

Provincial Stroke Steering Committee Meeting

Location: Heart and Stroke Foundation of BC & Yukon Boardroom

Date & Time: December 8, 2009

Present: Barbara Carver; Mark Collison (Co-Chair); Michelle de Moor; Devin Harris; Kevin Harrison; Kennely Ho; Lisa Hoefler; Allan Holmes; Dean Johnston; Hans Krueger; Diane Layton; Diego Marchese; Andrew Penn; Jacquie Pettersen; Doug Querns; Prathap Raghavan; Tim Readman; Lori Seeley; Mary Stambulic; Rita Sweeny; Philip Teal; Valerie Tregillus (Co-Chair); Karen Wagner and Jennifer Yao

By Audio: Darlene Arsenault; Shawn McCann; Leighanne Mackenzie

Absent: David Babiuk; Rohini Charan; Todd Collier; Robert Crisp; and Leigh Ann Seller.

Welcome & Call to Order – Mark Collison (1:00 – 1:05)

Introductions, Agenda, and Housekeeping – Mark Collison (1:05 – 1:10)

Administrative Update – Mark Collison & Valerie Tregillus (1:10 – 1:15)

- Minutes from the June 19th, 2008 Steering Committee meeting approved.
- Financial update included overview of funding received to date of \$3.9 million. Year-to-date expenditures totaled \$2,634,528 or 68 per cent of total budget with \$1,295,914 remaining.
- There are forecasted budget pressures of \$30,442 that will be offset by additional funding expected from the province.
- On September 22, 2009, a meeting was held with the Minister and Deputy Minister of Health Services. Presentation and discussion illustrated some of the gaps in care for stroke, what has been achieved and what needs to change as well as funding required.
- A very receptive meeting, there was a positive response from the both the DM and the Minister.
- On November 13, 2009, another presentation was made to about the 40 MLAs at Heart and Stroke's annual MLA breakfast and wellness fair on the BC Stroke Strategy.

Agenda Topic: Priority Project Updates – Telestroke: Diane Layton (1:15 – 1:35)

Presentation content reviewed within the meeting; main points of discussion:

- Telestroke program is coming up to its last year guided by efforts from the BC Telestroke Team and health authority partners at VIHA, FH and VCH.
- VIHA prototype has been established successfully. On July 8th 2009, the first videoconferenced Telestroke consultation was initiated by Dr. Penn. Working from the Victoria General Hospital, Dr. Penn diagnosed and prescribed treatment for a patient at Cowichan District Hospital, one of the two referring sites. Since then, 14 calls have been directed through *bcbedline*. Of these, 13 consults were conducted either by videoconferencing or by telephone, and tPA was administered to six patients.
- *bcbedline* was introduced for the VIHA prototype (historically, referrals were through a contact list and on-call schedule posted on the VIHA intranet site). To date, *bcbedline* referral management model is working reasonably well at VIHA.
- Patient response and satisfaction with the Telestroke consultation has been very positive.
- An Alternative Points of Care Task Group has been charged by the VIHA Telestroke Steering Committee to investigate ways for neurologists to access videoconferencing technology for Telestroke consultations from other points of care, such as their office or home. Their recommendations are expected in winter 2010.
- In July 2009, the BC Telestroke Team together with leads from the respective health authorities have initiated phase 1 of the prototype project at FH and VCH.
- After a two-month delay, FH and VCH found a solution for enabling videoconferencing connectivity between their networks. While the new e-Health Network Gateway (eNG) is in place to support the bandwidth requirements for videoconferencing, it does not address challenges of crossing firewalls. BCTelestroke has added a technical advisor to the team to facilitate a provincially scalable and sustainable technology solution for the prototype project.
- Planning two referring sites at Peach Arch and Chilliwack and one consulting site at VGH.
- Estimate 11 to 19 potential tPA patients at these two hospitals annually.
- Privacy Impact Assessment draft has been jointly developed, and is in the process of refinement.
- Goal of a late-February “go live” date at Chilliwack District Hospital first and then Peace Arch Hospital later.

- Limited evaluation data is expected from this aspect of the Prototype due to delays in start-up.
- *bcbedline* provides a key referral management interface for Vancouver-based consultants and referring physicians. *bcbedline* will continue to play a role in referral management for Telestroke and may also support digital imaging transfer from FH to VCH in the event that the Diagnostic Imaging Viewer solution does not meet its projected implementation timelines. The DI Viewer is now up and running.

