STATE OF COLORADO

John W. Hickenlooper, Governor
Larry Wolk, MD, MSPH
Executive Director and Chief Medical Officer

Dedicated to protecting and improving the health and environment of the people of Colorado

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Colorado Department
of Public Health
and Environment

January 31, 2014

The Honorable Beth McCann
Chair, House Health, Insurance,
and Environment Committee
Colorado State Capitol
200 East Colfax
Denver, CO 80203

RE: Initial report concerning the Stroke Advisory Board

Dear Representative McCann:

Pursuant to Senate Bill 13-225 and C.R.S. § 25-3-115, enclosed is the initial report of the Stroke Advisory Board created within the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division. This report is being provided electronically to each member of the Health, Insurance, and the Environment Committee of the House of Representatives and the Senate Health and Human Services Committee.

If you need any additional information concerning the Stroke Advisory Board or have any questions on this report, please contact me at 303-692-2945 or via email at randy.kuykendall@state.co.us.

Sincerely,

D. Randy Kuykendall

D. Randy Kuykendall, MLS
Director
Health Facilities and EMS Division

Enclosure

cc: House Health, Insurance and Environment Committee
Senate Health and Human Services Committee

Colorado Department of Public Health and Environment

Emergency Medical and Trauma Services Branch

2014
Stroke Advisory Board
Legislative Report

July 2013 – January 2014

Submitted to the Colorado Legislature by the

Emergency Medical and Trauma Services Branch

Health Facilities and Emergency Medical Services Division

Colorado Department of Public Health and Environment

www.coems.info

Report to the Colorado Legislature Concerning the Formation and Initial Assessment by the Stroke Advisory Board

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Background

This report, concerning the development of a statewide plan to improve quality of care for stroke patients is pursuant to Senate Bill 13-225, which was signed into law by Gov. John Hickenlooper on May 24, 2013. (C.R.S. § 25-3-115) This statute is effective until the repeal date of September 1, 2018.

The legislation called for the creation, within the Colorado Department of Public Health and Environment, of an 18-member, governor-appointed Stroke Advisory Board by Aug. 1, 2013. The required composition of the advisory board is as follows:

- Six physicians who are actively involved in stroke care, meeting the following criteria:
  - one physician who is board-certified in primary care
  - one physician who is board-certified in vascular neurology
  - one physician who is privileged and actively practicing interventional neuroradiology
  - one physician who is board-certified in neurosurgery
  - one physician representing a statewide chapter of emergency physicians
  - one physician who is a board-certified neurologist serving patients in a rural area in the state
- One member representing a statewide association of physicians
- One member representing a statewide hospital association
- One member who is an emergency medical service provider, as defined in C.R.S. § 25-3.5-103 (8)
- One member who is a registered nurse involved in stroke care
- One hospital administrator from a hospital located in a rural area of the state
- One hospital administrator from a hospital located in an urban area of the state
- One representative from a stroke rehabilitation facility
- One member who is a Colorado resident representing a national association whose goal is to eliminate cardiovascular disease and stroke
- One member who is a Colorado resident representing a national stroke association
- One member who is a physical or occupational therapist actively involved in stroke care
- One member of the public who has suffered a stroke or is the caregiver of a person who has suffered a stroke
- One member who is an expert in stroke database management
- The executive director of the department or the executive director's designee to serve as an ex- officio member of the stroke advisory board

Members of the advisory board serve without compensation and are not entitled to reimbursement of expenses incurred in serving on or performing duties of the advisory board.

The board is charged with studying and making recommendations for developing a statewide plan to improve the quality of care for stroke patients. Components to consider during the study include, but are not limited to:

- The creation of a state stroke database or registry
- Access to aggregate stroke data (excludes patient and provider confidential information)
- Evaluation of currently available stroke treatments and the development of recommendations, based on medical evidence, for ways to improve stroke prevention and treatment
- A plan to encourage coordination of services between rural and urban providers

- Whether a stroke designation system is appropriate or needed to assure access to quality care for Colorado residents

Task force member recruitment and appointments occurred July through August 2013. Since September 2013, the advisory board has met monthly with meetings available via teleconference for members who cannot attend in person. The board has decided to continue the monthly schedule into 2014, with meetings scheduled from 1 p.m. to 3 p.m. on the third Tuesday of each month at a Colorado Department of Public Health and Environment location. The board also has divided into work groups to cover different aspects of the study prescribed in the legislation, including:

- Data Registry and Public Access to Stroke Data
- Treatment and Prevention of Stroke – Evidence-Based Practice
- Rural/Urban Coordination of Care
- Stroke Designation

Meeting minutes, historical information, national articles and other related materials can be found at the stroke website: http://www.colorado.gov/cs/Satellite/CDPHE-EM/CBON/1251645695202. A list of the current Stroke Advisory Board members can be found in Appendix 1.

