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Summary of the Rhode Island Stroke Task Force Report to the General Assembly

Stroke is the leading cause of disability and the #3 cause of death in the United States. This year in Rhode Island (RI), more than 3,000 people will fall victim to a potentially treatable stroke and more than 600 Rhode Islanders will die from related stroke-related complications. This tragic loss of life and viability creates an annual financial burden for our state of over $312 million in medical costs, supportive care, and lost productivity.

Recognizing the grave importance of stroke care for Rhode Island's citizens, the General Assembly enacted An Act Relating to Health and Safety – Stroke Task Force (Chapter 544 2004-§2905 Substitute A) on July 9, 2004. This legislation charged the Stroke Task Force with ensuring that "state-of-the-art information on stroke education, prevention and treatment is available to healthcare providers and patients." The General Assembly defined fourteen points of inquiry for Task Force review and requested an interim report followed by final recommendations. As called for by the General Assembly, Rhode Island's Stroke Task Force represents a cross-section of medical, EMS, and lay members involved in stroke care. The Stroke Task Force chairman selected these members with input from RI Department of Health (RIDOH) and American Heart Association (AHA) leadership.

The Task Force has met regularly and has examined present stroke care practices in Rhode Island in the context of contemporary national recommendations from leading medical organizations and societies. Additionally, RI Stroke Task Force representatives have also participated in the Northeast Cerebrovascular Consortium (NECC), an ongoing collaboration of stroke care specialists sharing practice experiences with the goal of improving stroke care throughout the Northeast region.

Rhode Island Stroke System of Care

Submitted by: Rhode Island Stroke Task Force, Rhode Island Department of Health, and American Heart Association

Stroke Task Force Roster

(per legislation)

FOUR PHYSICIANS ACTIVELY INVOLVED IN STROKE CARE, WITH AT LEAST ONE FROM THE FOLLOWING FIELDS: NEUROLOGY, NUERORADIOLOGY, NEUROSURGERY, AND EMERGENCY CARE

ONE REGISTERED PROFESSIONAL NURSE OR NURSE PRACTITIONER ACTIVELY INVOLVED IN STROKE CARE

ONE PHYSICIAN'S ASSISTANT ACTIVELY INVOLVED IN STROKE CARE

ONE HOSPITAL ADMINISTRATOR OR DESIGNEE FROM EACH HOSPITAL THAT IS DESIGNATED AS A COMPREHENSIVE STROKE TREATMENT CENTER BY THE NATIONAL JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

ONE REPRESENTATIVE FROM THE EMS AMBULANCE SERVICE ADVISORY BOARD

ONE REPRESENTATIVE FROM THE PUBLIC HEALTH FIELD ACTIVELY INVOLVED IN PUBLIC HEALTH EDUCATION ON STROKE APPOINTED BY THE DIRECTOR

ONE REPRESENTATIVE FROM A STROKE REHABILITATION FACILITY APPOINTED BY THE DIRECTOR

ONE STROKE SURVIVOR OR CAREGIVER APPOINTED BY THE DIRECTOR

ONE REPRESENTATIVE FROM THE AMERICAN STROKE ASSOCIATION

ONE REPRESENTATIVE FROM RHODE ISLAND QUALITY PARTNERS OR STATE-RECOGNIZED QUALITY IMPROVEMENT ORGANIZATION (QIO)

ONE REPRESENTATIVE FROM A MINORITY HEALTH ORGANIZATION INVOLVED IN STROKE CARE

Medical science has seen dramatic advances in stroke care and Rhode Island must keep up by establishing a statewide integrated and coordinated response to stroke care. In neighboring states, as well as nationally, systems of stroke care have been adopted and dramatic improvements in care have taken place. The Rhode Island Stroke Task Force feels confidant that our state is poised to implement significant advances in stroke care. We possess the medical knowledge, resources and motivation and our geographic size places us in a unique position to have one of the most successful systems for saving lives from stroke in the US.

Initial Findings

1. Hospital "Stroke Centers" provide superior stroke care and outcomes for acute stroke victims.
2. Acute Stroke Care is most effective when part of a statewide "Stroke System" linking Stroke Centers with local hospitals.
3. Only 1 in 11 of RI's acute care hospitals is a nationally certified Stroke Center. Two more are in the process of certification and provide quality stroke care.
4. Only 1 in 5 Acute Rehabilitation Centers is CARF-accredited (Commission on Accreditation of Rehabilitation Facilities)
5. Approximately half of RI stroke victims do not receive Acute Stroke Care.
6. RI's EMS system lacks a coordinated plan to deliver acute stroke patients to the most appropriate hospital; stroke victims lose valuable time and potentially miss the window of opportunity to treat the evolving stroke.
7. Diminishing reimbursement from third party payers combined with shorter lengths of stay removes patients from the optimal environment for initial treatment, secondary prevention and rehabilitation.

Obstacles

1. Hospitals may be reluctant to give up patients for transfer to designated Stroke Centers out of concern for loss of revenue and local physician follow-up.
2. Limited resources and a current policy of not accrediting hospitals compromises the ability to facilitate a statewide "Stroke System".
3. Rhode Island's statewide EMS system is under-funded and lacks sufficient statewide coordination, posing significant challenges for implementing a new coordinated system of pre-hospital stroke care.
4. External funding for statewide stroke system oversight will likely be difficult to come by and even more difficult to sustain.

