. What the possibility of having another stroke our. This is from an earlier report but they are the same percentages as of 2006 as well.

Here are some secondary prevention guidelines that you might like to think about in all settings to make sure that patients who have either had a stroke or or at risk for stroke that there are modifiable behaviors that can reduce the risk of stroke. It is the ones that many are familiar with because they are the same issues that address other conditions as well. Screening stroke and TIA survivors for diabetes and obesity because those are conditions that put someone more at risk of stroke. Screening with sleep apnea. Nutritional assessment. Long-term monitoring for a failed -- for a ask. Use of new oral anticoagulants in specific situations. It may be better for noncompliant patients.

We have gone over this communication point emphasizing again the importance of good information at the handoff period.

Now Chris, I will turn it back over to you if there are any questions. I don't see any in the chat box.

Thank you, Anna.

If you have a question at this time please press star than one on your touchtone telephone.

There is a question what we're waiting of the chat box. Is there a coalition development to help support facility involvement in establishing and developing programs post acutely that utilize the Coverdale protocol and support the partnership with the Coverdale DAR hospital.

This is a great question. I am happy to have it be asked because this is what we are trying to develop in the next year. As I stated, we warrant specifically funded through the CDC grant or the post hospital stay but based on my involvement in the past with nursing homes and with discharge planning I am looking to develop a partnership through either the nursing home association or with IPRO to look to help those who would like to follow along with what we are doing in tracking those performance measures because they certainly help patients beyond stroke. What we have done through the learning collaborative in this past year -- we will have to modify a little because it was specifically targeted to having a quality advisor work with our program. Kate rose and I the project coordinator will be trying to reach out to more settings to work with our hospitals in having a forum where we can discuss these issues and develop best practices. That might be a long-winded answer to say it is not in place right now but it is our hope within the next year to welcome nursing homes and home care agencies to the table as we work through these issues. And strategies.

Thank you. Are there any questions?

No questions at this time.

I neglected to mention that when stroke designation was developed there was a pilot period in 2002-2004 that IPRO was actively engaged in. There were 19 hospitals in the Brooklyn and Queens area that were part of a pilot that were dedicated to that 60 minute time frame and the system of care approach. So it was looking at the brain attack coalition recommendations and seeing if it really could work in New York. During that pilot phase data was collected. That was analyzed and evaluated by IPRO which led to a determination focusing on those time targets. And having a system in the hospital where all those team members imaging labs and a stroke unit really did improve outcomes for those patients. I want to acknowledge the role that IPRO played in this early days that led to the statewide designation program.

Our partnership with IPRO goes way back and I certainly value the work that Sarah and Chris have done on transitions of care and welcoming me particularly back to do this transitions work. I look forward to working with all of you on making what has been developed and what we've learned in this past year and the value of the learning collaborative and taking that further to include the post hospital settings.

I want to comment to say that certainly the care of stroke patients has cross setting implications. The emphasis on communication exchange that you pointed out is paramount. A stroke -- a person who has a stroke really could benefit -- all people could benefit from postacute discharge planning with home help or skilled nursing facility. The recuperation period from a stroke is long. Patients can plateau during that we have days and then start getting better. And then changing get better and then plateau again. It really is a long process and the importance of the communication exchange between the providers is really stressed and including the physicians.

Under resources that are available to those who might be interested, I think there was a question about what are the designation requirements on the department website. There is the application for hospitals to become stroke centers that others can review to see further detail. Of what is required. We also are instituting and initiative -- and initiative that emphasizes the importance of the prehospital care working with the DMS. In the early days there was DMS protocol developed in 2005 that is still in existence that requires that certain information be collected and communicated to the ED that really what lead to that reduced time to treatment. EMS certainly does a great job for many conditions like, and hard seems to be those that have the most focus. Stroke -- there may not be the numbers of patients that they bring to hospitals with those conditions but I would like to elevate the recognition of stroke where time is so significant and if EMS communicates that information prior to arriving on the scene, clear information and emphasizing that it's a stroke to activate the team is certainly helpful. We will be working with our EMS partners to educate them of the importance of clear communication and protocol exists. Many times in implementing a protocol things are done quickly and something left off or not documented doesn't allow us to improve if we can't look at the data and recognize whether something was done or not. Emphasizing documentation and we hear that all the time the importance of that. Those who are on the line that might work in the ED I want to applaud you for the improved relations that you tried to have with EMS and give them the feedback that they

need to let them know the importance of their roles in the overall outcome for the stroke patient and what happens prior to arrival is equally important.

Thank you.

There are other QIOs that have been part of other states covered -- Coverdale and initiative so I look forward to -- we look forward to working with you in the development of your coalition. And bringing in cross setting components.

Sounds wonderful.

Thank you for that offer and this opportunity because the more the merrier. We have a lot of people to thank for what we've achieved thus far. I am well aware of the great work that you have achieved in the transitions of care work that you have done so bringing you into this particular project would be wonderful. I welcome all to visit the departments website for more information. To feel free to call me as well. I'm happy to talk to you. We love this program and we would love to work with many more of you. Thank you, Chris.

Everyone that registered for this presentation also was sent an evaluation form so we encourage you to fill out that evaluation form and facts that back because the feedback that we get on this forms works to improve these presentations as well as provide guidance on what statewide the communities would like to hear about. With that I would like to thank Anna for her presentation answer program team and everyone please have a nice afternoon.

Thank you.

Thank you for participating. You may all disconnect. Everyone have a great day.

[Event Concluded]