COLORADO
Department of Public
Health & Environment
Dedicated to protecting and improving the health and environment of the people of Colorado

Dec. 16, 2016

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

The Honorable Jim Smallwood
Chair, Senate Health and Human Services Committee
Colorado State Capitol
200 East Colfax
Denver, CO 80203

RE: Annual report concerning the Stroke Advisory Board

Dear Representative Ginal and Senator Smallwood:

Pursuant to Senate Bill 13-225 and C.R.S. § 25-3-114, enclosed is the annual 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 Environment Committee of the House of Representatives and the Health and Human Services Committee of the Senate.

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

Emergency Medical and Trauma Services Branch

2016
Stroke Advisory Board Legislative Report

January 2016 – December 2016

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

2016 Stroke Advisory Board Legislative Report

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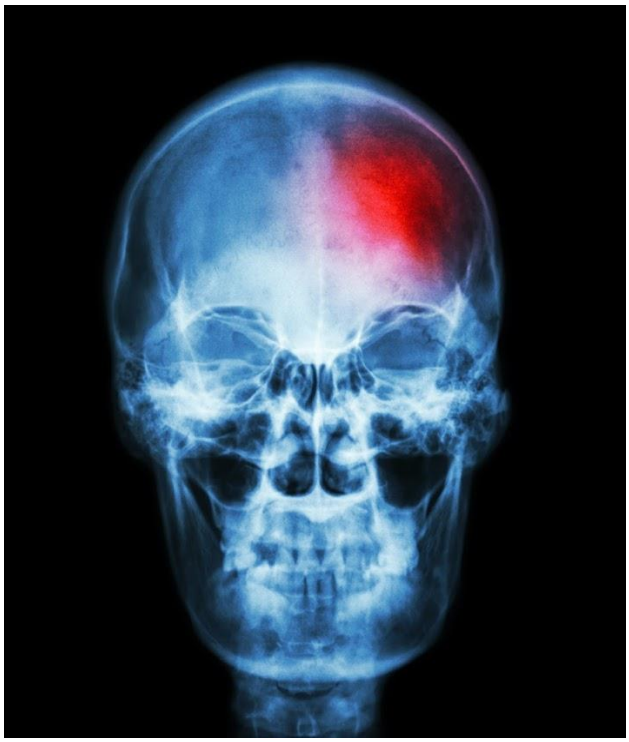
Executive Summary



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 that address four different areas that could improve stroke care in Colorado. 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 is essential for quality improvement because of its ability to identify areas of success and deficiencies within and across systems. Useful data requires a large pool of accurate information. Therefore, data elements should be minimal and measure evidence-based practices across the continuum of care.

Prevention and Treatment

In 2016, the board developed a diagram to map out the continuum of care for stroke. The board created minimum standards for each phase of care and refined the minimum standards from 2015. The main focus of 2016 was drafting minimum standards for the recovery phase to help emphasize the role of rehabilitation in the continuum of care.

Rural and Urban Care Coordination

The board developed educational recommendations to help prehospital providers and hospitals meet best practices for stroke care. Stroke education is most effective when it is delivered through collaborative efforts between EMS agencies, rural hospitals and urban hospitals.

State Designation of Stroke Facilities

Stroke certification is a credential awarded by nationally-recognized organizations and requires ongoing reviews, data analysis and criteria that match current best practices. The department currently recognizes facilities that are nationally certified as stroke centers but has no authority over the operation of those facilities. Designation generally refers to a state oversight process to assure compliance with standards set by the state. Designation is not authorized under current legislation.

2016 Recommendations

The following is a cumulative list of recommendations to improve the stroke system of care in Colorado based on information gathered from 2013-2016. These recommendations are described in detail with background on the decision-making process later in this report.

	Data
1	The board recommends the department have access to prehospital, hospital and rehabilitation data for stroke patients. The department would need resources to develop a repository to house sensitive information.
2	The board recommends the department convene a council of stroke experts to recommend data measures to collect, review de-identified data and make recommendations to improve the system of care.
	Prevention and Treatment
3	The board recommends hospitals and emergency medical services collaboratively develop a stroke process that includes: a prehospital stroke assessment, a stroke severity assessment and a prehospital notification process.
4	The board recommends adoption of a rehabilitation scope of care, which includes a model and minimum standards for rehabilitation across the continuum of care.
5	The board recommends minimum standards for the following: • Facilities that transfer and do not treat stroke patients • Facilities that treat and admit or treat and transfer ischemic stroke patients • Facilities that provide endovascular services • Facilities that provide rehabilitation in the inpatient setting • Facilities that provide rehabilitation in the community setting
	Rural and Urban Hospital Coordination
6	The board recommends statewide support to expand education through partnerships between stroke centers, rural facilities and EMS agencies. The recommended education would include: • Seminars on stroke recognition and treatment • NIH stroke scale certification • Stroke assessment and stroke severity assessment for prehospital providers
7	The board recommends hospitals provide feedback to prehospital providers on each stroke patient for quality improvement purposes.
8	The board encourages the use of expert consultation through telemedicine or other methods for stroke assessment and treatment.
	Stroke Designation
9	The board recommends a statewide system of support for stroke care but does not recommend state designation. The board recommends a collaborative and voluntary system that includes the following components for statewide quality improvement: • Department access to data • A council of experts, convened by the department, to recommend measures, review data and provide feedback • A quality improvement process that allows and encourages all hospitals to participate

2017 Priorities

Data

- Define prehospital data measures
- Define data measures for endovascular services
- Propose a method to submit data to the department