Recommendations

Rhode Island does not currently have an integrated statewide system of stroke care and rehabilitation. This reduces the likelihood of positive outcomes for stroke victims and creates an ever-increasing social and financial burden for the State. As a result of the analysis conducted by the Stroke Task Force we make the following observations and recommendations:

1. A statewide Stroke System of Care should be established with oversight and coordination by the Rhode Island Department of Health and its Stroke Task Force. All components of this system should adopt and follow standardized stroke care protocols that are consistent with current nationally accepted guidelines for screening, transferring, treating, and rehabilitating all patients with a history or suspected history of stroke or transient ischemic events.
2. Rhode Island's stroke care system should be part of a broader statewide plan to improve prevention and treatment of all cardiovascular disease.
3. Consistency of stroke care among all of Rhode Island's hospitals should be accomplished through greater oversight by the Department of Health. This should include a process for designation of "Primary Stroke Centers" by the Department of Health, though actual accreditation might be accomplished through an outside organization such as the Joint Commission.
4. The Department of Health should establish and maintain a public education campaign designed to make the general public sufficiently aware of stroke warning signs, risk factors and the need for early access to the emergency medical system for suspected stroke patients.
5. The Department of Health should re-establish greater central coordination and quality control for the statewide EMS system in order to ensure EMS providers deliver the quality of care needed by acute stroke victims. The State Legislature will need to allocate new funding and resources to re-invigorate the state EMS system.
6. The State's pre-hospital Stroke Protocol should be updated to reflect recent advances in stroke triage/care and to ensure EMS providers transport suspected stroke patients to designated "Primary Stroke Centers" (see #3 above.)
7. The state's fragmented approach to dispatching emergency services should be better coordinated, particularly with respect to adopting national standards for training and credentialing emergency medical dispatch personnel. All EMS dispatchers should be trained on stroke-specific guidance; quality-assurance processes should be in place to ensure compliance.
8. Data collection and analysis mechanisms should be established that allow the Department of Health to monitor patient outcomes and ensure compliance with accepted treatment guidelines. Data should be collected and integrated from all components of the Stroke System of Care with particular attention paid to pre-hospital care and access to designated "Primary Stroke Centers." This data collection and management process should reflect current nationally accepted standards.
9. Post-stroke rehabilitative care should be an integral part of the state's stroke care system. A standardized screening and assessment tool should be employed to measure functional status during post-stroke rehabilitative care.
10. The Stroke System of Care should include continual processes to identify and mitigate barriers that prevent stroke patients from accessing and receiving appropriate, definitive care.

Achieving this goal will require the commitment of many players in the state's healthcare community. Of these, the Rhode Island Department of Health's key leadership and oversight role will be critical to develop this initiative, with the support of the American Stroke Association, a division of the American Heart Association, and the continued efforts of the Rhode Island Stroke Task Force and other committed groups.

Progress

The RI Stroke Task Force was established, Chair identified/recruited, and membership convened.

The RI Stroke Task Force completed a statewide survey of stroke care services and analyzed the results/data.

The RI Stroke Task Force report on stroke care recommendations for Rhode Island was approved by the Rhode Island Department of Health Director's Office and submitted to the RI General Assembly.

Rhode Island received Heart Disease and Stroke Prevention Funding from the Center for Disease Control and Prevention (CDC).

A 1st draft of the RI Heart Disease & Stroke Prevention State Plan is drafted that includes stroke.

The F.A.S.T. campaign (stroke identification) was implemented statewide.

The 1st Annual Heart Disease and Stroke Prevention Program Summit was held.

Douglas DeOrchis, MD received the Rhode Island Health Community Partnership Award recognizing his efforts to improve stroke care in Rhode Island.

A succeeding Stroke Task Force Chair was identified and recruited.

Future

The RI Stroke Task Force will work with the RI Department of Health to implement the recommendations for an improved and integrated statewide system of stroke care as outlined in the Stroke Task Force report.

Improving the stroke system of care will be included in the RI Heart Disease and Stroke Prevention State Plan.

The RI Department of Health will create a process for the designation of "Primary Stroke Centers" as accredited by an outside organization such as the Joint Commission.

The RI Department of Health will conduct an annual messaging platform to make the general public sufficiently aware of stroke warning signs, risk factors, and the need for early access to emergency medical system for suspected stroke patients.

The RI Stroke Task Force will advise the Rhode Island General Assembly on the allocation of funding and resources to the state EMS system.

The State's pre-hospital care protocol will be updated to reflect recent advances in stroke triage/care and ensure EMS providers transport suspected stroke patients to designated "Primary Stroke Centers".

The State's fragmented approach to dispatching emergency services will be better coordinated by adopting national standards for training and credentialing emergency medical dispatch personnel.

A standardized stroke discharge packet will be created and adopted statewide that educates patients and families on secondary prevention and rehabilitation.

The Rhode Island Stroke Task Force will continue oversight of the Stroke System of Care and will identify and mitigate barriers that arise.