COLORADO
Health Facilities & Emergency Medical Services Division
Department of Public Health & Environment

Emergency Medical and Trauma Services Branch

2015
Stroke Advisory Board Legislative Report

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2015 Stroke Advisory Board Legislative Report

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Executive Summary

On May 24, 2013, Gov. John Hickenlooper signed C.R.S. 25-3-115 into law, originally Senate Bill 13-225, which called for the formation of the Stroke Advisory Board to make recommendations to improve stroke care in the state of Colorado by addressing the following four topics. The Stroke Advisory Board is instructed to produce an annual report on its progress each January and a final legislative report by September 2018.

Data registry
Data collection is correlated with improved care, partly due to enhanced focus on stroke care processes. The board recommends collecting specific data elements essential to evaluating stroke care and providing information for quality improvement at the facility level and statewide. The board has identified sources of the data and potential reporting and collection methods.

Prevention and treatment
The board recommends two sets of statewide minimum standards for stroke care. Standards are targeted to hospitals that transfer all stroke patients or hospitals that treat some stroke patients. Nationally certified stroke centers meet and exceed the proposed criteria. Establishing statewide minimum standards will help increase the availability of evidence-based acute and post-acute stroke care in Colorado. These standards in conjunction with the education recommendations can maximize Colorado's existing infrastructure.

Rural and urban care coordination
The board recommends minimum standards for emergency medical services and hospitals to improve the coordination of stroke care across the continuum of care from symptom onset through rehabilitation and community reintegration. These minimum standards will provide more uniform education and standards for EMS and hospital providers to optimize stroke care across the state. Statewide standards and guidelines are intended to be customized at the regional level to ensure that providers are able to adequately meet the needs of stroke patients in Colorado's diverse regions. Recommendations were built from feedback from the Regional Emergency Medical and Trauma Advisory Councils, urban and rural hospitals, as well as stroke centers and hospitals that are not certified as stroke centers.

State designation of stroke facilities
The board does not recommend state designation above and beyond an accreditation or certification in stroke care by a national accrediting organization. In 2016, the board's objective will be to consider the potential support system for facilities that are not certified as stroke centers.

Definitions and Acronyms

AHRQ: Agency for Healthcare Research and Quality- This agency works within the U.S. Department of Health and Human Services to produce evidence and promote healthcare that is safer, more accessible, affordable and higher quality.

CAH: Critical Access Hospital

CHA: Colorado Hospital Association

CMS: Centers for Medicare and Medicaid Services

ED: Emergency Department

EMS: Emergency Medical Services

GWTG: Get With The Guidelines- Stroke registry is a hospital database that is operated and managed by the American Heart Association and American Stroke Association.

RETAC: Regional Emergency Medical and Trauma Advisory Council

STK 4 (Stroke Measure #4): This CMS core measure addresses the time it takes to provide tPA. All acute care hospitals and some critical access hospitals report CMS core measures.

The board: refers to the Stroke Advisory Board

The department: Colorado Department of Public Health and Environment

tPA: tissue plasminogen activator, a medication administered to ischemic stroke patients to dissolve blood clots and improve blood flow to the brain.

Background

On May 24, 2013, Gov. John Hickenlooper signed Senate Bill 13-225 into law. The bill called for the formation of the Stroke Advisory Board to make recommendations to improve stroke care in the state of Colorado by addressing the following issues:

- State database or registry
- Public access to aggregated data
- Treatment and prevention of stroke using evidence-based practice
- Rural and urban care coordination
- Whether stroke designation is necessary to ensure appropriate quality care

The board is made up of 18 governor-appointed members and one ex-officio member from the department. A description of the board make-up is listed in C.R.S. 25-3-115, located in Appendix 4. The current membership is listed in Appendix 3. Meetings are facilitated by the Colorado Department of Public Health and Environment.

Stroke Advisory Board meeting information and materials can be found online at https://www.colorado.gov/pacific/cdphe/stroke-advisory-board.

Introduction

Stroke has, for many years, been among the top five causes of death in both Colorado and the nation. In 2014 there were 1,692 deaths from cerebrovascular disease accounting for 4.8 percent of all deaths in Colorado[1]. Stroke is also a leading cause of disability as many stroke survivors experience lifelong impairment.

