
2019

Stroke Advisory Board Legislative Report

January - December 2019

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

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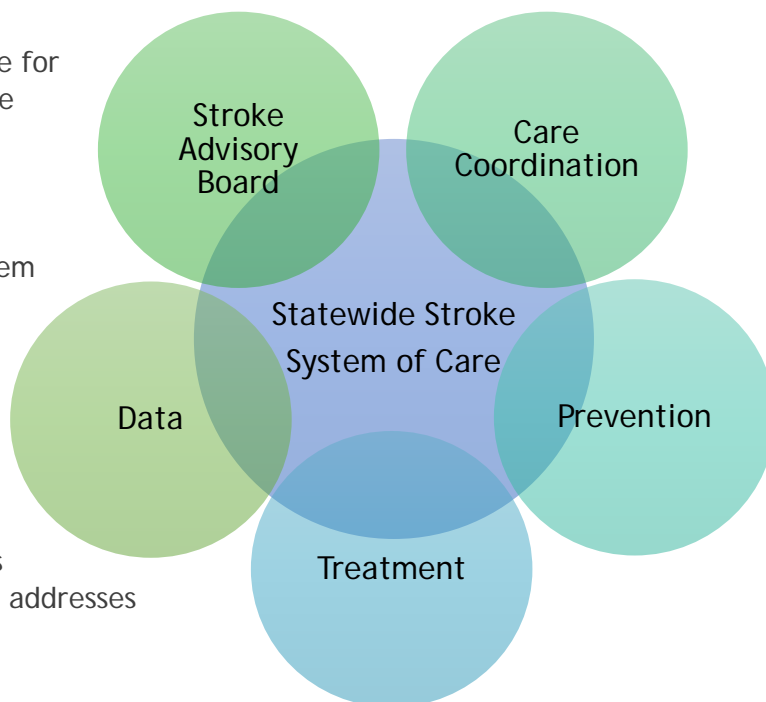


Executive Summary

The Stroke Advisory Board is a governor-appointed board that makes recommendations to the legislature each January on how to improve stroke care in Colorado. 25-3-115 C.R.S originally created the board in 2013.

The board recommends a statewide system of care for stroke that addresses local, regional and statewide resources that support the full continuum of care which includes prevention, acute treatment and rehabilitation.

The board's recommendation for a statewide system includes five elements, each essential to its overall function. The proposed model for a statewide system of care is comprehensive and customized to meet Colorado's unique needs. It has the potential to obtain better care outcomes, be more cost effective, and be more beneficial to Colorado's citizens than other existing statewide systems of care for stroke. This report contains the board's recommendations and addresses legislative implications.



Recommendations for a Statewide System of Care for Stroke

The board continues to recommend a statewide system of care for stroke that is facilitated by the Colorado Department of Public Health and Environment (the department). The board continues to oppose state designation of stroke centers because it would be duplicative and require extensive resources. These recommendations include the following elements to provide support that is targeted toward facilities that are not nationally certified to continue the pursuit of excellence in stroke care.

1. The Stroke Advisory Board should act as a resource for facilities, agencies and Regional Emergency Medical and Trauma Advisory Councils (RETACs). The board also recommends expanding its current directives, outlined in the legislation, to allow for a more active role in supporting a formal and voluntary statewide system of care.
2. Care coordination is necessary to address gaps in care and improve prevention, treatment and recovery from stroke. Care coordination recommendations address local, regional and statewide needs by connecting facilities, agencies, RETACs, the Stroke Advisory Board and the department.
3. Toolkit development and implementation will help facilities and EMS agencies meet the board's evidence-based recommendations. Stakeholders are encouraged to participate in revisions and continuous quality improvement.
4. Prevention recommendations include education for recognizing stroke, calling 911 and managing risk factors to prevent primary and secondary stroke. These recommendations standardize language in the community setting and apply to both prevention and recovery.
5. Data collection, analysis and feedback for quality improvement purposes is essential to evaluate the system of care, identify gaps and improve performance. These recommendations have the largest legislative impact because the department does not currently have access to clinical stroke data.