Agenda Topic: Priority Project Updates – Rapid Assessment TIA Grants: Andrew Penn (1:35– 2:10)

Presentation content reviewed within the meeting; main points of discussion:

- Implementation updates of each of the five health authority priority areas:
 1. *Interior* – two clinics have been opened in Kamloops and Cranbrook. For one patient, a follow-up call by the stroke nurse practitioner resulted in a change in case management for the patient, who was in an evolving stroke. Although the sample size is very small, latest survey shows a high level of patient satisfaction
 2. *Vancouver Island* – has also expanded hours at Victoria General and opened a new clinic in Campbell River. As a result, volumes in the VIHA clinics, which have historically seen approximately 1,200 patients per year, have increased by 40 per cent to over 1,700. Stroke nurse triage patients by phone in South Island. Intake in North Island up dramatically. Data collection linkage remains a problem. Latest survey shows a high level of patient satisfaction.
 3. *Vancouver Coastal* – problem with data collection still continuing as currently not centralized, unfunded and not resourced in the local clinic. No system in place to capture data at SPH. Hours of existing clinics at Vancouver General expanded and new clinic at St. Paul's. LGH has been working with family practice physicians to streamline TIA specialist referral links.
 4. *Northern Health* – distributed model a problem as neurological cover is sparse. Currently defining how referral and diagnostic imaging will work. Currently, management of most patients will take place in the ER, followed by Rita triaging patients to see an available neurologist. For now, with limited resources at hand, as much as a stand-alone TIA clinic is preferred, NHA's use of the ER as the "first TIA clinic," makes good use of equipment on hand. Working on ensuring that the primary care physician "stays in the loop." May need to reevaluate model as the public and family physicians become more familiar with symptoms causing increased demand on the ER.
 5. *Fraser Health* – 3 Rapid Access TIA clinics up and running; electronic systems in place; community-wide scheduling in place; referral forms created; staffing in place. Since opening in February 2009, have seen 1,100 patients and are on track to meeting its annual target of patients assessed of 1,400. Minister of Health Services visited the TIA clinics in which all three clinics were showcased. Minister was keenly interested in what can be done to increase public awareness and in innovative ways to promote prevention.

Discussion Points:

- ❖ Sustainability an issue given limited resources.
- ❖ As volume of patients seen increases, "data may get worse" as mimic rates will be higher.
- ❖ The proposed complex management fee for stroke patients provided to general practitioners needs to be better thought out.
- ❖ The option of an additional fee item for GPs to encourage urgent/acute care is under review by GPSC.
- ❖ While ER department as first point of contact for a stroke patient makes better use of resources on hand, particularly in rural areas, the Oxford trial in the UK shows that a seven-day a week, stand-alone TIA clinics is the most affordable.
- ❖ Under management of atrial fibrillation patients by GPs continues to be a problem.
- ❖ As the volume of TIA cases seen goes up, the ability to see patients within the 48-hour period varies with available clinic days.

Agenda Topic: Priority Project Updates – Measurement and Evaluation: Hans Krueger (2:10 – 2:25)

Presentation content reviewed within the meeting; main points of discussion:

- First year of the BC stroke strategy focused on measurement. Second year of the strategy will focus on evaluation.
- The world-class stroke registry is close to being signed off. Uses both hospital and physician billing data.
- Registry still requires a chart audit to test accuracy and validity. There is currently no funding for this audit.
- Ability to track incidence based on whether or not TIA is included. If TIA is included as part of ACVS, then the TIA becomes the 'first-ever' event, rather than the subsequent full stroke.

- Prevalence is based on each patient only being in one stroke category in a given year, even if they have had multiple stroke events. The patient is assigned to a stroke category based on a hierarchy from TIA to ischemic to hemorrhagic diagnoses.
- Work still required on defining an algorithm(s) for stroke recurrence.
- Can identify whether the event was identified via MSP as well as in hospital data.
- The group received an overview of the interim evaluation of the VIHA TIA rapid assessment program. Data shows that with enhanced funding for TIA rapid assessment clinics, there has been a 40 per cent increase in volume and a mimic rate of between 31 and 42 per cent.
- For FH, there have been 867 new patients (536 of which were diagnosed with either a stroke or TIA, which means about a 38 per cent mimic rate), 90 follow-up visits (9.4%). Time between event and appointment about 4.3 days with about 25 per cent of patients seen within 48 hours.
- Abstract will be submitted to the first annual international stroke congress in Quebec City in June 2010.
- To see what care was missing, can a cohort of patients be traced back through the registry or the rapid assessment units? If identified, may wish to recommend an “incentive” going forward.