Stroke is a time-sensitive condition with treatment options that decrease significantly as time progresses from the onset of symptoms. Early intervention and effective rehabilitation have been shown to improve outcomes with regard to death and disability.

In 2015, the Stroke Advisory Board developed standards for stroke care to help resolve gaps in the stroke care continuum that were identified in 2014. All treatment and educational recommendations are intended to be used as guidelines that can be customized for each region in Colorado. Specific attention has been given to the unique aspects of Colorado's population density, medical needs, medical resource availability, geography, topography and the culture of health and medicine in Colorado.

The following report addresses each legislative topic individually. The board created subgroups for the legislative topics: Data, Prevention and Treatment, and Rural and Urban Care Coordination. The larger group would convene each meeting to come to consensus on work group objectives and recommendations. Each section provides the board's actions in 2015, followed by the current recommendations and, finally, the objectives for 2016.

[1] Colorado Health Information Dataset (CoHID) http://www.chd.dphe.state.co.us/cohid/

Data Registry and Public Access to Stroke Data

Data collection is correlated with improved care, partly due to an enhanced focus on stroke care processes. Data collection provides the opportunity for quality improvement by identifying areas of success and deficiencies within and across systems. Data elements should be aligned with evidence-based practices that decrease crucial time intervals in acute stroke treatment, improve outcomes in post-acute settings and optimize care overall.

Report on 2015 Priorities

The board determined that data collection for stroke care should initially focus on the time from symptom onset until treatment because this is the period of greatest opportunity for positive patient outcomes. Furthermore, the board sought to define a list of data elements that would provide useful information for each segment of that interval for quality improvement purposes. The board then carefully considered existing data collection options.

Data Elements Considered

The board reviewed data elements from various sources in 2015 (see Appendix 1) to ensure that the proposed data elements were in fact obtainable and meaningful. Data elements must also be useful for quality improvement at both the facility and statewide system level. The board considered the following questions in developing the recommended data elements shown in the table below.

- What measures are useful in evaluating stroke care and performing quality improvement?
- Do the elements address the three types of data?
  - Process measures: Evaluate appropriate and timely care
  - Outcome measures: Assess the patient's outcome to help measure the quality of care
  - Structure measures: Analyze the function of the system as a whole
- What is the most reasonable data collection method(s) for various facilities?
- How could the submitted data be used for quality improvement?
- Who should submit data?

Data Measure	Source	Purpose	Collection Method	Type of Data
EMS stroke alert prior to hospital arrival Yes/No	EMS data	Improve EMS-hospital communication	Department can pull report from EMS data	Process
	Hospital reported data	Assess stroke alert accuracy	Request hospitals report voluntarily to department	
Mode of arrival	CHA data	Identify community education needs	Department can pull report from CHA data	Process
Door to needle time	GWTG	Decrease time to less than 60 minutes	Request hospitals report voluntarily to department	Process
Percent of eligible patients receiving thrombolytics	GWTG	Increase percentage over time	Request hospitals report voluntarily to department	Process
CMS Core measure STK 4 (timely tPA administration)	Hospital reported data	Increase tPA administration to eligible stroke patients	Request hospitals report voluntarily to department	Process
Door to call for	Hospital	Decrease the time to	Request hospitals report	Process

consult	reported data	identify a stroke and call for help	voluntarily to department	
Time from arrival to transfer	Hospital reported data	Over time, decrease the interval from patient arrival to transfer	Request hospitals report voluntarily to department	Process
30 day readmit- all cause	CHA- only for admit to same hospital	Improve initial treatment	Department can pull report from CHA data	Outcome
Number of certified stroke centers	Certifying organization	Increase access to stroke centers over time	Department can gather information online	Structure
Percent patients treated in stroke-certified hospitals vs. those hospitals not stroke-certified	CHA data	Increase the number of patients treated at a stroke center over time	Department can pull report from CHA data	Structure
Acuity adjusted mortality	CHA AHRQ	Decrease mortality over time	CHA will explore potential for this measure in 2016	Outcome

Exploring registry options: The board found that no single data source provides all of the desired information. Additional information on the reviewed data sources is provided in Appendix 1. The following data options were considered:

- State access to stroke center data submitted to Get With The Guidelines-Stroke registry
  - The department could request the 24 Primary and Comprehensive Stroke Centers in Colorado to provide the GWTG- Stroke registry reports voluntarily or by mandatory participation. The department would likely receive reports in a format which does not provide the ability to perform data analytics. Raw data would provide the department with the ability to analyze the data and run customized reports.
  - Stroke centers do not enter all stroke patients into the registry; thus the registry represents only a portion of the stroke patients treated at each hospital.
  - 58 of the 82 acute care and critical access hospitals in Colorado are not certified as a stroke center but may treat stroke patients arriving emergently. These hospitals do not report to the GWTG- Stroke registry.
- State-developed database for stroke patients
  - Direct data submission to the department provides flexibility in data analysis and adaptability to accommodate a changing system of care.
  - This would require creation of a state repository to house and operate the registry as well as provide on-going technical assistance to entities collecting data. This could be as complex or simple as deemed appropriate. The board agrees that a minimalist approach would be the most reasonable.
  - This type of registry requires significant state resources to develop a standardized set of metrics and data collection criteria.
  - This type of registry would require significant data abstraction by facilities and other providers (such as EMS agencies), many of which have limited resources for data collection and reporting.
- Facility-level data collection shared through an on-site quality improvement survey
  - This is an option in lieu of a state database. It would require experts to travel to the facility, review the data and make quality improvement recommendations on-site. This model has been utilized in other states with rural facilities that have low patient

volumes. This model would be more resource intensive than annual data submission to the department with an off-site data review by a council of experts.

Current Recommendations

Any recommendations for data collection would require legislation to provide the department with the authority and resources to collect and analyze data. If instructed to collect data, the department would specify what data a council of experts would have access to for the purpose of quality improvement.

- The board recommends that the department have access to the following data elements for the purpose of state-wide continuous quality improvement.
- The department would need to develop a secure repository to house sensitive information which would likely come from multiple sources, as no one data source offers all desired data.
- The department should consult a council of experts to review de-identified data and make recommendations to improve the system of care.

Data Element	Source	Purpose	Collection Method	Type of Data
Mode of arrival	CHA data	Identify community education needs	Department can pull report from CHA data	Process
Door to needle time	GWTG	Decrease time to less than 60 minutes	Request hospitals report voluntarily to department	Process
Percent of eligible patients receiving lytics	GWTG	Increase percentage over time	Request hospitals report voluntarily to department	Process
CMS Core measure STK 4 (timely tPA administration)	Hospital reported data	Increase tPA administration to eligible stroke patients	Request hospitals report voluntarily to department	Process
Door to call for consult	Hospital reported data	Decrease the time to identify a stroke and call for help	Request hospitals report voluntarily to department	Process
Time from arrival to transfer	Hospital reported data	Over time, decrease the interval from patient arrival to transfer	Request hospitals report voluntarily to department	Process
30 day readmit-all cause	CHA- only for admit to same hospital	Improve initial treatment	Department can pull report from CHA data	Outcome
Number of certified stroke centers	Certifying organization	Increase access to stroke centers over time	Department can gather information online	Structure
Percent patients treated in stroke-certified hospitals vs. those hospitals not stroke-certified	CHA data	Increase the number of patients treated at a stroke center over time	Department can pull report from CHA data	Structure

2016 Priorities

- Recommend a quality improvement process and the role of a council in reviewing data.
- Recommend options for data submission to the department.
- Address possible funding needs to support data recommendations.
- Further explore the following potential data elements:

Data Measure	Source	Purpose	Collection Method	Type of Data
EMS stroke alert Yes/No	EMS data	Improve EMS-hospital communication	Department can pull report from EMS data	Process
	Hospital data	Assess stroke alert accuracy	Request hospitals report voluntarily to department	
Acuity adjusted mortality	CHA, Agency for Healthcare Research and Quality	Decrease mortality over time	CHA may be able to generate based on methodology from AHRQ	Outcome

Prevention and Treatment of Stroke

The board previously found that certified stroke centers provide sufficient stroke care and perform adequate quality improvement. In 2015, the board explored ways to establish a statewide system of support and define minimum standards to equip all hospitals in Colorado with the ability to treat acute stroke patients with confidence. The board's emphasis was on the treatment of acute ischemic stroke. Priority was given to strategies with a patient-centered approach addressing statewide needs across the continuum of care.