Prevention and Treatment

Prehospital

- Draft an education plan to improve prehospital recognition, notification and treatment of stroke
- Develop a guideline for stroke assessment and prehospital notification criteria that can be customized by regions
- Develop transport guidelines based on prehospital stroke assessment that can be customized by regions
- Develop criteria for appropriate modes of transport that can be customized by regions

Rehabilitation

- Explore ways to improve access to rehabilitation services
  - Catalog how other states have improved availability of rehabilitation services
  - Catalog options to advance telehealth capabilities for rehabilitation
  - Explore, then list options to decrease barriers so rehabilitation services match stroke survivor needs

Rural and Urban Coordination of Care

- Identify processes that improve hospital responses to prehospital notification
- Identify processes that improve communication regarding hospital service availability
- Identify strategies to improve prehospital stroke assessments, stroke severity assessments and prehospital notification
- Explore thrombolytic therapy treatment education that would be appropriate for rural hospitals that may treat ischemic stroke patients

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Designation-Statewide System of Care

- Clarify the roles and responsibilities of the council of experts
- Draft quality improvement processes
- Identify strategies to help facilities meet minimum standards
- Discuss whether designation is appropriate for endovascular services
- Investigate the opportunity for increasing access to expert consultations, including telestroke and other telehealth alternatives

Definitions and Acronyms

Alteplase: a type of tissue plasminogen activator that is an endorsed treatment for ischemic stroke.

CHA: Colorado Hospital Association

CMS: Centers for Medicare and Medicaid Services

ED: Emergency Department

EMS: Emergency Medical Services

G code: These are codes for rehabilitation that measure a current functional status and include a functional goal. These measures are submitted to the Centers for Medicare and Medicaid Services.

IA: intra-arterial

IV: intra-venous

NIHSS: National Institutes of Health Stroke Scale

PACS: picture archiving and communication system is a method to share and store images. Some medical facilities use this system to consult other health professionals for medical treatment decision making.

Recanalization: partial or complete re-opening of an artery

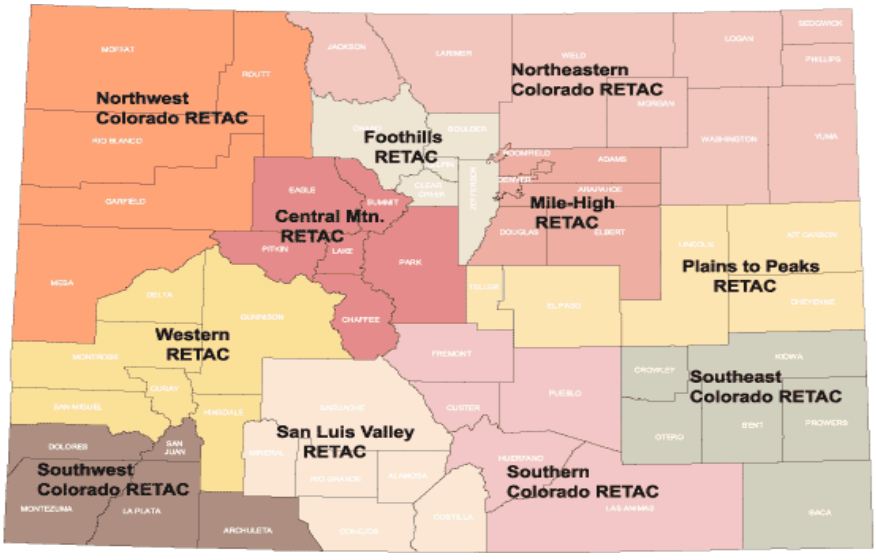
RETAC: Regional Emergency Medical and Trauma Advisory Council, also referred to as a region. Colorado has 11 different regions or RETACs, see Image 1.

tPA: tissue plasminogen activator, currently available as Alteplase (see above), a medication administered to ischemic stroke patients to dissolve blood clots and improve blood flow to the brain.

The board: refers to the Stroke Advisory Board

The department: refers to the Colorado Department of Public Health and Environment

Image 1
Regional Emergency Medical and Trauma Advisory Councils



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's membership is listed in C.R.S. 25-3-115, located in Appendix 3. The current members are listed in Appendix 2. Meetings are facilitated by the Colorado Department of Public Health and Environment.

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

Introduction

Stroke is a time-sensitive condition and requires early intervention and effective rehabilitation to improve outcomes. In Colorado and the nation, stroke continues to be among the top five causes of death and a leading cause of disability as many stroke survivors experience lifelong impairment. In 2015 there were 1,857 deaths from cerebrovascular disease accounting for 5.1 percent of all deaths in Colorado.[1]

In 2016, the Stroke Advisory Board developed a model for a continuum of care for stroke that begins with prevention and continues through the recovery phase. The board made recommendations for each phase of care through the work of three subgroups: Statewide System of Care, Rehabilitation Standards and Emergency Medical Services Standards. The larger group convened and arrived at a consensus to further guide the work of the subgroups throughout the year.

This report addresses each legislative topic in order: Data, Prevention and Treatment, Rural and Urban Care Coordination and Stroke Designation. Each section provides the board's recommendations, background on the work in 2016 and, finally, the objectives for 2017.

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

Data Registry and Public Access to Data

Data is essential for quality improvement because of its ability to identify areas of success and deficiencies within and across systems. Useful data requires a large pool of accurate information. Therefore, data elements should be kept to a minimum with a focus on collecting accurate data that measures evidence-based practices in stroke treatment across the continuum of care.