Action Items:

- Follow-up requested on discharge disposition statistics for stroke patients-Where are they being discharged to, after how long and what should the target be to reduce direct long-term care admissions?
- Place item on MEWG agenda.

Agenda Topic: Priority Project Updates – Rehabilitation & Reintegration Presentation: Jennifer Yao (2:25 – 2:45)

Presentation content reviewed within the meeting; main points of discussion:

- The Rehabilitation and Reintegration working group was reconvened in November 2009 to develop a high-level service delivery framework to address gaps in care identified in September 2008. Committee membership is changing; working group meeting planned for late December.
- Three focus areas: development of a service delivery framework; establishing Telerehabilitation fees; promotion of stroke units.
- Telerehabilitation fee codes are being developed; BCSS Consultant will work with the Psychiatry Section towards endorsement of new codes.
- ACVS consensus document and the service delivery framework to be dovetailed (draft framework expected late December).
- The Canadian Stroke Strategy’s best practice resource guide for the development and implementation of stroke units (with contributions from Drs. Collier and Raghaven) has been released and is ready to be distributed to members. The document outlines national minimum standards for setting up stroke units and will be included in the 2010 version of Canadian Stroke Strategy Best Practices.
- Resource guide to be built into framework, as appropriate.

Action Item:

- As part of a directive from the Ministry of Health Services to health authorities, a provincial survey on publicly-funded (HA funded) and privately-funded (third party insurance) community rehabilitation services (PT, OT and SP) is currently being compiled to determine current state. Contact will be made with the ministry to see if data can be shared with the RRWG.
- Refer item to RRWG.

Agenda Topic: Other Updates – GPSC Stroke /TIA Guidelines: Mark Collison (2:45 – 2:50)

Presentation content reviewed within the meeting; main points of discussion:

- BC (GPAC) guidelines on stroke/TIA prevention and management was signed off by GPSC and released in September 2009.
- GPAC typically does not reinforce awareness and uptake of the guidelines by physicians.
- Opportunity to link the guidelines with BCSS and increase the likelihood of adoption into clinical practice.
- To reinforce awareness and uptake, a package was mailed out to 5,000 physicians across the province. Package included a cover letter from Mark and Valerie, a summary of the guideline, a sheet on TIA rapid assessment clinic locations in the province and a DVD on how to recognize, prevent and treat TIAs.
- A presentation has been developed by Dr. Warneboldt and Chelsea Patrick from the Ministry of Health Services, which will be presented by local neurologists in their respective regions.
- Working on accrediting the presentation by the College for both the regional presentations and the upcoming TeleLearning series in January 2010.

- Working on creating an accredited, web-based interactive e-learning module that includes clinical scenarios (a first for BC).

Agenda Topic: Other Updates – TeleLearning Series: Mary Stambulic (2:50 – 2:55)

Verbal Update:

- BCSS TeleLearning series was launched October 30, 2009 with Dr. Patty Lindsay on Canadian best practices guidelines for stroke care. There were 16 sites participating plus audio lines from IHA, VCH and VIHA. Presentation was uploaded onto the website. Session went very smoothly with no technical glitches.
- Second event was on November 19, 2009, with Dr. Penn presenting on understanding and managing TIAs in BC. There were 18 confirmed sites participating from all the health authorities. About 75 people were in attendance for a cost of about \$5 per person to put on the event. There were some technical glitches that resulted in some lessons learned that will be carried forward into other planned events.
- Next event is planned for January 26, 2010 with Drs. Teal and Warneboldt presenting on the recently released GPAC guideline.
- As much advanced notice as possible is needed to ensure high numbers of participants and that videoconferencing rooms can be booked for the events

Agenda Topic: Other Updates – BCMJ Special Stroke Issue: Devin Harris (2:55 – 3:05)

Presentation content reviewed within the meeting; main points of discussion:

- The BCMJ is circulated to all BCMA members with full online content. BCMJ will feature a Stroke/TIA themed issue.
- Nine articles and an editorial is planned for the issue.
- Topics planned for the issue, authors assigned and status of chapters includes the following:

Topic	Authors	Status
Guest editorial	Mark and Valerie	Awaiting draft
EDPWG stroke/TIA pathway	W. Cunningham, Allan, Devin	Not completed
Secondary prevention stroke & TIA	Andrew, Phil, Todd	Not completed
Thrombolytic therapy	Phil and Devin	Not completed
Future of Telestroke in BC	Phil, Andrew, John Rowlandson	Not completed
Rehab of the stroke patient	Jennifer, Prathap, S.Vallentyne	In the works
Optimal ACVS Care in BC	Allan, Kennely, Karen	Initial draft done
Measurement of Care	Devin, Hans, Andrew	Initial draft done
GPAC guideline	R. Warneboldt, C. Patrick	Done

- Looking at a deadline for submissions by early 2010 for publication by mid-2010.