Background

On May 24, 2013, Gov. John Hickenlooper signed 25-3-115, C.R.S. into law and it was revised in May 2018 to extend the Stroke Advisory Board until Sept. 1, 2028. This legislation formed and instructed the Stroke Advisory Board to make recommendations to improve stroke care in Colorado and specifically address the following issues.

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

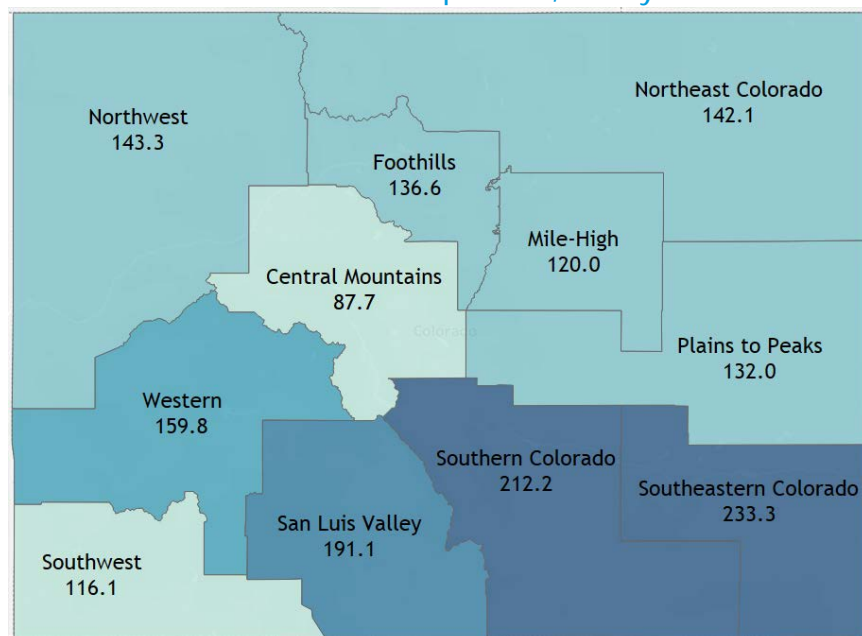
The board is made up of 18 governor-appointed members and one ex-officio member from the Colorado Department of Public Health and Environment. The legislation for the board is 25-3-115, C.R.S., located in Appendix 6. Board members who contributed to this annual report are listed in Appendix 4. Meetings are facilitated by the Colorado Department of Public Health and Environment.

In May 2017, the legislature adopted [Senate Joint Resolution 17-027](#), located in Appendix 5, which recognized the need to expand access to effective stroke care through education and support for providers. Members of the Stroke Advisory Board found that the resolution aligned with the legislation that directs the work of the Stroke Advisory Board.

The map below illustrates the varying impact stroke has on each of Colorado's 11 Regional Emergency Medical and Trauma Advisory Councils (RETACs). The need for and access to resources are key factors in developing recommendations that meet Colorado's unique needs.

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

Map 1: Rate of Colorado Residents Diagnosed With Ischemic Stroke in 2016 per 100,000 by RETAC



This data was taken from hospital discharge data and analyzed by the Colorado Department of Public Health and Environment EMTS Data Section. Ischemic strokes were identified by using The Joint Commission code tables. Darker shading indicates a higher rate of stroke.

Introduction

Acute stroke treatment is time-sensitive and requires early recognition, intervention and rehabilitation to improve outcomes. In Colorado and the nation, stroke continues to be the leading cause of long-term disability and among the top five causes of death in adults. In 2018, there were 1,992 deaths from cerebrovascular disease accounting for 5.2 percent of all deaths in Colorado.¹ The Centers for Disease Control reported that survivability rates from stroke have slowed since 2013 and Colorado is among 22 other states where mortality is rising.² In the United States, the total stroke-related medical costs are expected to more than double between 2015 and 2035 from \$36.7 billion to \$94.3 billion.³ A majority of people who suffer from stroke survive and those survivors require additional care to recover from disability or impairment from stroke.

Image 1: Ischemic stroke survivors in 2017 received additional care after leaving the hospital.