Report on 2015 Priorities

The board used the following methodology to investigate educational strategies that would best meet the needs of Colorado facilities and providers.

1- Survey hospitals to assess the current stroke care capabilities in Colorado's regions
2- Define the minimum standards for ischemic stroke care that hospitals across the state should meet
3- Identify the education and tools necessary to help Colorado hospitals meet the recommended minimum standards

The board surveyed all Colorado hospitals to assess existing capabilities for acute ischemic stroke care. The survey addressed the following:

- Which hospitals are already a stroke center, are pursuing stroke center certification or are not pursuing certification and do not anticipate doing so
- What access to stroke care exists in Colorado- See map with stroke centers on page 15
- What facilities treat or transfer stroke patients
- Which of the following resources are available in each facility:
  - Stroke coordinator and/or a stroke team
  - Neurology available in 20 minutes
  - Neurosurgery access
  - Triage/EMS response plans in place
  - Stroke admission orders
  - Stroke transfer protocol
  - Stroke treatment protocol
  - Standard stroke scale
  - tPA
  - Discharge protocol that includes rehabilitation referral
  - Data collection and quality improvement plan
  - Community education
  - Reasons for not pursuing stroke certification
- On-site availability of:
  - CT (X-ray Computed Tomography)- imaging helpful in diagnosing serious injury
  - MRI (Magnetic Resonance Imaging)- imaging helpful in diagnosing soft-tissue injury
  - CTA (CT with Angiography)- adds visualization of the inside of blood vessels
  - MRA (MRI with Angiography)- adds visualization of the inside of blood vessels
  - Carotid Ultrasound- real-time imaging using sound waves
  - Echocardiogram- ultrasound with specialized waves for viewing the heart
  - Telemedicine- technology that allows for clinical direction from a distance

The survey results provided information on how Colorado's stroke system of care could be most efficiently and effectively improved. Some of the most significant findings from the survey include the following:

- Colorado has 82 critical access and acute care hospitals. Twenty-four of those are already certified as stroke centers. This survey targeted the stroke care capabilities in the other 58 critical access and acute care hospitals. Thirty-one of those hospitals completed the survey. The following information is based on the feedback from the 31 participating hospitals.
- Three of the 31 responding hospitals are not able to provide tPA.
- Twenty hospitals report that all stroke patients or suspected stroke patients are transferred to a higher level of care.
- Nineteen hospitals have telemedicine available.
- Seventeen hospitals have access to a neurological consult within 20 minutes.
- Eleven hospitals do not transfer all stroke patients, and six of those have rehabilitation referrals as a part of the discharge plan.

Conclusions from the survey

- There is a gap in the transition of care between hospital discharge and post-acute services. The Rural and Urban Care Coordination subgroup adopted this as a priority and will work to make recommendations for rehabilitative minimum standards.
- Rural communities need improved access to acute and post-acute stroke care in their region. The board resolved to make recommendations that help create minimum standards for stroke care that all hospitals in Colorado can achieve and a statewide infrastructure to help hospitals achieve the minimum standards.
- The board defined some clear distinctions in the stroke care capabilities in Colorado, but the capabilities did not consistently correlate with a hospital's licensure or trauma level (the system currently in place that defines different levels of care). The survey provided the following levels of stroke care:
  - ~ Facilities that transfer all stroke patients
  - ~ Facilities that treat and admit certain stroke patients while transferring others
  - ~ Facilities that treat and receive stroke patients from other facilities.

Identified gaps in rehabilitative care

- The board found that insurance reimbursement is a barrier to accessing appropriate rehabilitative care. Improving rehabilitative coverage would improve the provision of post-acute services that are necessary to achieve maximal recovery and decrease the emotional, communal and fiscal impacts of stroke disability. Insurance reimbursement for telehealth services has been addressed recently through the legislature, and rehabilitation services may benefit from pursuing similar legislation.
- Hospital personnel involved in the discharge process may need education regarding local rehabilitative services. Stroke patients, family and caregivers will need education to understand the rehabilitative continuum of care and how each stage would benefit the stroke survivor's return to home and maximum function.
- Rehabilitation representatives on the board also expressed interest in the potential to utilize telehealth services for rehabilitation purposes to expand access to care in rural areas. This will be considered in 2016.