Agenda Topic: Other Updates– Communication: Barb Carver (3:05 – 3:15)

Presentation content reviewed within the meeting; main points of discussion:

- Website launched and expanded, including a scrolling “Take Note” column. A review of content is planned in the coming months.
- Winter newsletter to be released that will include a new format.
- Constant Contact, an on-line e-mail marketing tool, is being used to manage database and to gather Google analytics (tracking what people do with their e-newsletter).
- Barb has offered to help with the BCMJ if needed.
- Valerie encouraged more proactive placing of stories in media, publications and journals with clinicians acting as spokespersons. Val has found that the more primary health care is kept in front of the media, the easier policy and budgetary decisions are made.

Agenda Topic: New Business & Discussion – Stroke as Priority Focus Area: Valerie Tregillus (3:15 – 4:15)

- The profile of stroke is increasing at senior levels in the Ministry of Health Services (MoHS) and all health authorities with the work of the BC Stroke Strategy becoming more apparent and widely recognized.

- A presentation was made to the Health Authority Leadership Committee of CEOs on July 17, 2009, updating the CEOs with progress to date and on the cost to HAs to embed stroke into system plans. The group recognized and supported the work of the BCSS to date and agreed that the work of the BCSS should continue with an annual province –wide investment of \$4.5 to \$5 million to be redistributed from within existing budgets.
- The CEOs acknowledged that this was a “no brainer” and that BC had to catch up. Despite mostly positive feedback from CEOs, a concern was expressed that rural areas need to be looked after (i.e. geographic and resource sensitivities for rural populations).
- The leadership committee tasked the BCSS steering committee to work with each health authority to further develop plans for the next two to three years, including reviewing and costing the implementation of current state to desired state to be phased in over the next two to three years. Desired state includes policy changes management, Telestroke, and embedding protocols and guidelines). Changes to be implemented within existing budgets (ie. No new money), starting in 2011.
- The committee also asked that BCSS create a “report card” and plan that each CEO could sign off and which could be embedded into service plans.
- MoHS has agreed to embed stroke as a priority within the health care system, which includes performance agreements, service plans, metrics, dedicated and protected funding.

Action Item

- Using new ACVS registry, run “current state” stroke statistics by health region. Build this information into regional stroke report cards for use by CEO and senior HA officials. Report cards would include commentary on “desired state” and initiatives/recommendations to move towards best practice.
- Current state will be based on updated stroke profiles. Report card format to be based on an abbreviated presentation format.

Agenda Topic: New Business & Discussion – Provincial Stroke Priorities Document and Regional Stroke Report Cards & Plans: Mark Collison & Valerie Tregillus

- MoHS budgetary focus on balancing priorities with movement towards innovation and specific strategies. Focus areas are to be collapsed to four or five from 18, and includes primary prevention, clinical improvements, system efficiencies and patients as partners (their ability to influence the system).
- Huge debate within ministry regarding focus on cardiovascular versus cerebrovascular components of primary care. Argument landed on the cerebrovascular side and now a health system priority.
- Process involves presenting BCSS work to ministry action team then to the implementation plan stage, integration plan stage and finally integrating into the health system (“integrate the integration – getting the health system to move as one”).
- Long term governance for the Stroke Strategy still needs to be addressed.
- Regional coordination approach of the BCSS should be highlighted in document.
- There is an opportunity to review investments in cardiovascular care versus cerebrovascular care (i.e. Per capita spending) .
- Examine cost avoidance/savings piece as savings are realized when strokes are prevented (possibly look at length-of-stay data).
- Dementia is a major cost to the system and a direct relationship between stroke and dementia.
- As budget cycle for 2010 is closed, health system priorities will be within existing budgetary envelopes.
- Lifestyle prevention a strategic priority in the ministry – should be embedded into documents.