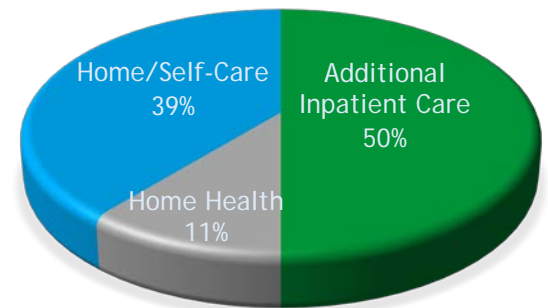
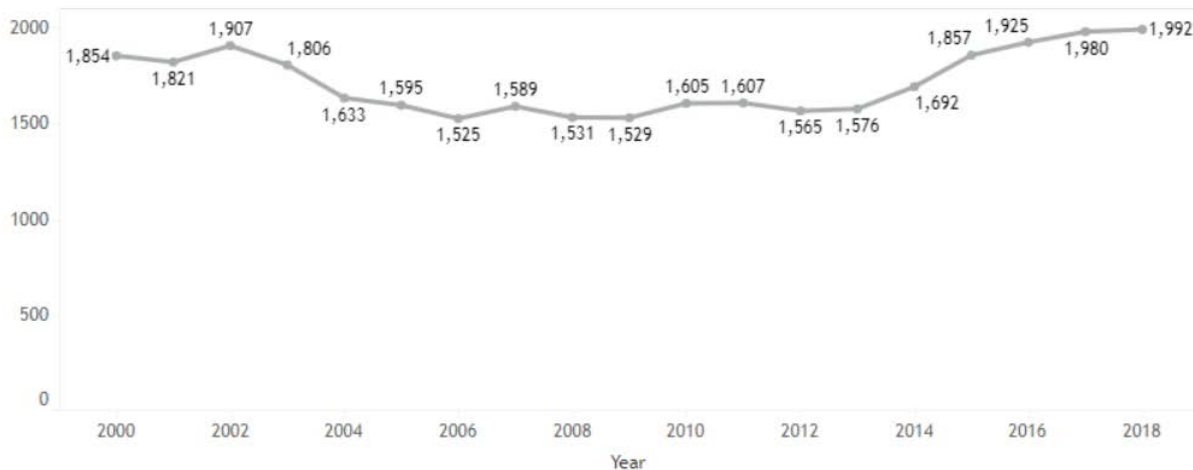


Image 1 reflects hospital discharge data analyzed by the Colorado Department of Public Health and Environment, Emergency Medical and Trauma Services Data Section using the Joint Commission code tables for stroke.

Image 2: Number of deaths from stroke in Colorado over time from 2000 to 2017



For additional information on death data, please visit the Vital Statistics Program at <https://www.colorado.gov/pacific/cdphe/vital-statistics-program>

Source: Vital Statistics Program, Colorado Department of Public Health and Environment

The board identifies two overarching goals. Those goals are to decrease mortality and to decrease disability and impairment by expediting acute treatment. This report outlines the foundation and infrastructure of a voluntarily driven system of care for stroke that focuses on delivering the best possible care to each person affected by stroke in Colorado. The board proposes an exemplary model for a stroke system of care that targets support to facilities that need it the most, provides sustainable quality improvement, and empowers facilities to provide excellent care in the communities they serve without overburdening facilities, agencies or state resources. Special attention is given to the potential costs to the citizens of Colorado, stroke survivors, facilities and agencies. While the board's recommendations are customized to Colorado's unique needs, this model has gained popularity and attention from several other states.

¹ Colorado Health Information Dataset (CoHID) <http://www.cohid.dphe.state.co.us/>