Recommendations

The board recommends that the department have access to prehospital, hospital and rehabilitation data from all agencies and facilities that treat stroke patients for the purpose of statewide quality improvement. Any recommendations for data collection would require legislation to provide the department with the authority and resources to collect and analyze data. The following conditions apply to data:

- Data collection should gather a minimal set of data elements in order to expand the number of facilities reporting data, improve the accuracy of the collected data, and minimize the burden on facilities. Currently recommended measures are detailed in Table 1.
- The department would need to develop a secure repository to house sensitive information. Data would likely come from multiple sources, as no one source offers all desired data.
- All facilities that provide rehabilitation to stroke survivors should track and report one of the following:
  - G code: This is a CMS measure for disability that includes one measure for current function and one for a functional goal
  - Verified functional assessment, defined by the facility

The board recommends that the department convene a council of stroke experts that make recommendations on what data to collect based on best practices, review de-identified data and make recommendations to improve the system of care.

Table 1

Recommended Data Measures
Mode of Arrival
Door to IV needle time for: • all patients treated with alteplase • patients treated with alteplase and a final diagnosis of ischemic stroke
Door to IA recanalization time
Percent of eligible patients receiving lytics
Door in to door out time (hospital arrival to transfer)
30 day readmit- all cause
Number of certified stroke centers
Percentage of stroke patients treated at a stroke-certified center vs. at a hospital not stroke-certified
Functional measure (a score used during the rehabilitation phase that measures ability to perform activities of daily living): • G-code (specific to CMS) • Facility defined functional assessment

Report on 2016 Priorities

Previously, the board agreed that data is necessary for quality improvement and recommended data collection and reporting for stroke. In 2016, the rehabilitation subgroup chose to add a rehabilitation-specific data element, as seen in Table 2, to the previously recommended data elements. The board recommends that hospitals use a G-code or a facility-defined functional assessment. A G-code is a functional measure that is part of the required reporting to Centers for Medicare and Medicaid Services. These codes are accessible for Medicare and Medicaid patients. Other verified functional assessments are utilized in various settings. There are existing tools that translate functional assessments, including G-codes, to allow for comparative analysis. These tools provide the capability to perform outcome analysis on all rehabilitation patients, regardless of payer source or the type of functional assessment that is reported.

Table 2

Rehabilitation data measure added in 2016

One of the following functional measures:

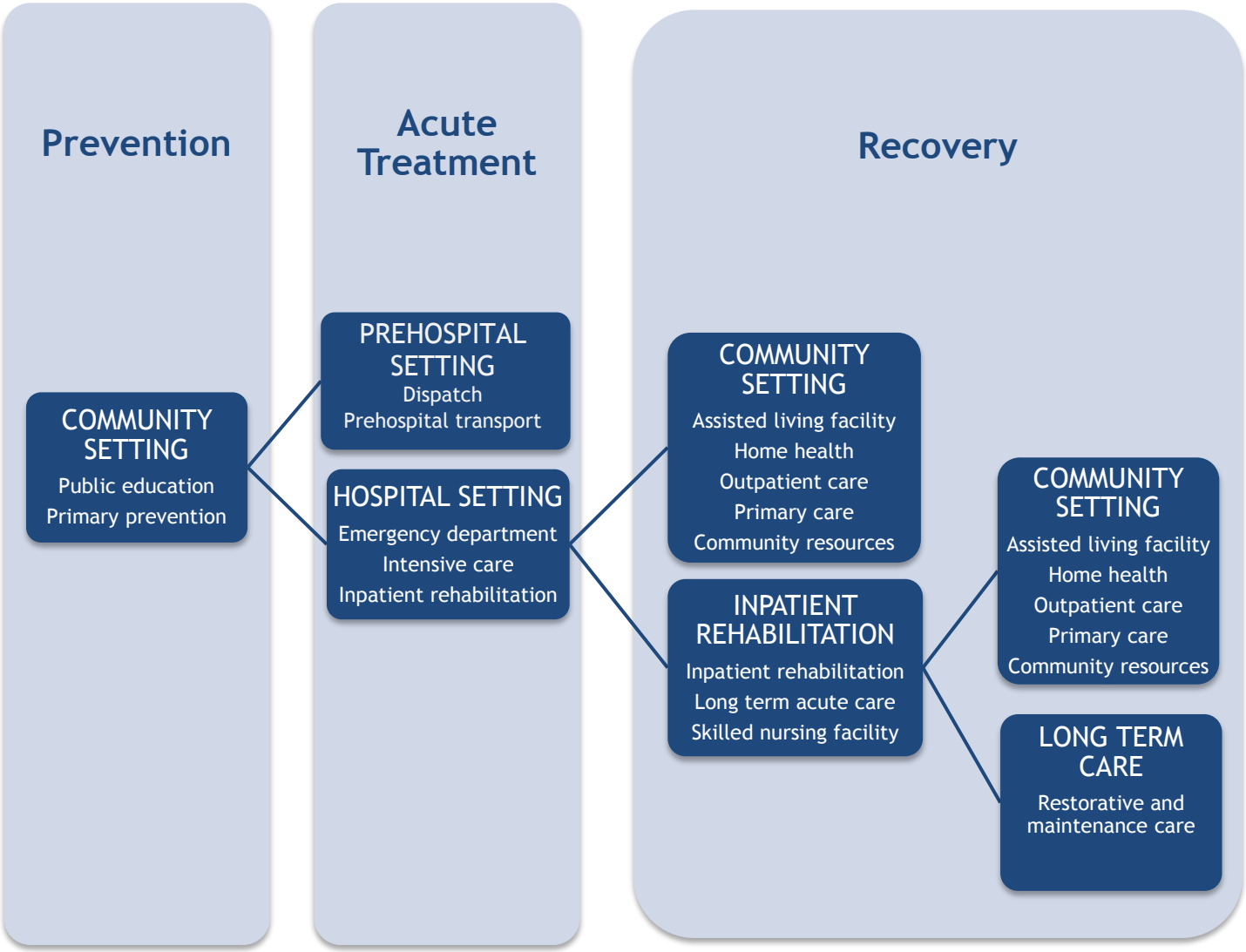
G-Code	Functional measure reported to Centers for Medicare and Medicaid Services
Verified functional measure	Various assessments exist and can be translated

2017 Priorities

- Define prehospital data measures
- Define data measures for endovascular services
- Propose a method to submit data to the department

Prevention and Treatment of Stroke

In 2016, the board developed the diagram below to map out the continuum of care for stroke. The board created minimum standards for each phase of care and refined the minimum standards from 2015. The main focus of 2016 was drafting minimum standards for the recovery phase and emphasizing the role of rehabilitation in the continuum of care.