The board worked to address the gaps in rehabilitative care. The following objectives will be further refined in 2016 to develop recommendations for rehabilitative minimum standards.

- Each stroke patient should receive a comprehensive rehabilitation evaluation by a multidisciplinary team. The stroke survivor and caregiver(s) should be educated on the continuum of rehabilitative care that will maximize physical and cognitive ability and overall quality of life.
- Hospitals with care coordination services should provide information to the stroke survivor and caregivers on available resources that meet the patient's rehabilitative needs per the evaluation. Available resources could include: local/national resources, community agencies with sliding scale fees, offer Medicaid applications when appropriate, etc.

Current Recommendations

The board recommends the following minimum criteria for acute ischemic stroke care:

- For facilities that do not have CT or tPA and transfer all suspected stroke patients:
  - ~ Educate staff and community to recognize stroke symptoms
  - ~ Use a statewide standardized stroke assessment tool
  - ~ Call 911 and have a transfer plan that includes destination options
- For facilities that treat and admit some ischemic stroke patients
  - ~ Use a statewide standardized stroke assessment tool
  - ~ Have CT and tPA capabilities readily available
  - ~ Have a facility-defined Stroke Alert Response Plan to expedite care from hospital arrival to CT scan and interpretation in the most efficient manner
  - ~ Plan for access to expertise: neurologist consult by phone or telestroke capabilities
  - ~ Have a transfer plan that includes destination options

Recommended educational efforts:

- Advanced Stroke Life Support Training: certified stroke centers offer this training on-site at rural facilities. The curriculum provides education that prepares hospitals to treat acute stroke patients and meets the board's recommended minimum standards. This training would be most beneficial if offered to rural hospitals on a biennial rotation or as needed to maintain competency.

Recommendations to improve resource availability

- The board recommends a state-level infrastructure that supports rural hospitals by advancing telestroke or other secure methods that provide long-distance consultation.

2016 Priorities

- Explore potential minimum standards for the care of pediatric stroke patients
  - ~ Consider that there are different causes for stroke in pediatric stroke patients
  - ~ Distinguish between symptom presentation for stroke vs. other neurological conditions
  - ~ Explore access to expert consultation services for pediatric stroke patients
  - ~ Research tPA guidelines for pediatric stroke patients
- Research minimum standards for the care of ischemic vs. hemorrhagic stroke
  - ~ Ischemic stroke care has improved more than hemorrhagic stroke care according to feedback from reviews of certified stroke centers. Additional attention is needed to define recommendations for hemorrhagic stroke recognition, treatment and processes. The board will continue to gather information on evolving guidelines.
- Research and develop recommendations that would improve rehabilitation and other post-acute stroke care services in Colorado. Specific topics to address include:
  - ~ Rehabilitation minimum standards
  - ~ Improve insurance reimbursement for skilled rehab and other post-acute care services
  - ~ Consider how other states have improved availability of rehabilitative services
  - ~ Gather evidence based guidelines across the rehabilitative continuum of care
  - ~ Explore options to advance telehealth capabilities for rehabilitation
- Investigate options to advance telestroke or other secure communication methods that would allow experts to evaluate long-distance stroke patients
- Develop strategies to disseminate the Advanced Stroke Life Support training to hospitals across the state
- Recommend education for rural areas that meets the following criteria:
  - ~ Provide education in rural areas
  - ~ Minimize the time providers are taken away from their role
  - ~ Ensure education for rural facilities is cost-effective
  - ~ Provide continuing education credits

Rural/Urban Coordination of Care

The board gathered information from various emergency medical services and hospital professionals to identify needs that exist in Colorado and develop strategies to meet the greatest needs. The board crafted minimum standards for EMS and hospitals to improve the coordination of stroke care across the continuum of care from symptom onset through rehabilitation and community reintegration. These minimum standards will result in more uniform education. Statewide standards and guidelines are also intended to be customized at the regional level to ensure that providers are able to adequately meet the needs of stroke patients in Colorado's diverse regions.