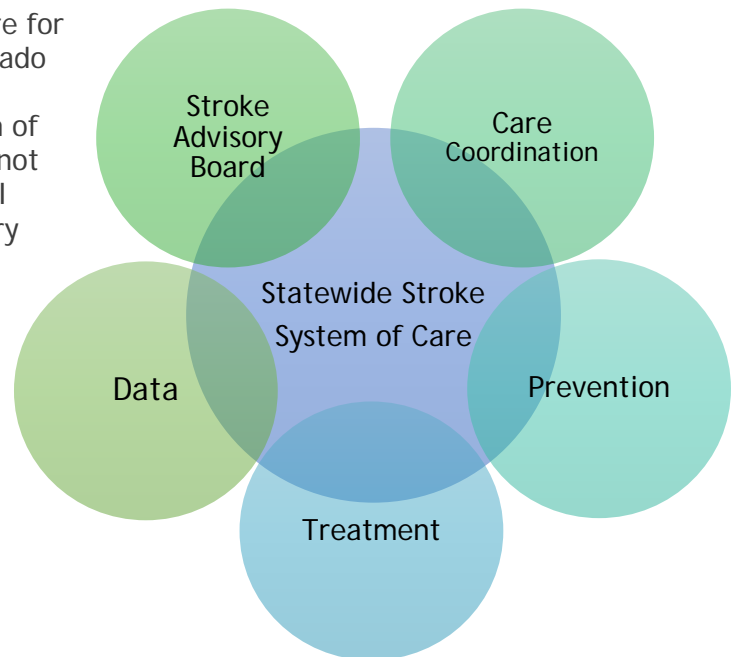
²Centers for Disease Control <https://www.cdc.gov/vitalsigns/stroke/infographic.html#graphic>

³ American Stroke Association https://www.heart.org/-/media/data-import/downloadables/heart-disease-and-stroke-statistics-2018---at-a-glance-ucm_498848.pdf

Statewide System of Care for Stroke

Currently, there is no formal statewide system of care for stroke in Colorado. The board recommends the Colorado Department of Public Health and Environment (the department) facilitate a formal and voluntary system of care that incorporates support for facilities that are not nationally certified as a stroke center. The board will continue to develop a plan and process for a voluntary system of care.

The board's recommendations endorse a system of care that improves coordination across the continuum of care, improves access to evidence-based treatment, and provides data for performance improvement purposes in order to save lives and improve quality of life for stroke survivors.



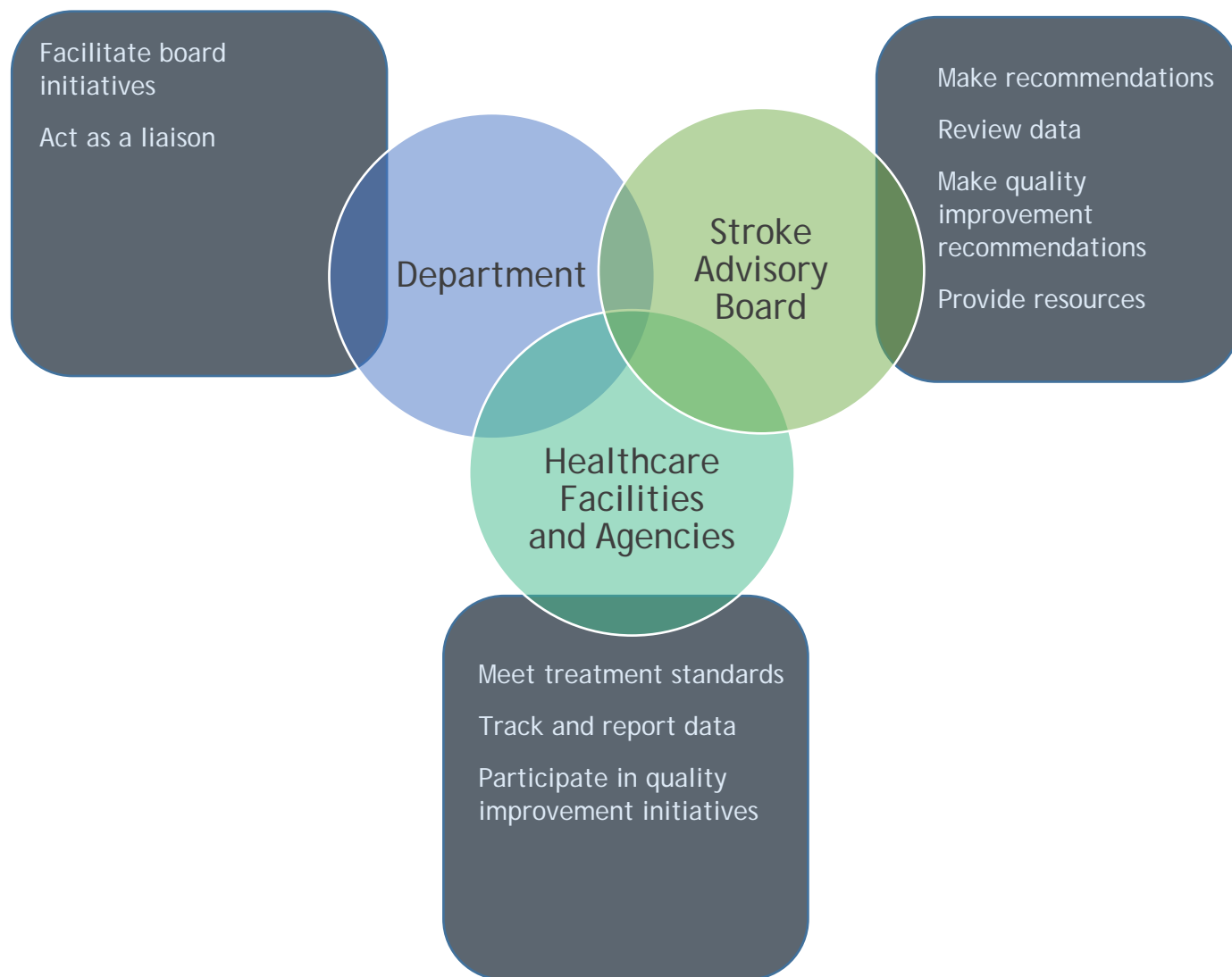
Recommendations for a Statewide System of Care for Stroke	Legislative Implications
A system of support should be established that is voluntary and incorporates facilities that are not certified as a stroke center. The board describes the following aspects as essential to meet the needs of a sustainable system of care in Colorado.	
Implement the recommendations outlined in the Care Coordination section of this report to address the full continuum of care involving facilities, agencies, the Stroke Advisory Board and the department to improve care at the local, regional and statewide level. This recommendation does not change the responsibility or autonomy that RETACs, EMS or facilities have over the services they provide.	None
Continue work, along with the changes recommended in the Stroke Advisory Board section of this report, to develop more robust involvement between the board and stakeholders in the stroke system of care.	Legislation would be required to make modifications.
Provide guidance to help facilities and agencies meet the recommended standards outlined in the Prevention and Treatment sections of this report.	None
Implement a process for data collection, analysis and reporting as detailed in the Data section of this report for the purpose of statewide quality improvement. Without stroke specific data, it will be difficult to make further data-driven and evidence-based recommendations to improve stroke care that is tailored to Colorado.	The department would need to be granted statutory authority and resources to receive, review and report out on data.