Recommendations

Acute treatment phase

The board recommends hospitals and emergency medical services agencies collaboratively develop a stroke process that includes: a prehospital stroke assessment, a stroke severity assessment and a prehospital stroke notification process. The board agreed that stroke assessments and severity assessments must be fast, easy and have support from the prehospital community. The board also recommends the following for prehospital and hospital quality improvement purposes:

- Ongoing monitoring and improvement to meet best practices in stroke recognition and treatment
- Ongoing monitoring and improvement of prehospital notification of potential stroke patients
- Quality improvement efforts for stroke assessment and prehospital notification using prehospital data
- Statewide education for provider competency

Acute treatment phase

The board developed the following minimum standards for acute stroke treatment in the facility setting for varying levels of services.

Minimum standards for:

Facilities that transfer and do not treat acute stroke patients:

- Educate staff and community to recognize stroke symptoms
- Use a standardized stroke assessment tool, such as the NIHSS
- Have an emergency transfer plan that includes destination options and contact information
- Have a plan for quality monitoring and improvement

Facilities that treat and admit or treat and transfer ischemic stroke patients:

- Use a standardized stroke assessment tool, such as the NIHSS
- Have brain imaging and guideline recommended thrombolytic therapy readily available
- Have a goal for door-to-IV needle time consistent with national best practices
- Have a facility-defined response plan to prehospital notification of stroke, developed with emergency medical services, to expedite care from hospital arrival to brain imaging, interpretation and treatment in the most efficient manner
- Have a plan for access to expert consult (i.e., in person, by phone, telestroke, etc.)
- Have an emergency transfer plan that includes destination options and contact information
- Have a plan for quality monitoring and improvement

Facilities that provide endovascular services

- Have a goal for door-to-recanalization time consistent with national best practices
- Develop a scope of care explaining the clinical platform for endovascular services including: staffing, equipment and education
- Establish 24/7/365 capability or a plan to communicate when services are not available
- Have a plan for quality monitoring and improvement
- Develop a policy to communicate the following with prehospital providers and

partner hospital(s):
  - Schedule of endovascular services availability
  - Changes in the schedule for endovascular services availability
  - Feedback to prehospital providers on patient outcomes and loop closure
  - Continuing education for prehospital providers on stroke recognition

Recovery phase

The board offered recommendations for rehabilitation, which may be the most overlooked and least coordinated aspect of stroke care. The board developed the following scope of care for rehabilitation, which includes a model for care and minimum standards for rehabilitation across the continuum of care.

Scope of care

Model

A stroke, or "brain attack," can cause physical, cognitive, language, emotional and social impairments that require treatment to restore or improve function and quality of life to a stroke survivor. Recovery starts in the hospital and may continue for several years in the community setting. The goal of rehabilitation is to maximize function and promote independence. Many professionals need to work together to help the stroke survivor recover. A successful multidisciplinary team for rehabilitation may include:

- Stroke survivor
- Family members
- Other caregivers
- Trained medical providers such as:
  - Physicians and advanced practice providers to direct and oversee the plan of care
  - Nurses to facilitate ongoing assessment and education for acute and post-acute care
  - Social and case workers to connect the patient with important resources for recovery
  - Physical therapists to improve safe and efficient movement
  - Speech-language therapists to improve communication skills and swallowing
  - Dietitians to promote healthy lifestyle habits, dietary choices and reduce stroke risk factors
  - Neuropsychologists to improve thinking and problem-solving skills
  - Occupational therapists to improve the ability to perform activities of daily living
  - Counselors or psychologists to improve the ability to cope with the effects of stroke
  - Recreational therapists to improve participation in previous or new leisure activities
  - Orthotists to create and provide bracing that supports independence
  - Wheelchair seating specialists to maximize comfort with sitting and repositioning
  - Community resource representatives to provide education and social support

Rehabilitation minimum standards for:

Facilities that provide rehabilitation in the inpatient setting (hospitals, rehabilitation facilities, skilled nursing facilities)

- Perform physical, occupational and speech therapy evaluations to determine impairments for all stroke survivors
- Develop a multidisciplinary care plan to address current impairments and outline the expected progression through the rehabilitation continuum of care
- Incorporate the stroke survivor, family and caregiver(s) into the care team as early as possible
- Arrange for equipment that improves mobility and protects the patient from further impairment (including, but not limited to, wheelchairs, splints, orthotics)
- Perform or schedule a needs assessment of the home before discharge to determine the stroke survivor's rehabilitation needs and a recommendation for treatment after discharge
- Define a discharge plan for stroke survivors that includes:
  - A current functional score and a goal using a hospital-defined validated functional assessment
  - A multidisciplinary care plan for current and future rehabilitative needs
  - Patient, family and caregiver education on:
    - The stroke continuum of care, current status and the next goal
    - Rehabilitation progression expectations
    - Fall prevention
    - Prevention of secondary impairment and disability
    - Proper use of equipment that improves mobility
    - Monitoring and addressing mental and emotional health issues as they arise
- If any of the equipment or services listed below are not provided, the facility will have a plan to connect stroke survivors with providers of those services or equipment