Action Item

- Incorporate feedback from members and finish the provincial stroke priorities document for consideration by MoHS by January 15, 2010 to Hans.
- Programs costs and cost avoidance information to be included in the draft.
- Emphasize the degree of regional coordination that has been going on under the Stroke Strategy as there is not a lot of that going on in the system.
- Over next three months, provide an economic model for the BCSS incorporating the dementia story line as able.
- Begin a process of regional stroke planning with HAs in order to identify and plan for regional-specific stroke initiatives. These would form three-year regional stroke plans and would be funded by the CEOs commitment to a collective \$4.5 million a year as part of the overarching Stroke Strategy. Out of the new directional policy document, aim to have provincial endorsement and several priority initiatives which can be supported by the regions in their won plans over the next three years.

Agenda Topic: New Business & Discussion – ACVS Part 2 Implementation Plan: Allan Holmes

- Part 1 of management of ACVS resulted in a consensus statement of neurologists and ERPs in December 2008. This statement on providing optimal stroke/ACVS in BC was a vision statement defining what should be done to improve access to optimal care at the right time and at the right place in BC.
- Part 2 will be a detailed “how to” work plan or “road map” for improving the management of stroke/ACVS care in a provincially-structured and organized way.
- Goal is to build comprehensive hyperactive capacity in the province as defined by the consensus statement with support from MoHS and HAs. . Entails governance and MoHS and HA support and; hospital designations (could create tensions); barriers to care; access to stroke specialists through a provincial Telestroke program (have prototypes in place already); ambulance bypass protocols and a measure and evaluation framework.
- Important to get process right and to not get people’s backs up and to determine what resources are required to drive the process forward.

Action Items:

- Initiate the development of a draft ACVS Implementation Plan and consult with HAs on how best to seek their input and support.
- Draft Terms of Reference.
- Reactivate the ACVS Clinical Leadership Group and consider an expanded membership by adding senior operational officials from each health authority.
- Dovetail work of the Rehabilitation and Reintegration Working Group into work of reactivated committee.
- Link into the Rural Hospital Expert Panel, which works on designating hospitals and determining what is available.

Agenda Topic: New Business & Discussion – ED Stroke Audits & Alignment: Allan Holmes

- In 2008, the Current Practice Indicator Project (CPIP) identified recommendations to improve the diagnosis and treatment of stroke in emergency rooms across BC. As a result, the emergency department protocol working group established stroke/TIA protocols, which have been disseminated to all Health Authorities.
- The BC Stroke Strategy invested significant resources and worked with health authorities to encourage awareness and uptake of the protocols.
- In 2010, another CPIP survey is planned, this time measuring the outcome of hospitals' efforts to implement these protocols over the past two years.
- Would initially look at the feasibility of aligning the ED stroke audit, re-measuring CPIP that was completed in 2007, auditing VIHA’s rapid assessment program and validating the BCSS registry.
- Coordination planned with the CSS National Stroke Audit and funding

BCSS Over Next Six Months (Dec/09 – May/10) – Diane Layton (4:00 – 4:15)

- Funding, HA staffing changes and MoHS priorities for ACVS remain uncertainties.
- Alignment of ACVS, Telestroke and rehabilitation pillars in next set of planning work, TIA rapid assessment clinics to continue to succeed, and movement from proof of concepts to regional responsibilities.
- Timelines established for VIHA Telestroke project, VC/FH Telestroke project, evaluation and TIA rapid assessment clinic reporting data.
- New projects emerging due to directives from the leadership committee and MoHS now that stroke is deemed as a priority focus area. Projects include a directional document for stroke care; ED stroke audits; ACVS implementation plan; “current state” stroke report cards and priority plans by health authority.

Meeting Recap & Next Steps – Mark Collison & Valerie Tregillus (4:15 – 4:30)

- Attempt to secure additional stroke strategy funding for 2010/11 in order to sustain prototype projects and initiate new system-wide priorities of mutual benefit e.g. ACVS strategy, rehabilitation and reintegration projects, etc.
- Keep the Steering Committee informed of any new planning and funding developments and seek regional input and support along the way.
- Distribute Emergency Medical Services (EMS) Reference to group for review and comments. Feedback to be sent to Dr. Wagner.
- Distribute slide deck on the *Stroke Distinction Program* being piloted through Accreditation Canada. Information on this program can be provided by Dr. Patty Lindsay of the Canadian Stroke Network.
- Plan to continue to communicate internally with newsletters, updates, bulletins, etc. concerning the Stroke Strategy either through the website or the backend of the website.

- Next meeting to be scheduled for either May 2010 or December 2010. TIA working group meeting planned for late February 2010 and a Telestroke working group meeting for early March 2010.

Meeting Adjourned 4:30 pm

Prepared by:

Mary Stambulic

BCSS Administrative Coordinator

January 5, 2009