Future Priorities

- Develop a platform for a voluntary system of care facilitated by the department.
- Develop a plan that engages participation from all facilities providing stroke care.

Statewide System of Care for Stroke

This diagram illustrates the recommended collaborative interaction between facilities, agencies, the department and the Stroke Advisory Board. This model is similar to other states that facilitate a system and utilize an advisory board for subject matter expertise.



Stroke Advisory Board

The revisions to 25-3-115, C.R.S. and Senate Joint Resolution 17-027 continue to remind the board of priorities for Colorado. The board continues to assess the current landscape of stroke care in Colorado and the nation to determine what strengths and opportunities for improvement exist. With that, the board continues to develop recommendations and tools to address gaps in the system. The board strongly recommends that this board continue and have an expanded role to provide guidance to a formal system of care to establish statewide support and quality improvement. This role expansion does have legislative implications as outlined below.

Recommendations for the Stroke Advisory Board	Legislative Implications
The board recommends the following changes.	
<p>Change the membership of the Stroke Advisory Board to:</p> <ul style="list-style-type: none"> Edit the primary care physician seat to include advanced practice practitioners and remove the board certification listed because currently, there are no board certifications that match the description in the legislation. Change the second national stroke association representative to representative from a Regional Medical Director's group. Change the representative of a statewide association of physicians to a medical insurer or payer. 	Legislation would be required to modify the membership.
<p>The board is already instructed to gather information and make recommendations for treatment standards. The board also recognizes the need to make these evidence-based recommendations available to facilities, agencies and all of Colorado by:</p> <ul style="list-style-type: none"> Developing toolkits for facilities, agencies and the community setting with standards for prevention and treatment. Sharing existing resources that facilities, agencies, regions and community partners can use to meet the evidence-based recommendations. 	None
The board recommends it have access to aggregate data for the purpose of data-driven recommendations, statewide benchmarking and the capability to perform quality improvement initiatives.	Enabling legislation and resources would be required to gather, analyze and develop reports for the board's review.