Facilities that provide rehabilitation in the community setting (outpatient and home health facilities):

- Develop a multidisciplinary care plan to address current impairments and the expected progression through the rehabilitation continuum
- Refer the patient to other community based resources for emotional, social and physical recovery (i.e., stroke support groups or organizations)
- Provide education for:
  - Home modification to maximize safe function and independence
  - Fall prevention

Report on 2016 Priorities

Acute treatment phase priorities

- Assess if a statewide standard stroke scale for prehospital providers is appropriate

  The board felt it was necessary to make a recommendation for the use of stroke assessments and stroke severity scales based on prehospital and hospital feedback regarding inconsistencies in stroke assessments, prehospital notification and transitions of care processes. Members and community stakeholders agreed that stroke scales should meet the following criteria for prehospital providers.
  - Easy and fast
  - Easy transition from current practice
  - Specificity and sensitivity for large vessel occlusions considering new information on the importance of early intervention for endovascular services

  Several stroke scales met the criteria described above. Refer to Table 3 for stroke assessments that were considered. The board favored the Cincinnati Prehospital Stroke Severity Scale, see Table 4, for the following reasons:
  - EMS agencies in Colorado are already familiar with the Cincinnati Prehospital Stroke Scale.
  - The CPSSS would be a relatively easy assessment for large vessel occlusions.

  The board endorsed this scale but did not choose to include that in the recommendation to avoid unintended consequences related to the dynamic nature of evidence-based practice. The consensus was that hospitals and EMS agencies must work together to choose the most appropriate stroke assessment, stroke severity assessment and prehospital notification process.

Table 3

Stroke Assessments	Application
FAST Face, Arms, Speech, Time	Community assessment
BEFAST Balance, Eyes, Face, Arms, Speech, Time	Community assessment Severity component
LAPSS Los Angeles Prehospital Stroke Scale	Prehospital assessment
CPSS Cincinnati Prehospital Stroke Scale	Prehospital assessment
CPSSS Cincinnati Prehospital Stroke Severity Scale	Prehospital assessment Severity component
RACE Rapid Arterial oCclusion Evaluation	Prehospital assessment Severity component
MENDS Miami Emergency Neurologic Deficit	Prehospital assessment Severity component
NIHSS National Institutes of Health Stroke Scale	Hospital assessment Severity component

Table 4

Cincinnati Prehospital Stroke Severity Scale	
2 points	Conjugate gaze deviation (NIHSS ≥1 for gaze)
1 point	≥1 incorrect answers to two NIHSS questions for level of consciousness (age/gender) + doesn't follow 1 of 2 commands (close eyes, open/close hand) (≥1 on NIHSS level of consciousness 1b and 1c)
1 point	Cannot hold one or both arms up for 10 seconds before arm(s) fall to bed (≥2 for NIHSS Motor Arm)

Acute treatment phase priorities continued

- Improve frequency and accuracy of stroke assessment and notification
  While it is unclear how many stroke patients do not have a reported stroke scale or prehospital notification of stroke, hospitals and prehospital communities agree that improvement is necessary. Prehospital notification is important because it expedites stroke care by making the prehospital to hospital transition more efficient. The board found several factors that could improve frequency and accuracy of stroke assessment and notification.
  - Expand stroke education through regional, prehospital and hospital coordination.
  - Decrease variations in hospital and prehospital assessments and notification processes.
  - Expand education for stroke assessments in the hospital setting for prehospital and hospital providers.

- Minimum standards for endovascular services
  Several compelling studies have demonstrated that endovascular intervention is an effective treatment to decrease mortality and disability for acute ischemic stroke due to large vessel occlusion. The board, along with the support of hospital representatives, chose to further explore guidelines for endovascular services for the following reasons:
  - Nationally certified Comprehensive Stroke Centers are required to provide endovascular services and participate in continuous quality improvement while other certified stroke centers may choose to provide endovascular services but are not required to do so. This leads to inconsistent service availability among stroke centers that are not certified as Comprehensive.
  - Hospitals in Colorado that are not nationally certified in stroke care may choose to provide endovascular services. In Colorado, there is no benchmarking or quality improvement platform required of these hospitals.

Recovery phase priorities

- Defining the scope of care
  The board recognized the importance of rehabilitation and that utilization of rehabilitation services after hospital discharge has not increased. For this reason, the board chose to establish a scope of care model with minimum standards for rehabilitation that reaches beyond hospital discharge to complete the continuum of care.

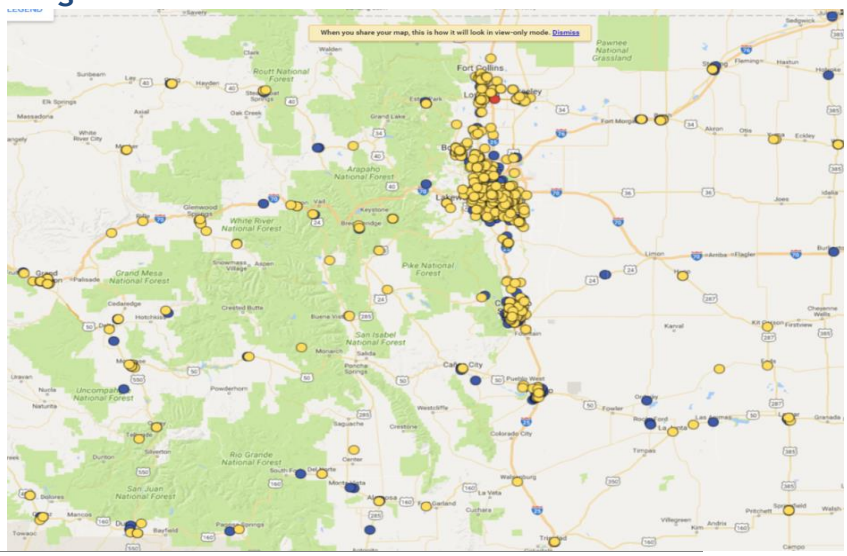
- Gather best practice guidelines for rehabilitation
  The board welcomed a presentation by the National Stroke Association on the patient navigator program. This program connects stroke survivors in the hospital setting with appropriate stroke recovery resources for the first six months after hospital discharge, and addresses many of the gaps in care that the board previously identified. The board identified the following three focus areas for stroke rehabilitation inspired by this program.
  - Connect patients with the patient navigator program
  - Connect stroke survivors with other recovery resources
  - Help stroke survivors navigate resources after hospital discharge