Introduction

Stroke has, for many years, been among the top five causes of death in both Colorado and the nation. In 2012 there were 1,565 deaths from cerebrovascular disease accounting for 4.7 percent of all deaths in Colorado. Stroke also is a leading cause of disability as many stroke survivors experience lifelong impairment after a stroke.

Stroke is a time-sensitive disease with the treatment options narrowing as the time between onset of symptoms and receipt of treatment lengthens. Rapid treatment leads to improved outcomes both with regard to death and disability. Delayed treatment, due to the lack of recognition by the patient or others or delay in receiving appropriate care, increases mortality, long-term morbidity, disability and costs.

The legislation establishing the Stroke Advisory Board (See Appendix 2 for a copy of SB 13-225) directed the board to study several aspects of stroke in Colorado. The board is to report on its -"findings and recommendations"- each January to the Health and Human Services Committee of the Senate, the Health, Insurance, and Environment Committee of the House and the Colorado Department of Public Health and Environment. The following report is hereby submitted per the above cited requirement.

Since the board was named in August 2013 and convened in September 2013, the board has not had enough time to thoroughly research most topics and prepare recommendations on potential strategies for stroke prevention and treatment. However, the board has made significant progress toward identifying the gaps in knowledge and has begun planning how to bridge those gaps. This next year should provide the opportunity to look for ways to improve or revise current efforts while considering new efforts that may bridge gaps in stroke prevention, care and rehabilitation.

Data Registry and Public Access to Stroke Data

In Colorado, while there are many data sources that provide pieces of the picture, there are no data sources that provide a comprehensive review of the risk factors, incidence and prevalence of stroke and its related long-term effects. Only for mortality do we have population based numbers, and those do not include important details about risk factors and care received prior to death. Here is what we do know about the data sources.

Current Resources

Death Certificate Data

"The death certificate is a permanent legal record of the fact of death of an individual… [It] provides important information about: the decedent (such as age, sex, race, education, date of death, his or her parents, and, if married, the name of the spouse), the circumstances and cause of death, and final disposition… Statistical data from death certificates are used to identify public health problems and measure the results of programs established to alleviate these problems. These data are a necessary foundation on which to base effective public health programs. Health departments could not perform their duties without such data." (from http://www.cdc.gov/nchs/data/misc/hb_fun.pdf)

Note: death data are not linked back to other data sources such as hospital records, EMS records, etc., except during specially funded studies.

Centers for Medicare and Medicaid Services - Hospital Inpatient Quality Reporting (IQR)

"The Hospital IQR Program was developed as a result of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The Hospital IQR Program is intended to equip consumers with quality of care information to make more informed decisions about health care options. It is also intended to encourage hospitals and clinicians to improve the quality of inpatient care provided to all patients. The hospital quality of care information gathered through the program is available to consumers on the Hospital Compare website… [Hospitals are required] to submit data for specific quality measures for health conditions common among people with Medicare." (from http:/www.cms.gov)

Data is collected on stroke patients with a primary discharge diagnosis of stroke and Transient Ischemic Attack. Data submission is required for all hospitals except for critical access hospitals; 29 of 79 hospitals are critical access. Since critical access hospitals treat a small minority of the patients seen in Colorado, the majority of stroke patients should appear in this database.

Outcome Sciences (vendor for Get With The Guidelines Patient Management Tool)

"Get With The Guidelines®-Stroke is an in-hospital program for improving stroke care by promoting consistent adherence to the latest scientific treatment guidelines… [It allows for] submission of CMS (Center for Medicare and Medicaid Services) Core Stroke Measures and other data [and] performance feedback reporting for continuous quality improvement…

Data submission and feedback reporting are performed using the American Heart Association's Patient Management Tool™ (PMT), an online, interactive system provided by Outcome, A Quintiles Company… [There are] 14 pilot Comprehensive Stroke Center metrics reported on via Get With The Guidelines-Stroke…[In addition, there are] 30-Day Measures…that can be reported on via the Get With The Guidelines-Stroke 30-day follow-up form. This form allows

hospitals to capture patient data in the 30-day period after hospitalization, such as mortality, re-hospitalization, follow-up visits, medication adherence, rehabilitation, patient education, etc." (from http:/www.heart.org)

In addition, this database is used by The Joint Commission Comprehensive and Primary Stroke Center accreditation process and hospitals using the American Heart Association/American Stroke Association Get with the Guidelines criteria. The data contained is a thorough description of the course of care for stroke patients.