Care Coordination

The board recognizes gaps in the continuum of care and the need for statewide initiatives to meet unique challenges in rural and urban areas. The following recommendations address needs and challenges in each of Colorado's Regional Emergency Medical and Trauma Advisory Councils (RETACs).

Recommendations for Care Coordination	Legislative Implications
The following recommendations are to improve care coordination between the prehospital and hospital settings.	
<ul style="list-style-type: none"> The board continues developing an EMS toolkit to address the following topics to improve care coordination. <ul style="list-style-type: none"> > Guidance on data reporting to help improve validity and reliability in the EMS dataset for the purpose of quality improvement. The guidance aligns with messaging to EMS agencies for data compliance. > Metrics for EMS to provide hospitals. The board continues developing a hospital toolkit that includes a template for hospitals to use to provide helpful feedback to EMS on stroke patients. The board recommends expansion of the EMResource platform to include stroke service availability to improve patient triage and transport efficiency. 	None
The following recommendations are to improve coordination between facilities.	
<ul style="list-style-type: none"> To improve communication and increase access to expert consultation, the board recommends that hospitals utilize existing and explore new HIPAA compliant communication methods. Resources that are currently available include telestroke, Picture Archiving and Communication System (PACS), and phone consultation. The board is developing a hospital toolkit which includes recommendations that address gaps in the transition from hospital discharge to the community setting for continued rehabilitation, recovery and preventing a second stroke. 	None
The board recommends establishing partnerships with policy development organizations in efforts to improve insurance reimbursement for services that align with best-practices and expand access to rehabilitation services.	
<p>Legislation has already improved insurance payment for locum tenens providers and national loan repayment programs for providers serving rural areas. Additional incentives for the following would be beneficial.</p> <ul style="list-style-type: none"> Inpatient and outpatient rehabilitation services. Restorative and adaptive rehabilitation. Patient-centered rehabilitation services as recommended by physicians and rehabilitation experts. Traveling providers to serve rural areas. 	None
<p>Legislation has improved insurance payment for telehealth services. Additional incentives for the following services would be beneficial.</p> <ul style="list-style-type: none"> Therapeutic activity assignment and monitoring through smart device applications. Rehabilitation treatment sessions facilitated by web conferencing or telehealth. 	

Future Priorities

- Continue engaging with the prehospital community by attending meetings and conferences.
- Develop and disseminate EMS and hospital toolkits.
- Develop a plan to communicate stroke capability services to EMS.

Prevention

The board is taking an innovative approach to address prevention with consistent messaging in different settings. The board has included how to identify stroke, improve recovery and prevent another stroke or other complications from stroke as a part of its prevention initiatives. The board is partnering with experts in prevention and community based healthcare to develop a comprehensive, evidence-based plan that addresses prevention in each setting across the continuum of care.

Recommendations for Prevention	Legislative implications
The board recommends consistent messaging to the general public in the community, hospital and recovery setting.	
<p>Public messaging should focus on the importance of risk factor management and its effect on stroke prevention. Additionally, common language along with medical terms the general public may encounter is listed below.</p> <ul style="list-style-type: none"> • Diet • Smoking • Diabetes • Physical inactivity • Overweight (obesity) • High blood pressure (hypertension) • High cholesterol (hyperlipidemia) • Blood thinner medications (anticoagulation) • Heart disease including irregular heart rhythm (atrial fibrillation) 	None
For stroke survivors, the importance of the primary care physician's role should be emphasized in disseminating the messaging listed above for stroke prevention, preventing other complications from stroke and preventing another stroke.	
Public education messaging for stroke should focus on survival rates and the importance of timely treatment for stroke. Public messaging should help identify stroke using the Balance, Eyes, Face, Arm, Speech, Time (BE FAST) assessment or similar tool and call 911 when a stroke is suspected.	

Future Priorities

- Develop a recommendation to address Transient Ischemic Attack (TIA) as a risk factor.
- Work with stroke prevention organizations to standardize messaging in the community, hospital and recovery settings.