Report on 2015 Priorities

In 2015, the board met with the Regional Emergency Medical and Trauma Advisory Council coordinators to gather information on how to improve the coordination of stroke services in Colorado. The feedback is summarized in the table below. Three main focus areas were the coordination between:

- EMS and hospitals
- Rural and urban hospitals
- Certified stroke centers and hospitals not certified as a stroke center

<table>
<tr><th></th><th>EMS</th><th>Hospital</th></tr>
<tr><td>Data/ benchmarks</td><td>Define data elements for benchmarking</td><td>Defined data elements for benchmarking</td></tr>
<tr><td>Treatment</td><td>Prehospital Assessment Protocols
Destination guidelines</td><td>Transfer protocols
Standard facility response to EMS alerts
Treatment guidelines
Divert guidelines
Standardize procedures between facility/EMS</td></tr>
<tr><td>Care Coordination</td><td colspan="2">EMS and Hospital CQI
Feedback to EMS
Treatment standards
Transitions of care standard</td></tr>
<tr><td rowspan="2">Education</td><td>Dispatch screening
When to call flight</td><td>Rural facilities are a site for education</td></tr>
<tr><td colspan="2">Continuing education courses in rural areas
Webinars/ DVDs/ downloads/ newspaper / radio/ posters/ social media
Training similar to Rural Trauma Team Development Course
Understanding facility capabilities to treat stroke</td></tr>
<tr><td rowspan="2">Resources needed</td><td>Pocket cards: symptoms, assessments, checklists</td><td></td></tr>
<tr><td colspan="2">Facility lists with one-call numbers
Critical care transports</td></tr>
</table>

In 2015, the board discussed its objective to improve the transition of care between EMS and hospitals. Recommendations will be refined in 2016 for the following topics:

- Statewide standardized stroke scale- The board believes that this would improve the validity of information exchanged between hospitals and EMS. It would also decrease communication barriers between EMS providers, rural and urban hospitals and stroke centers and facilities that are not certified as a stroke center. In 2016, the board will consider evidence-based guidelines to determine if there is a single assessment that could be a standard for Colorado.
- Statewide standardized stroke alert criteria
  - In urban areas, this would provide a standard of excellence in each hospital and EMS agency. Advance notice provides better coordination between facilities when transfers or flight is necessary.
  - In rural hospitals, this would help ensure rural facilities have adequate time to staff and prepare for stroke assessment, treatment and transfer when appropriate.

Current Recommendations

The board recommends working with the Regional Emergency Medical and Trauma Advisory Councils to standardize and coordinate with EMS and hospitals to implement the following recommendation.

EMS Minimum Standards: The board agreed on the following recommendation in light of current research, which stresses the importance of EMS in acute stroke care.

- All providers should have ongoing education in identifying the signs and symptoms of stroke and be able to route stroke patients appropriately according to regionally specific protocols.

2016 Priorities

- Detail the statewide recommendations for:
  - Educational strategies to equip all providers to recognize stroke symptoms
  - Statewide standard stroke scale for EMS and hospitals
  - Transport guidelines based on stroke assessment scores, customized by regions
  - Statewide stroke alert criteria recommendations
  - Statewide criteria for appropriate modes of transport, customized by regions
  - Statewide standardized data submission
  - Consider EMSystems or other media to communicate stroke services status
- Recommend a hospital feedback plan for EMS that addresses:
  - Stroke alert accuracy
  - Appropriateness of patient routing
  - Debrief to assess efficiency of patient transition

Stroke Designation for Hospitals

The department is currently recognizing facilities that are nationally certified as stroke centers but has no authority over the operation of those facilities. Certification is a credential awarded by a nationally-recognized organization and requires ongoing reviews, data analysis and criteria that match current best practices.