Colorado Hospital Association Discharge Dataset

"The Colorado Hospital Association (CHA) Discharge Data Program (DDP) database consists of administrative claims data derived from hospital billing information for all patients discharged from Colorado hospitals and patients who have hospital-based outpatient surgery. Beginning with 1988, the discharge data comes from all general acute care hospitals in Colorado. The 2012 database (most current full year) consists of 473,777 inpatient records and 427,025 outpatient surgery records. There are up to 32 different data elements (demographic, diagnoses and procedures, admission, length of stay and discharge status, and charges) recorded for each patient…Inpatient quality indicators at www.cohospitalquality.org are also derived from this data." (from the Colorado Hospital Association)

Emergency Medical Services Dataset (prehospital data)

The Health and Safety Data Services Program at the Colorado Department of Public Health and Environment manages and uses data to assess the emergency medical services system in Colorado. This program analyzes patient care data from ambulance trip reports submitted by EMS agencies through ImageTrend or other vendors. The Colorado EMS Database is based on the National Emergency Medical Services Information System (NEMSIS) PreHospital EMS Dataset Version 2.2.1. The NEMSIS project was developed to help states collect more standardized elements and eventually submit the data to a national EMS database. Data submitted to the state are de-identified and are only released in aggregated format.

All-Payer Claims Database (Sponsored by the Center for Improving Value in Health Care)

As of December 2013, the APCD "includes 2009-2012 historic claims data from the 21 largest commercial payers' individual and large-group fully-insured lines of business, plus Medicaid, representing over 2.5 million Coloradans. Additional payer data, including Medicare and self-insured business will be added over time, eventually encompassing the vast majority of [insured Coloradans]." (from https://www.cohealthdata.org/#/home)

2014 Priorities

The board will identify those data points that are absolutely necessary for progress in the acute care of stroke and in the prevention of stroke. The focus of 2014 will be on clarifying what data is available from where and identifying gaps in our current knowledge. Further, the board will look for ways to collect those data deemed essential while using currently available data to refine possible strategies for prevention, treatment and rehabilitation.

- Determine what data is collected in each of the major databases. Obtain and develop spreadsheet of data points collected by:
  - Centers for Medicare and Medicaid Services
  - Outcome Science (Patient Management Tool for Get With The Guidelines – Stroke)

    - Emergency Medical Services (Patient Care Report Data from ImageTrend)
    - Colorado Hospital Association – Discharge Data Set
- Determine what data are unavailable but would be important to decision-making.
    - Is the data collected somewhere?
    - If so, what are the barriers to obtaining such data?
    - If not, is collection feasible?
- Funding: Who will monitor and analyze data? What will it cost?
- Narrow recommended required data points to the top 10 providing the most impact on stroke care in the state of Colorado.
    - What are most important data points for acute care of stroke?
    - What are most important data points for prevention of stroke?
    - What are most important data points for rehabilitation?
- Determine state-wide number and location of each type of facility including:
    - General hospitals
    - Critical access hospitals
    - Community emergency centers
    - Urgent care centers (determine if there is a need to contact urgent care centers which are unlicensed in Colorado and thus less easily accessible)
    - Rehabilitation settings/facilities

Treatment and Prevention of Stroke – Evidence-Based Practice

This issue, as identified by the legislature, is perhaps the broadest and most complex. Prevention is comprised of primary, secondary and tertiary prevention. Primary prevention aims to prevent individuals from developing risk factors for stroke such as hypertension or diabetes. Secondary prevention is aimed at preventing stroke in people with established risk factors (smoking, hypertension, diabetes). Finally, the goal of tertiary prevention is to prevent complications and long-term disability during the recovery period thus minimizing the impact of a stroke on a survivor's functional abilities and quality of life.

The Stroke Advisory Board members decided, at the moment, they would not focus on primary or even secondary prevention. They decided to look first at tertiary prevention associated with the person who has survived a stroke. Even these interventions are multiple, including both immediate treatment (see discussion below) to reduce the damage from a stroke, rehabilitation to re-establish abilities lost during a stroke and appropriate interventions to reduce the likelihood of a complication or recurrent strokes. Primary and secondary prevention strategies will be reconsidered as a priority in future years.

Likewise, treatment is a complicated subject as the settings are varied. Treatment cannot begin unless there is identification of a stroke or potential for a stroke. Thus one could argue that the identification of a potential stroke, generally in the out-of-hospital environment, is the first step in the treatment process and one that cannot be ignored. Treatment begins, potentially, in the prehospital emergency medical services (EMS) setting, where a stroke has not yet been confirmed but may be suspected resulting in EMS notification to the receiving facility. Such notice is designed to assure immediate and appropriate care of the patient based on the time-critical nature of stroke. Once the facility has been reached, there are additional settings for evaluation and treatment including the emergency department, radiology, the operating room, the intensive care unit and other inpatient care units. Each of those settings must be considered to determine what is current practice and where improvements can be made to align with best practices.

Current Resources

- Telehealth: Resources to allow a specialist in one location remote from the patient to view the patient and discuss the situation with the provider on site. While telehealth is available in some locations in the state, there remain significant barriers to full implementation including the issues of privileging remote providers and financing telehealth.
- Diagnostic Imaging and Therapy: Determine where in Colorado there are gaps in the ability to diagnose and treat strokes. Work with Rural/Urban Coordination work group on this topic.