  The board gathered information and then developed a list of best practices from the review of international literature, recommendations from various stroke organizations and considered the existing International Classification of Functioning, Disability and Health used by the World Health Organization. The board agreed on a set of minimum resources that all stroke patients should have access to and incorporated these with the recommended minimum standards, see page 10.

  The rehabilitation subgroup gathered local stroke recovery resources including support groups, classes, therapeutic services and stroke organization contacts. The subgroup identified community resources that are underutilized. Members are working within their healthcare systems to share knowledge of these resources.

- Assess stroke rehabilitation resource availability in Colorado's regions.
  The subgroup compiled a list of licensed resources for stroke rehabilitation and created an interactive map, Image 2. The geography of rehabilitation resources closely aligns with the availability of acute services. Click to view interactive map.

Image 2 Licensed Rehabilitation Resources



Map legend:

- Inpatient rehabilitation facility
- Skilled nursing facility
- Home health agencies

2017 Priorities

Prehospital

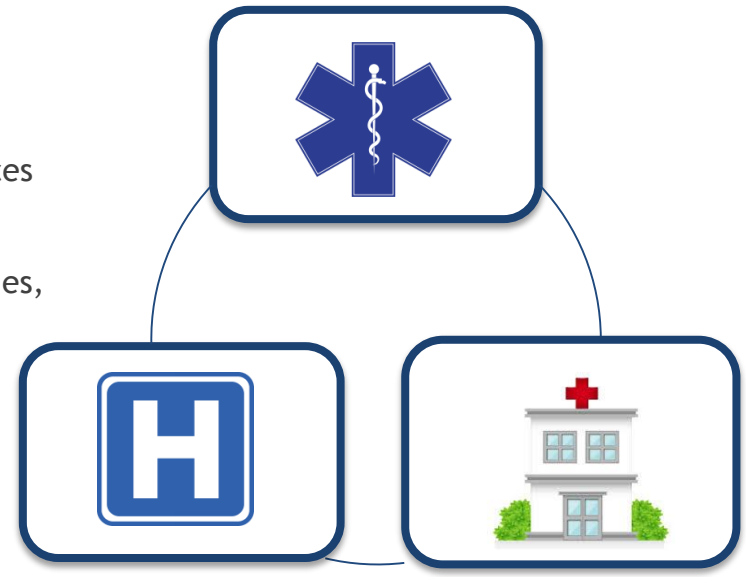
- Draft an education plan to improve prehospital recognition, notification and treatment of stroke
- Develop a guideline for stroke assessment and prehospital notification criteria that can be customized by regions
- Develop transport guidelines based on prehospital stroke assessment that can be customized by regions
- Develop criteria for appropriate modes of transport that can be customized by regions

Rehabilitation

- Explore ways to improve access to rehabilitation services
  - Catalog how other states have improved availability of rehabilitation services
  - Catalog options to advance telehealth capabilities for rehabilitation
  - Explore and list options to decrease barriers so rehabilitation services match stroke survivor needs

Rural and Urban Coordination of Care

The board developed educational recommendations to help prehospital providers and hospitals meet best practices for stroke care. Stroke education is most effective when it is delivered through collaborative efforts between EMS agencies, rural hospitals and urban hospitals.



Recommendations

The board recommends statewide support to expand education for prehospital and hospital providers through partnerships between stroke centers, rural facilities and EMS agencies. This rural and urban collaboration should help streamline transfer processes and provide education on stroke recognition and treatment. The department would act as a liaison to connect rural and urban hospitals and prehospital providers with their local hospital. The most beneficial education for rural areas includes:

- Seminars on stroke recognition, emergent treatment and case studies for hospital and prehospital providers. Certified stroke centers offer this education to non-certified facilities.
- NIH stroke scale certification for hospital professionals. Certified stroke centers offer this education to non-certified facilities.
- Stroke assessment and stroke severity assessment education for prehospital providers. Hospitals offer this education to prehospital providers.

The board recommends hospitals provide feedback to prehospital providers for each stroke patient. Hospitals are encouraged to develop a feedback process with data elements based on the feedback template, see Table 5.

The board encourages the use of expert consultation through telemedicine or other methods for stroke assessment and treatment.

Report on 2016 Priorities

Hospital and prehospital coordination

- Educational support for hospitals and prehospital providers
  The board gathered information from stroke centers, rural hospitals and EMS agencies. Those groups agreed that the most beneficial education includes NIH stroke scale certification, stroke assessment, stroke severity assessment, short seminars and case studies for both hospital and prehospital providers. Prehospital providers need ongoing education to identify stroke and large vessel occlusions.

