# Health Promotion Community Education


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# Current Work Group Members

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- Florence Chukwuneke, RN. BS, Clinician, JFK Med. Ctr., NJ
- Rochele Clark, BS, RN, Dir. Clinical Svcs., REACH Call, NY
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- Johanna Demirjian, NP, CNRN, Stroke Coord., RWJU Hosp., NJ
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- Tiana Howland, RN, Health Care Coord., Healthy Heart Prog., NY
- Megan Mazza, MPH, CPHQ Dir. QII, AHA/ASA, MA
- Angela McCall-Brown,  RN, MSN, Stroke Prog. Coord., Overlook Hosp., NJ
- Marie McCune, BS, RN, Stroke Nurse Coord., Mt. Auburn Hosp., MA
- Jennifer Nascimento, BS, RN, St. Vincent’s Med. Ctr., CT
- Marianne Stepanian, RN, Cardiac Proj. Coord., Lifespan Comm. Health, RI
- Rita Zanichkowsky, Dir. State Health Alliances, AHA/ASA, ME

# Health Promotion Community Education

## Regional Recommendations:

1. Hospital or community based prevention messaging should continue to be a required activity in any stroke center designation program within the NECC region, and specific evaluation components should be developed and implemented to measure effectiveness.

2. Stroke community education programs should be concept tested and an evaluation plan should be in place prior to broad dissemination. Resources should be dedicated to annually monitor the impact of such interventions, with a special emphasis on high risk populations and/or those with documented disparities in care.

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3. Local prevention messaging should be supplemented by NECC regional prevention messaging utilizing an appropriate combination of earned and paid media as well as Public Service Advertisements and organized grass roots initiatives leveraging materials across the region and purchasing at the regional level.

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4. NECC State Legislatures should dedicate revenues to assist state public health agencies in developing media campaigns that raise awareness of stroke risk, the preventable nature of stroke, stroke warning signs, the treatable nature of stroke, the importance of activation the emergency medical system when a stroke is suspected, and the need for follow-up medical care after hospital discharge.

5. Advocacy organizations within the NECC region should continue to pursue state and federal public policy changes that focus on reducing stroke risk factors including, but not limited to; tobacco use, physical inactivity, hypertension, and obesity.

# 2008 Summit Identified Priorities

## NECC Recommendations #s2 - 3:

***Health Promotion/Community Education Recommendation #2*:**

Stroke community education programs should be concept tested and an evaluation plan should be in place prior to broad dissemination.

Resources should be dedicated to annually monitor the impact of such interventions, with a special emphasis on high risk populations and/or those with documented disparities in care.

***Health Promotion/Community Engagement Recommendation #3*:**

Local prevention messaging should be supplemented by NECC regional prevention messaging utilizing an appropriate combination of earned and paid media as well as Public Service Advertisements and organized grass roots initiatives leveraging materials across the region and purchasing at the regional level.

# 2009 Summit Identified Priorities

- Decrease the level of “missingness” and over-use of “unknown” in the capture of stroke symptom onset time
- Collect information on the types, duration and audience for community-based programs/PSAs that focus on stroke as an emergency

# Workgroup Goals

- Decrease the average time from stroke symptom onset to patient/family activation of 911.
- Increase public awareness on the importance of early stroke recognition, emphasizing the element of time; the urgency of knowing when symptoms began, activating 911 quickly, and accurately measuring time.

# Planned Intervention

- Enhance public education on the short window of time in stroke recognition and treatment, coupled with an increase in the volume of accurate (informed) time span measurement between the beginning of symptoms and first medical contact.

# Outcomes

- Increased stroke symptom recognition in communities
- Heightened awareness of the criticality of the time component and knowing what time symptoms began
- The development of a “time algorithm” to measure symptom onset to increase accurate data capture
- An increase in the percentage of time from symptom onset that is informed vs. estimated by X% over X years (the percentage and years can vary by NECC market)

# Methodology for Measurement of Outcomes:

Potential Data Capture Points:

- The "witnessed" time as captured in reporting
- Estimated or actual "last known well" time
- EMD and EMS run records as well as GWTG data points
- Comparison of baseline vs. post-intervention time measures: from last known well to 911 access

# Tools Available:

- GiveMe5, Suddens, FAST or other evidence-based public education
- GWTG data collection points to fill in the “missingness” factor
- Existing partnerships (ex: DOH, AHA, Stroke Committees, health systems, EMS, CDC etc.) and existing platforms for public awareness
- PSAs, and Stroke Programs within the health systems
- NECC web site as a repository for shared information
- EMS run reports to capture symptom onset time
- Discharge education for patients to avoid additional events

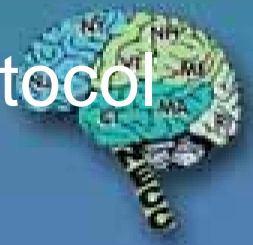
# Current Project Status

Current Status:

- 16 member Writing Group convened to define project details and determine method of capturing current status of symptom onset times
- Criteria for target hospitals defined
- Survey tool developed and disseminated to target hospitals
- Data from responding hospitals analyzed and formatted for NECC presentation

# Pilot Survey Highlights

- 25 GWTG-Stroke Hospitals Responded
  - CT (5), MA (5), ME (3), NJ (7), NY (4), RI (1)
  - 65% of individual responders - "Stroke Coordinators"
- Medical Record is most common extraction source for patient symptom onset (56%)
- Half of respondents stated that witness contact info is consistently documented - most stated it is documented in medical record
- Most sites (64%) do not have a written protocol for establishing stroke symptom onset

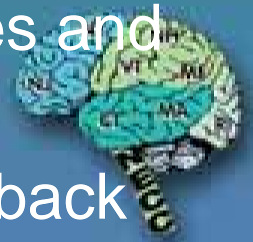


# Highlights Continued

- Considerable variation among sites' process for establishing accurate symptom onset time:
  - Confirmation with primary source (patient or witness)
  - Comparison between two or more sources
  - Neurologist validation
- Witness, Patient and EMS Team were most often probed sources when onset time initially thought to be "unknown"
- Majority stop probing for onset time if stroke is known to have occurred >6 hours prior

# Highlights Continued

- Considerable variation - utilization of “unknown” as symptom onset time:
  - Patient found “down” with no witness, or no witness to last known well within several hours or days
  - Stroke occurred during sleep
  - Vague history with reoccurring symptoms
- Stroke Team/Neurology ultimately responsible for validation of symptom onset time – 68%
- EMS Linkage
  - Wide variation in number of transporting services and consistent pre-hospital notification
  - 80% provide EMS education; 40% provide feedback



# Next Steps…

Next Steps:

- Analyze complete data set when all responses captured
- Refine survey and process for a broader, randomized study across hospitals in the NECC region
- Define process to identify and collect forms of consumer messaging that emphasize stroke as an emergency

# Feedback and Discussion

# How can you get involved?

- Participate in the Work Group
- Participate in the Writing Group
- Work with NECC to include your facility in the ongoing project

# Open Discussion

- Efforts Across the Region
- Success Across the Region
- Barriers Across the Region
- Suggested methods of capturing community education messaging
- Suggested methods of outreach to change behavior when stroke symptoms are recognized

# What Resources or Tools do you need?

- Tools that can be shared across NECC
- Develop a list of needed tools
- Develop a wish list of items to be included on the NECC website
- Identify interested participants to help collect the tools for website posting

# Thank You!