Identified Areas for Improvement

The Evidence-Based Practice work group has identified the following areas with the potential for improvement. Prioritization and specific recommendations will occur during 2014.

- Improve access to stroke expertise, which is largely concentrated in the urban areas along the Front Range and in Grand Junction.
- Additional stroke education to health care workers, including EMS.
- Additional stroke education/awareness to the public.

2014 Priorities

- Evidence-Based Practices: Prioritization and development of specific recommendations with regard to educational strategies.
- Data Gathering and Analysis: Developing a survey for emergency medical service agencies to assess needs for education or protocol development around stroke.
- Telehealth: Investigate the possibilities of telehealth in the field, gaps in telehealth in facilities and possibilities for telehealth in rehabilitation.
- Conduct a survey in 2014 regarding rehabilitation options/availability.

Rural/Urban Coordination of Care

The American Heart Association/American Stroke Association released a policy statement in October 2013 regarding interactions within stroke systems of care and gave specific recommendations for the coordination of care to improve acute stroke care. This policy statement takes into consideration the unique challenges that urban, rural and frontier areas face when it comes to acute stroke care. "Solutions must be appropriate for the region and effective at guiding appropriate triage without being burdensome." Goals of emergency care include triage and routing considerations, levels and types of hospital care and the use of telemedicine as a method to ensure "24/7 coverage and care of stroke patients in a variety of settings." (Higashida, et al, 2013)*

Current Resources

- Within Colorado there are Joint Commission certified stroke centers:
  - 3 Comprehensive Stroke Centers.
  - 18 Primary Stroke Centers.
- Within Colorado there are almost 30 hospitals with stroke telemedicine capabilities.
- There is a broad range of coverage in urban, rural and even frontier areas of the state by Comprehensive Stroke Centers, Primary Stroke Centers and telemedicine capable hospitals. See the state map on the stroke website.

Identified Areas for Improvement

- Telemedicine coverage of rural and frontier areas in Colorado could be improved through the addition and use of equipment at hospitals without current capabilities.

2014 Priorities

- Data Analysis: The Stroke Advisory Board created a survey of all hospitals in Colorado to assess the use of stroke care protocols. Results of the survey will be used to determine where there are potential needs for education or technical assistance and to plan to meet identified needs. The board will analyze the results of the hospital survey mentioned above and use results to assess possibilities for system improvement.
- Transfer Agreements: Look for opportunities to improve the coordination of care between hospitals without stroke center designation or stroke telemedicine capabilities through the use of transfer agreements with Primary Stroke Centers / Comprehensive Stroke Centers.
- Prehospital Management: Look for ways to improve the prehospital management of patients with acute stroke through collaboration with the Regional Emergency Medical and Trauma Advisory Councils and the regional EMS directors. A regional approach is more likely to address the unique needs and challenges experienced locally.
- Funding: Identify what funding will be needed for implementation of any of the above priorities.

* Higashida, R., Alberts, M.J., Alexander, D.N., Crocco, T.J., Demaerschalk, B.M., Derdeyn, C.P., et. al (2013). Interactions within stroke systems of care: a policy statement from the American Heart Association/American Stroke Association. *Stroke*, 44, p 4961-2984.

Stroke Designation for Hospitals

The final issue the Stroke Advisory Board must consider is the process of stroke designation for hospitals providing different levels of stroke care. This issue was briefly discussed and tabled at several meetings. In December, the board agreed it would not reconsider this issue until staff was hired and the new staff member had time to research some of the issues regarding designation.

Current Resources

Tabled until 2014.

Identified Areas for Improvement

Tabled until 2014.

2014 Priorities

The Colorado Department of Public Health and Environment is pleased to report that a new STEMI/Stroke staff member began work on Jan. 6, 2014. Among the employee's first tasks will be to review and catalog how other states handle the stroke designation process, investigate the options for stroke certification or accreditation that are currently available, and provide this background information to the board for its consideration.

Appendix 1

Stroke Advisory Board Members

Alphabetical listing, term expiration dates and categories for the member

Michelle Whaley, RN, ANVP - Co-Chair
Castle Rock
Term expires - 08-01-16
RN involved in stroke care

Kevin Burgess, Paramedic
Loveland
Term expires - 08-01-16
EMS Provider

Donald Frei, Jr., MD
Denver
Term expires - 08-01-17
Interventional neuroradiologist

Christina Johnson, MD FACEP
Denver
Term expires - 08-01-16
Statewide chapter of emergency physicians

Michelle Joy, FACHE
Greeley
Term expires - 08-01-16
Rural area hospital administrator

Mary Ann Orr
Greenwood Village
Term expires - 08-01-17
Member of the public who has suffered a stroke

David Ross, DO, FACEP
Colorado Springs
Term expires - 08-01-17
Statewide association of physicians

Richard Smith, MD
Denver
Term expires - 08-01-17
National stroke association

Vacant - Board-certified neurosurgeon

Vacant - Primary care physician

Chris Wright, RN, MBA - Co-Chair
Conifer
Term expires - 08-01-16
Expert in stroke database management