- Prehospital feedback template for hospitals
  The board identified a gap in feedback to prehospital providers which limits quality improvement opportunities. Some of the challenges that exist in hospital feedback to prehospital providers include:
  - Hospital time commitment for case review and feedback preparation
  - EMS agency and prehospital provider time commitments to attend feedback discussions
  - Information security concerns with in-hospital information being shared with an outside agency

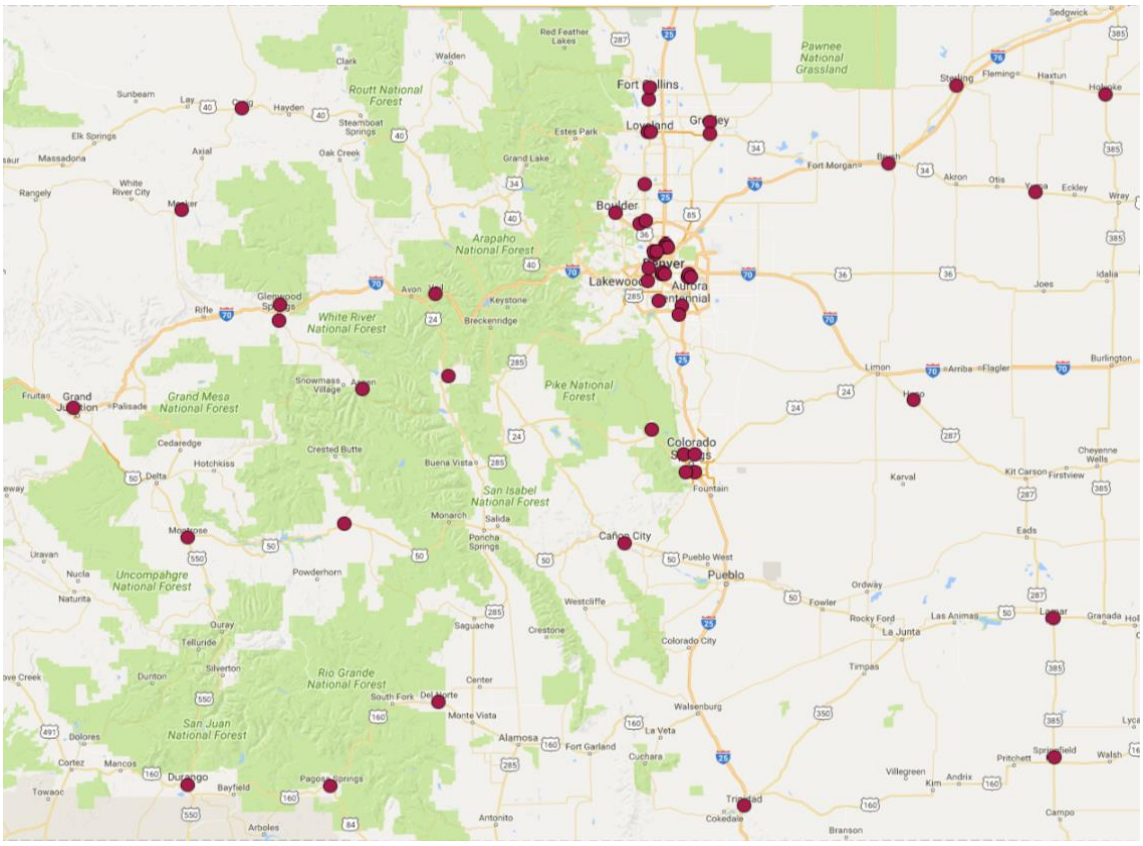
  In response, the board gathered information from hospitals with successful quality improvement programs and developed a template for suggested feedback elements that were vetted by hospitals and EMS agencies, see Table 5. The board also emphasized the importance of hospitals developing processes with EMS agencies to meet both EMS agency and hospital needs, including compliance with information security standards. The following considerations supported the board's decision:
  - All stakeholders agreed that feedback to prehospital providers also benefits stroke survivors and hospitals.
  - Utilizing case studies for feedback can help improve competency in identifying and appropriately treating stroke as well as providing continuing education for prehospital providers.

Table 5

Hospital feedback template suggested elements
Date of incident
EMS agency
Provider identifier
Patient gender
Patient birth date
Stroke assessment tool
Stroke severity assessment tool
Prehospital notification y/n
Prehospital notification accuracy
NIH stroke score
Diagnosis and interventions
Door to needle time
Door to interventional radiology
Share diagnostic images
Discharge disposition
Patient outcome
Additional comments
Discuss best practices

- Consider expansion of telestroke or other secure communication methods
  The board supports telestroke expansion and also received feedback that other secure communication methods may be appropriate.