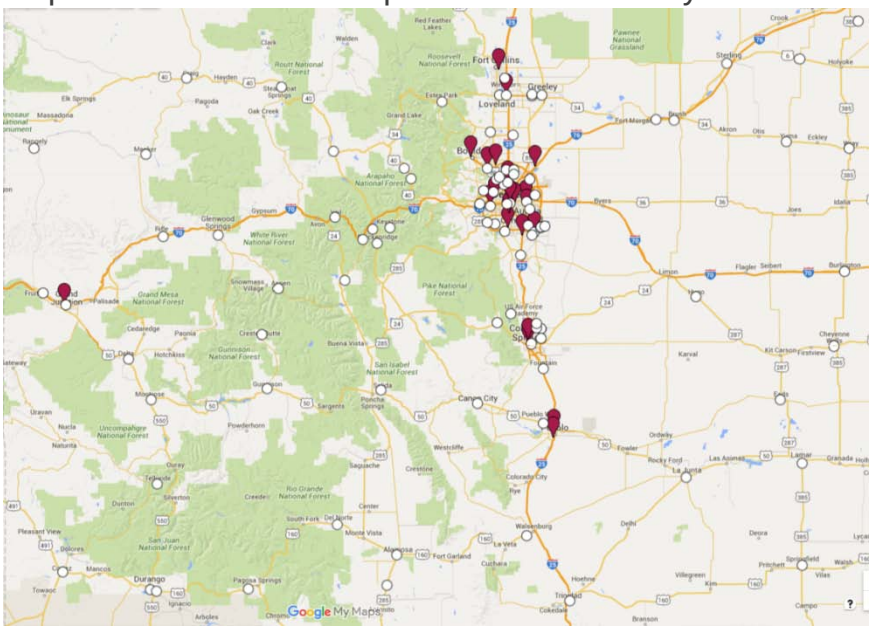
The board was charged with researching whether state designation is appropriate or necessary to assure access to the best quality care to stroke patients in Colorado. Designation differs from recognition and certification. The term designation implies that the state assigns an official status to a facility based on criteria written into state rule.

After thorough and careful review, the board concluded that designation, above and beyond national certification, is not necessary. The board is committed to recommendations that will improve access to stroke care and improve the quality of stroke care for all Colorado residents. The board's guiding principle is to increase the number of facilities that provide basic stroke care, which would increase early access to stroke care and therefore increase the number of stroke patients treated successfully. The board did not believe that a formal state designation process would further that goal. Details on the considerations for and against designation are summarized in Appendix 2.

Report on 2015 Priorities

The board gathered information on the current landscape of stroke care and certified stroke centers in Colorado.

- Colorado currently has three Comprehensive and 21 Primary Stroke Centers certified by The Joint Commission. The Joint Commission will be offering a third certification for Acute Stroke Ready hospitals in the near future. This certification is common in other states and considered essential in expanding access to baseline care.
- 2012 data from Colorado hospitals shows that 77 percent of stroke patients treated in a hospital are seen at a Comprehensive or Primary Stroke Center.



Map of hospitals in Colorado that receive emergency patients. Certified stroke centers are in red. Updated information on certified stroke centers is available at: www.qualitycheck.org.

Current Recommendations

The Stroke Advisory Board will not continue to investigate designation and does not recommend a state designation above and beyond national certification. Instead, the board will focus on developing a support system and infrastructure that would increase the number of facilities, especially in rural areas, that could meet the proposed minimum stroke care standards. The support system will address stakeholder feedback gathered in 2015.

2016 Priorities

Develop a recommendation for a support system for hospitals not certified as a stroke center:

- Address how to help hospitals meet minimum standards
- Consider current licensure and rules that could affect stroke care in all facilities that receive emergency patients
- Consider ways to incentivize national certification
- Consider stakeholder recommendations to improve access to stroke care
  - ~ Increased use of tPA through education efforts and ensuring availability of the medication
  - ~ Improved access to telemedicine
  - ~ Improved partnerships between stroke centers and facilities that are not stroke centers
  - ~ Standardized treatment and transfer protocols/ guidelines
  - ~ Improved coordination and accessibility of stroke resources throughout the state
  - ~ Appropriate data collection, analysis and quality improvement efforts
  - ~ Community education programs with an emphasis on rural communities

Appendix 1

Catalogue of Data Sources Utilized in 2015

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

In 2015, this was not a major source of information but was occasionally referenced and may be of future interest due to the inclusion of stroke core measures. This is considered a supplemental source of information; it holds claims data and is not limited to Medicare and Medicaid. A limitation is that claims-based data may not reflect procedures or patient information unrelated to a billed item. While many hospitals report to CMS, the 29 Critical Access Hospitals and 33 Community Clinics with Emergency Care are not required to submit Core Measures. These small hospitals are an integral part of the stroke care system, and data from these facilities is desirable.