Coral Cosway
Littleton
Term expires - 08-01-17
National assoc. working to eliminate cardiovascular disease and strokes

Nancy Griffith, RN, CPHQ
Centennial
Term expires - 08-01-17
Statewide hospital association

William Joseph Jones, MD
Denver
Term expires - 08-01-16
Board-certified vascular neurologist

Cynthia Kreutz, FACHE (resigned 1/31/14)
Englewood
Term expires - 08-01-17
Stroke rehabilitation facility

Michelle Reese, JD
Golden
Term expires - 08-01-16
CDPHE designee - ex officio

Karin Schumacher, PT, MPH
Denver
Term expires - 08-01-17
Physical therapist involved in stroke care

Mary White, FACHE
Englewood
Term expires - 08-01-16
Urban area hospital administrator

Vacant - Board-certified neurologist

Appendix 2

Senate Bill 13-225

NOTE: The governor signed this measure on 5/24/2013.

SENATE BILL 13-225

BY SENATOR(S) Giron, Guzman, Aguilar, Newell, Nicholson, Carroll, Heath, Kefalas, Todd, Morse;
also REPRESENTATIVE(S) Ginal and Primavera, Schafer, Fields, Garcia, Hamner, Hullinghorst, Kraft-Tharp, Labuda, Rosenthal, Ryden, Vigil, Young.

CONCERNING THE DEVELOPMENT OF A SYSTEM TO IMPROVE QUALITY OF CARE TO PATIENTS SUFFERING SPECIFIED ACUTE INCIDENTS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 25-3-114, 25-3-115, and 25-3-116 as follows:

25-3-114. STEMI task force - creation - membership - duties - report - repeal. (1) (a) THERE IS HEREBY CREATED IN THE DEPARTMENT THE STEMI TASK FORCE. NO LATER THAN AUGUST 1, 2013, THE GOVERNOR SHALL APPOINT FIFTEEN MEMBERS TO THE TASK FORCE AS FOLLOWS:

(I) ONE MEMBER WHO IS A COLORADO RESIDENT REPRESENTING A NATIONAL ASSOCIATION WHOSE GOAL IS TO ELIMINATE CARDIOVASCULAR DISEASE AND STROKE;

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(II) ONE MEMBER WHO IS A CARDIOLOGIST PRACTICING IN THIS STATE;

(III) ONE MEMBER WHO IS AN INTERVENTIONAL CARDIOLOGIST PRACTICING IN THE WESTERN SLOPE AREA OF THE STATE;

(IV) ONE MEMBER WHO IS AN INTERVENTIONAL CARDIOLOGIST PRACTICING IN THE FRONT RANGE AREA OF THE STATE;

(V) ONE MEMBER REPRESENTING A STATEWIDE ASSOCIATION OF CARDIOLOGISTS;

(VI) ONE MEMBER REPRESENTING A STATEWIDE ASSOCIATION OF PHYSICIANS;

(VII) ONE MEMBER REPRESENTING A STATEWIDE HOSPITAL ASSOCIATION;

(VIII) ONE MEMBER REPRESENTING AN EMERGENCY PHYSICIANS ASSOCIATION;

(IX) ONE MEMBER WHO IS AN EMERGENCY MEDICAL SERVICE PROVIDER, AS DEFINED IN SECTION 25-3.5-103 (8);

(X) ONE MEMBER WHO IS A REGISTERED NURSE INVOLVED IN CARDIAC CARE;

(XI) ONE HOSPITAL ADMINISTRATOR FROM A HOSPITAL LOCATED IN A RURAL AREA OF THE STATE;

(XII) ONE HOSPITAL ADMINISTRATOR FROM A HOSPITAL LOCATED IN AN URBAN AREA OF THE STATE;

(XIII) ONE MEMBER OF THE PUBLIC WHO HAS SUFFERED A STEMI HEART ATTACK; AND

(XIV) TWO MEMBERS WITH EXPERTISE IN CARDIOVASCULAR DATA REGISTRIES, ONE OF WHOM IS A CARDIOLOGIST.

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(b) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OR THE EXECUTIVE DIRECTOR'S DESIGNEE SHALL SERVE AS AN EX OFFICIO MEMBER OF THE TASK FORCE.

(c) MEMBERS OF THE TASK FORCE SERVE WITHOUT COMPENSATION AND ARE NOT ENTITLED TO REIMBURSEMENT OF EXPENSES INCURRED IN SERVING ON OR PERFORMING DUTIES OF THE TASK FORCE.