Current telestroke sites in Colorado



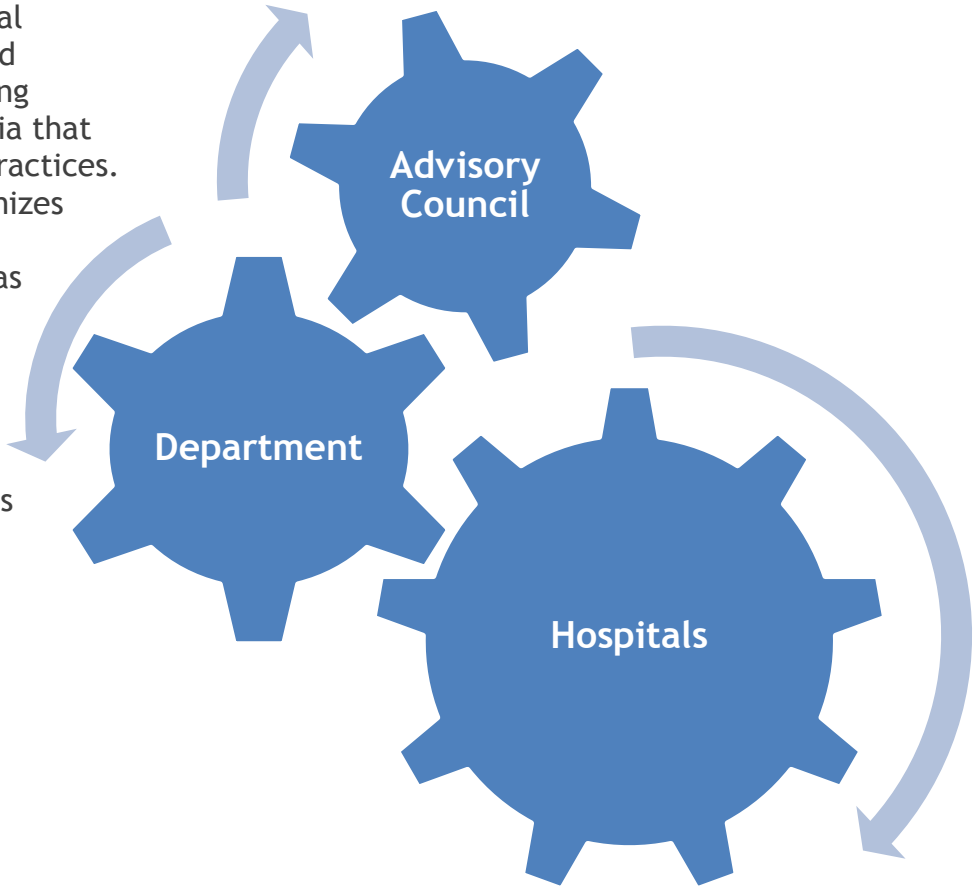
2017 Priorities

- Identify processes that improve hospital responses to prehospital notification
- Identify processes that improve communication regarding hospital service availability
- Identify strategies to improve prehospital stroke assessments, stroke severity assessments and prehospital notification
- Explore thrombolytic therapy treatment education that would be appropriate for rural hospitals that may treat ischemic stroke patients

Stroke Designation for Hospitals

Stroke certification is a credential awarded by nationally-recognized organizations and requires ongoing reviews, data analysis and criteria that match current evidence-based practices. The department currently recognizes facilities that are nationally certified as stroke centers but has no authority over the operation of those facilities.

Designation generally refers to a state oversight process to assure compliance with standards set by the state. This process is not authorized under current legislation.



Recommendations

The board recommends a statewide system of support for stroke care but does not recommend state designation. The board recommends a collaborative and voluntary system that includes the following components for statewide quality improvement.

- Department access to the recommended prehospital, hospital and rehabilitation data measures
- A council of experts, convened by the department, to make recommendations on what data to collect based on evidence-based practices, review de-identified data and make recommendations to improve the system of care.
- A quality improvement process that allows and encourages all hospitals to participate

Report on 2016 Priorities

- Quality improvement process
  The board explored existing quality improvement models in other states. The board then compared successes and challenges associated with each model and its components.

  The board concluded the following would be best for Colorado:
  - Voluntary participation by hospitals in a statewide stroke system with mandated data reporting by participating facilities. This helps to ensure hospitals are vested in the system and participate in continuous quality improvement.
  - A council of experts convened by the department would be necessary for a successful quality improvement program. The council of experts would review de-identified data that is provided by the department and make recommendations to the department, as a neutral party, to share with hospitals. Also, the department could connect hospitals with the council indirectly or directly depending on hospital-initiated requests. The board found that states without experts to review data did not have the resources to perform quality improvement on the stroke system of care.

- Improve access to expert consultation
  The board encouraged expansion of services to improve access to expert consultation.

2017 Priorities

Statewide system of care

- Clarify the roles and responsibilities of the council of experts
- Draft quality improvement processes
- Identify strategies to help facilities meet minimum standards
- Discuss whether designation is appropriate for endovascular services
- Investigate opportunities for increasing access to expert consultations, including telestroke and other telehealth alternatives

Appendix 1

Catalogue of Data Sources Utilized in 2016

Colorado Hospital Association Discharge Datasets (inpatient and emergency department data)

This was the most utilized source of data in 2016 and gives a general idea of what stroke care looks like in Colorado. This dataset includes almost all hospitals in Colorado except several rural 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. Additionally, this data will consistently be at least 18 months in arrears.

Emergency Medical Services Dataset (EMS data)

This data set contains prehospital care trip reports for most patients transported by EMS agencies in Colorado. A system upgrade is anticipated in January 2018 and should provide more meaningful stroke data. Currently, there are 67 required data elements where as the new dataset will contain over 250 data elements. Agencies are increasingly reporting additional data elements.

Appendix 2

Stroke Advisory Board Members

Robyn Moore
Evergreen
Term expires - 08-01-17
Representative of a national stroke association

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

Ginny Hallagin
Burlington
Term expires - 08-01-19
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

David Scott Miner, MD
Denver
Term expires: 08-01-19
Statewide chapter of emergency physicians

William Joseph Jones, MD Chair
Denver
Term expires - 08-01-17
Board-certified vascular neurologist

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

Jeanne-Marie Bakehouse
Franktown
Term expires - 08-01-19
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
Resident and member of a stroke association

Michelle Whaley, RN
Castle Rock
Term expires - 08-01-19
RN involved in stroke care

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

Christy Casper
Centennial
Term Expires – 08-01-19
Stroke database expert

Jason Schallenberger
Colorado Springs
Term Expires: 08-01-19
EMS provider

Vacant - Primary care physician

Members who terms expired in 2016

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

Jim Richardson
Basalt
Term Expired – 08-01-16
EMS provider

Connie Zachrich
Castle Rock
Term Expired – 08-01-16
Stroke database expert

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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