Quintiles (vendor for Get With the Guidelines Patient Management Tool)

This database was discussed and reviewed in 2015, and it contains most of the proposed data elements. Comprehensive and primary stroke centers participate in this database and account for 77 percent of stroke patients treated in a hospital according to the Colorado Hospital Association dataset, described below. The limitations include: the department does not have direct access to these data; small facilities do not have the resources to participate, and facilities are not required to enter all stroke patients. Thus reports that are produced from this source are not representative of all strokes and provide limited data. The board will continue to explore the use of this dataset.

Colorado Hospital Association Discharge Datasets (Inpatient and Emergency Department data)

This was the most utilized source of data in 2015 and gives a general idea of what stroke care looks like in Colorado. This dataset includes almost all hospitals in Colorado except several Critical Access Hospitals that see low patient volumes and very few stroke patients. This is an informative database but is of limited use for quality improvement. It is an administrative database and does not show all patient procedures and treatments. The board found referring facilities were not coding for tPA due to minimal reimbursement, resulting in the appearance that treatment was not delivered. Additionally, this data will consistently be at least 18 months in arrears also making quality improvement difficult.

Emergency Medical Services Dataset (EMS data)

This dataset has complemented the Colorado Hospital Association. A system upgrade is anticipated in January 2017 and should provide more meaningful stroke data. Currently, there are 67 required data elements. Agencies are increasingly reporting additional data elements voluntarily as it is of no extra burden to the agency.

Appendix 2

State Designation Considerations in 2015

The board met with hospital professionals in May to discuss various topics associated with potential stroke designation. One of the overarching questions was whether a state designation in addition to national certification, is necessary or appropriate for Colorado.

- Considerations in favor of designation
  - ~ State designation could be a way to develop a structure to support and standardize practices across facilities.
  - ~ State designation could be more attainable for rural facilities compared to resource-intensive national certifications.
  - ~ An inclusive rather than exclusive system could help increase the number of stroke-ready facilities and stroke care access across the state.
  - ~ Designation could provide the framework to improve compliance with best practices and the proposed minimal standards.
- Considerations against a state designation
  - ~ The board's priority is to raise the standard of care in all hospitals in Colorado. A state designation would only regulate participating facilities. This would not reach the goal to make stroke care access ubiquitous across the state.
  - ~ Both the state and hospitals could incur significant costs for regulatory oversight, which could discourage facility participation in the stroke care system.
  - ~ State designation could impact facility operations negatively. Rules authorize the department to enforce consequences based on the severity of non-compliance. Some issues could result in the loss of permission to provide specific services which directly impacts communities.

Hospital representatives and other interested stakeholders recommended the following goals for Colorado's stroke system of care.

- Increased use of tPA through education efforts and ensuring availability of the medication
- Improved access to telemedicine
- Improved partnerships between stroke centers and facilities that are not stroke centers
- Standardized treatment and transfer protocols/ guidelines
- Improved coordination and accessibility of stroke resources throughout the state
- Appropriate data collection, analysis and quality improvement efforts
- Community education programs with an emphasis on rural communities

Appendix 3

Stroke Advisory Board Members

Angie Baker
Littleton
Term expires - 08-01-17
Representative for a national association for stroke

Timothy Bernard, MD
Denver
Term expires 08-01-18
Board-certified neurologist

Ginny Hallagin
Burlington
Term expires - 08-01-16
Rural Hospital Administrator

Joseph Foecking, PT
Colorado Springs
Term expires - 08-01-17
Stroke rehabilitation facility

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

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

John Hudson, MD
Lakewood
Term Expires 08-01-18
Board-certified neurosurgeon

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

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

Melissa Coria
Lone Tree
Term expires - 08-01-17
Member of the public who has suffered a stroke

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

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

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

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

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

Cindy Giullian
Denver
Term expires - 08-01-16
Urban area hospital administrator

Vacant - Primary care physician

Vacant - Expert in stroke database management

Vacant - Paramedic

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;

(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

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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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