(2) (a) THE TASK FORCE SHALL STUDY AND MAKE RECOMMENDATIONS FOR DEVELOPING A STATEWIDE PLAN TO IMPROVE QUALITY OF CARE TO STEMI PATIENTS. IN CONDUCTING THE STUDY, THE TASK FORCE SHALL EXPLORE THE FOLLOWING ISSUES, WITHOUT LIMITATION:

(I) CREATION OF A STATE DATABASE OR REGISTRY CONSISTING OF DATA ON STEMI CARE THAT MIRRORS THE DATA HOSPITALS SUBMIT TO NATIONALLY RECOGNIZED ORGANIZATIONS;

(II) ACCESS TO AGGREGATED STEMI DATA, WHICH MUST EXCLUDE ANY IDENTIFYING OR CONFIDENTIAL INFORMATION ABOUT THE REPORTING HOSPITAL OR PATIENTS TREATED BY THE HOSPITAL, FROM A STATE DATABASE THAT MAY BE DEVELOPED OR FROM A NATIONALLY RECOGNIZED ORGANIZATION;

(III) A PLAN THAT WOULD ENCOURAGE RURAL AND URBAN HOSPITALS TO COORDINATE SERVICES FOR THE NECESSARY REFERRAL OR RECEIPT OF PATIENTS REQUIRING STEMI CARE IN THE STATE; AND

(IV) THE CRITERIA USED BY NATIONALLY RECOGNIZED BODIES FOR DESIGNATING A HOSPITAL IN STEMI CARE AND WHETHER A DESIGNATION IS APPROPRIATE OR NEEDED TO ASSURE ACCESS TO THE BEST QUALITY CARE FOR COLORADO RESIDENTS WITH STEMI EVENTS.

(b) BY JANUARY 31, 2014, THE TASK FORCE SHALL SUBMIT AN INITIAL REPORT, AND BY JULY 31, 2015, THE TASK FORCE SHALL SUBMIT ITS FINAL REPORT, SPECIFYING ITS FINDINGS AND RECOMMENDATIONS TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE, THE HEALTH, INSURANCE, AND ENVIRONMENT COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, AND THE DEPARTMENT. THE TASK FORCE SHALL INCLUDE IN ITS REPORTS A RECOMMENDATION ON WHETHER A DESIGNATION OF A HOSPITAL IN STEMI

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CARE IS APPROPRIATE OR NEEDED TO ASSURE ACCESS TO THE BEST QUALITY CARE FOR COLORADO RESIDENTS WITH STEMI EVENTS.

(3) THE DEPARTMENT MAY ACCEPT AND EXPEND, SUBJECT TO APPROPRIATION BY THE GENERAL ASSEMBLY, GIFTS, GRANTS, AND DONATIONS TO PAY THE DIRECT EXPENSES OF THE DEPARTMENT IN ASSISTING AND STAFFING THE TASK FORCE. THE DEPARTMENT SHALL TRANSMIT ANY MONETARY GIFTS, GRANTS, OR DONATIONS IT RECEIVES TO THE STATE TREASURER FOR DEPOSIT IN THE HEALTH FACILITIES GENERAL LICENSURE CASH FUND, AND THOSE MONEYS MAY BE USED ONLY TO PAY THE DIRECT EXPENSES OF THE DEPARTMENT.

(4) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT.

(b) "STEMI" MEANS ST-ELEVATION MYOCARDIAL INFARCTION.

(5) THIS SECTION IS REPEALED, EFFECTIVE AUGUST 1, 2015.

25-3-115. Stroke advisory board - creation - membership - duties - report - repeal. (1) (a) THERE IS HEREBY CREATED IN THE DEPARTMENT THE STROKE ADVISORY BOARD, THE PURPOSE OF WHICH IS TO EVALUATE POTENTIAL STRATEGIES FOR STROKE PREVENTION AND TREATMENT AND DEVELOP A STATEWIDE NEEDS ASSESSMENT IDENTIFYING RELEVANT RESOURCES. NO LATER THAN AUGUST 1, 2013, THE GOVERNOR SHALL APPOINT EIGHTEEN MEMBERS TO THE STROKE ADVISORY BOARD AS FOLLOWS:

(I) SIX PHYSICIANS WHO ARE ACTIVELY INVOLVED IN STROKE CARE AND WHO SATISFY THE FOLLOWING CRITERIA: ONE PHYSICIAN WHO IS BOARD-CERTIFIED IN PRIMARY CARE; ONE PHYSICIAN WHO IS BOARD-CERTIFIED IN VASCULAR NEUROLOGY; ONE PHYSICIAN WHO IS PRIVILEGED AND ACTIVELY PRACTICING INTERVENTIONAL NEURORADIOLOGY; ONE PHYSICIAN WHO IS BOARD-CERTIFIED IN NEUROSURGERY; ONE PHYSICIAN REPRESENTING A STATEWIDE CHAPTER OF EMERGENCY PHYSICIANS; AND ONE PHYSICIAN WHO IS A BOARD-CERTIFIED NEUROLOGIST SERVING PATIENTS IN A RURAL AREA OF THE STATE;

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(II) ONE MEMBER REPRESENTING A STATEWIDE ASSOCIATION OF PHYSICIANS;

(III) ONE MEMBER REPRESENTING A STATEWIDE HOSPITAL ASSOCIATION;

(IV) ONE MEMBER WHO IS AN EMERGENCY MEDICAL SERVICE PROVIDER, AS DEFINED IN SECTION 25-3.5-103 (8);

(V) ONE MEMBER WHO IS A REGISTERED NURSE INVOLVED IN STROKE CARE;

(VI) ONE HOSPITAL ADMINISTRATOR FROM A HOSPITAL LOCATED IN A RURAL AREA OF THE STATE;

(VII) ONE HOSPITAL ADMINISTRATOR FROM A HOSPITAL LOCATED IN AN URBAN AREA OF THE STATE;

(VIII) ONE REPRESENTATIVE FROM A STROKE REHABILITATION FACILITY;

(IX) ONE MEMBER WHO IS A COLORADO RESIDENT REPRESENTING A NATIONAL ASSOCIATION WHOSE GOAL IS TO ELIMINATE CARDIOVASCULAR DISEASE AND STROKE;

(X) ONE MEMBER WHO IS A COLORADO RESIDENT REPRESENTING A NATIONAL STROKE ASSOCIATION;

(XI) ONE MEMBER WHO IS A PHYSICAL OR OCCUPATIONAL THERAPIST ACTIVELY INVOLVED IN STROKE CARE;

(XII) ONE MEMBER OF THE PUBLIC WHO HAS SUFFERED A STROKE OR IS THE CAREGIVER OF A PERSON WHO HAS SUFFERED A STROKE; AND

(XIII) ONE MEMBER WHO IS AN EXPERT IN STROKE DATABASE MANAGEMENT.

(b) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OR THE EXECUTIVE DIRECTOR'S DESIGNEE SHALL SERVE AS AN EX OFFICIO MEMBER OF THE STROKE ADVISORY BOARD.

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(c) MEMBERS OF THE STROKE ADVISORY BOARD SERVE WITHOUT COMPENSATION AND ARE NOT ENTITLED TO REIMBURSEMENT OF EXPENSES INCURRED IN SERVING ON OR PERFORMING DUTIES OF THE ADVISORY BOARD.

(2) (a) THE STROKE ADVISORY BOARD SHALL STUDY AND MAKE RECOMMENDATIONS FOR DEVELOPING A STATEWIDE PLAN TO IMPROVE QUALITY OF CARE FOR STROKE PATIENTS. IN CONDUCTING THE STUDY, THE STROKE ADVISORY BOARD SHALL EXPLORE THE FOLLOWING ISSUES, WITHOUT LIMITATION:

(I) CREATION OF A STATE DATABASE OR REGISTRY CONSISTING OF DATA ON STROKE CARE THAT MIRRORS THE DATA HOSPITALS SUBMIT TO NATIONALLY RECOGNIZED ORGANIZATIONS;

(II) ACCESS TO AGGREGATED STROKE DATA, WHICH MUST EXCLUDE ANY IDENTIFYING OR CONFIDENTIAL INFORMATION ABOUT THE REPORTING HOSPITAL OR PATIENTS TREATED BY THE HOSPITAL, FROM A STATE DATABASE THAT MAY BE DEVELOPED OR FROM A NATIONALLY RECOGNIZED ORGANIZATION BY THE ADVISORY BOARD, BY ANY PERSON WHO SUBMITS A WRITTEN REQUEST FOR THE DATA;

(III) EVALUATION OF CURRENTLY AVAILABLE STROKE TREATMENTS AND THE DEVELOPMENT OF RECOMMENDATIONS, BASED ON MEDICAL EVIDENCE, FOR WAYS TO IMPROVE STROKE PREVENTION AND TREATMENT;

(IV) A PLAN THAT WOULD ENCOURAGE RURAL AND URBAN HOSPITALS TO COORDINATE SERVICES FOR THE NECESSARY REFERRAL OR RECEIPT OF PATIENTS REQUIRING STROKE CARE IN THE STATE; AND

(V) THE CRITERIA USED BY NATIONALLY RECOGNIZED BODIES FOR DESIGNATING A HOSPITAL IN STROKE CARE AND WHETHER A DESIGNATION IS APPROPRIATE OR NEEDED TO ASSURE ACCESS TO THE BEST QUALITY CARE FOR COLORADO RESIDENTS WITH STROKE EVENTS.

(b) BY JANUARY 31, 2014, AND BY EACH JANUARY 1 THEREAFTER, THE STROKE ADVISORY BOARD SHALL SUBMIT A REPORT SPECIFYING ITS FINDINGS AND RECOMMENDATIONS TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE, THE HEALTH, INSURANCE, AND ENVIRONMENT COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR THEIR SUCCESSOR COMMITTEES, AND THE DEPARTMENT. THE STROKE ADVISORY BOARD SHALL

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INCLUDE IN ITS REPORT A RECOMMENDATION ON WHETHER A DESIGNATION OF A HOSPITAL IN STROKE CARE IS APPROPRIATE OR NEEDED TO ASSURE ACCESS TO THE BEST QUALITY CARE FOR COLORADO RESIDENTS WITH STROKE EVENTS.

(3) THE DEPARTMENT MAY ACCEPT AND EXPEND, SUBJECT TO APPROPRIATION BY THE GENERAL ASSEMBLY, GIFTS, GRANTS, AND DONATIONS TO PAY THE DIRECT EXPENSES OF THE DEPARTMENT IN ASSISTING AND STAFFING THE STROKE ADVISORY BOARD. THE DEPARTMENT SHALL TRANSMIT ANY MONETARY GIFTS, GRANTS, OR DONATIONS IT RECEIVES TO THE STATE TREASURER FOR DEPOSIT IN THE HEALTH FACILITIES GENERAL LICENSURE CASH FUND, AND THOSE MONEYS MAY BE USED ONLY TO PAY THE DIRECT EXPENSES OF THE DEPARTMENT.

(4) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES, "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT.

(5) THIS SECTION IS REPEALED, EFFECTIVE SEPTEMBER 1, 2018. PRIOR TO THE REPEAL, THE DEPARTMENT OF REGULATORY AGENCIES SHALL REVIEW THE FUNCTIONS OF THE STROKE ADVISORY BOARD IN ACCORDANCE WITH SECTION 2-3-1203, C.R.S.

25-3-116. Department recognition of national certification - suspension or revocation of recognition - definitions. (1) A HOSPITAL THAT HAS AN ACCREDITATION, CERTIFICATION, OR DESIGNATION IN STROKE OR STEMI CARE FROM A NATIONALLY RECOGNIZED ACCREDITING BODY, INCLUDING BUT NOT LIMITED TO A CERTIFICATION AS A COMPREHENSIVE STROKE CENTER OR PRIMARY STROKE CENTER BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS AND PROGRAMS OR ITS SUCCESSOR ORGANIZATION OR AN ACCREDITATION AS A STEMI RECEIVING CENTER OR STEMI REFERRAL CENTER BY THE SOCIETY FOR CARDIOVASCULAR PATIENT CARE OR ITS SUCCESSOR ORGANIZATION, MAY SEND INFORMATION AND SUPPORTING DOCUMENTATION TO THE DEPARTMENT. THE DEPARTMENT SHALL MAKE A HOSPITAL'S NATIONAL ACCREDITATION, CERTIFICATION, OR DESIGNATION AVAILABLE TO THE PUBLIC IN A MANNER DETERMINED BY THE DEPARTMENT.

(2) THE DEPARTMENT SHALL DEEM A HOSPITAL THAT IS CURRENTLY ACCREDITED, CERTIFIED, OR DESIGNATED BY A NATIONALLY RECOGNIZED

ACCREDITING BODY AS SATISFYING THE REQUIREMENTS FOR RECOGNITION AND PUBLICATION BY THE DEPARTMENT. THE DEPARTMENT MAY SUSPEND OR REVOKE A RECOGNITION AND PUBLICATION OF A HOSPITAL'S ACCREDITATION, CERTIFICATION, OR DESIGNATION IF THE DEPARTMENT DETERMINES, AFTER NOTICE AND HEARING IN ACCORDANCE WITH THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, C.R.S., THAT THE HOSPITAL NO LONGER HOLDS AN ACTIVE ACCREDITATION, CERTIFICATION, OR DESIGNATION FROM A NATIONALLY RECOGNIZED CERTIFYING BODY.

(3) WHETHER A HOSPITAL ATTAINS A NATIONAL ACCREDITATION, CERTIFICATION, OR DESIGNATION IN STROKE OR STEMI CARE HAS NO BEARING ON, OR CONNECTION WITH, THE LICENSING OR CERTIFICATION OF THE HOSPITAL BY THE DEPARTMENT PURSUANT TO SECTION 25-1.5-103 (1) (a).

(4) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT.

(b) "STEMI" MEANS ST-ELEVATION MYOCARDIAL INFARCTION.

SECTION 2. In Colorado Revised Statutes, 2-3-1203, **add** (3) (ee.5) as follows:

2-3-1203. Sunset review of advisory committees. (3) The following dates are the dates for which the statutory authorization for the designated advisory committees is scheduled for repeal:

(ee.5) SEPTEMBER 1, 2018:

(II) THE STROKE ADVISORY BOARD CREATED IN SECTION 25-3-115, C.R.S.;

SECTION 3. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of public health and environment, for the fiscal year beginning July 1, 2013, the sum of

$41,402 and 0.6 FTE, or so much thereof as may be necessary, for allocation to the emergency preparedness and response division for the stroke and STEMI heart attack designation line item related to the implementation of this act.

SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

John P. Morse
PRESIDENT OF
THE SENATE

Mark Ferrandino
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED_____

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

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