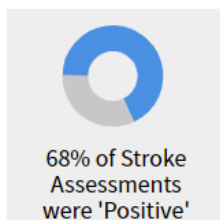
Treatment

Each year, the board revises the recommended treatment standards to align with evidence-based guidelines. Facilities that are nationally certified meet or exceed the recommended standards. In 2019, the board began developing a hospital and a prehospital toolkit to provide templates, guidance and resources to help facilities, agencies and regions meet the board's evidence-based recommendations. The toolkits are designed to disseminate evidence-based treatment standards to achieve facility and state-level performance improvement. The board works to develop recommendations that are reasonable, helpful and effective for facilities with varying stroke treatment capabilities in all of Colorado's diverse areas. The concepts for the prehospital toolkit can be found in Appendix 2 and the hospital toolkit concepts are available in Appendix 3.

Recommendations for Treatment	Legislative implications
The hospital toolkit should help the following types of facilities meet evidence-based treatment guidelines.	
<ul style="list-style-type: none"> Facilities that do not have intravenous thrombolytic capabilities (also known as alteplase, tPA, or clot dissolving medication). Facilities that can treat acute ischemic stroke with intravenous thrombolytic therapy but do not provide inpatient care for stroke patients. Facilities that can treat and admit acute ischemic stroke patients. Facilities that provide endovascular therapy. 	None
The Stroke Advisory Board should be available to provide assistance with resources for education, training and performance improvement related to stroke assessments, triage, transport, treatment, recovery and prevention.	Legislation is not required but would be beneficial to add these components to the scope of the board's work. This board's main charge is to make recommendations to the legislature and it does not include an advisory role to the department.

EMS data in 2018 used in developing recommendations and toolkits.

5,795
Stroke Calls in 2018



7
Average Response Time (Minutes)

13
Average Transport Time (Minutes)

Future Priorities

- Explore evidence-based guidelines for intravenous thrombolytic therapy treatment rate goals.
- Explore evidence-based guidelines for endovascular therapy treatment rate goals.

This data was taken from Emergency Medical Services data and analyzed by the Colorado Department of Public Health and Environment EMTS Data Section. Stroke calls identified by primary impression of stroke, stroke assessment was positive or a stroke alert was called.



Data Registry

Meaningful data, reporting and analysis are essential for quality improvement. The board has reviewed claims data from hospital discharge data and found it is not sufficient for system-level performance improvement. The board did review data in the EMS dataset that is increasingly helpful. Education to improve data reliability will be incorporated into the toolkits. The remaining barriers include access to stroke-specific data, linking hospital and EMS data, and obtaining functional outcomes data. To address the above barriers to accessing data, the board recommends department support for development and implementation of facility and system level performance improvement in Colorado.

Recommendations for a Data Registry	Legislative implications
<p>The board recommends a statewide system of support with a mechanism for data-driven quality improvement. This requires the department to gain access to stroke data. With access to data, any facility could request assistance and the department could then provide facility and patient blinded data for the board to review and develop recommendations. In order to perform quality improvement, the board recommends the department have access to analyze and develop reports with the recommended prehospital, hospital and rehabilitation data.</p>	
<p>The board recommends that facilities performing endovascular therapy procedures report to a national registry that includes metrics on stroke-specific endovascular procedures for the purpose of evidence-based practice compliance tracking at the facility level. The board recommends the department obtain a super-user account to access aggregated data for the purpose of statewide benchmarking and quality improvement.</p>	
<p>The board recommends that nationally certified stroke centers report to a national stroke registry and that the department be granted a super-user account to this registry for the purpose of statewide benchmarking and quality improvement. The board estimates a super-user account would cost \$2,000 annually.</p>	
<p>The board recommends facilities that are not nationally certified as a stroke center participate in tracking, reporting and performance improvement initiatives on stroke care as follows.</p> <ol style="list-style-type: none"> 1. Facilities are encouraged to internally track the recommended data measures, found in Appendix 1, to facilitate internal quality improvement initiatives and include EMS in the performance improvement plan. 2. The board encourages facilities to collaborate with groups, such as the regular meetings of stroke coordinators or stroke representatives from various facilities in Colorado, for the purpose of benchmarking and quality improvement locally and regionally. 3. The board recommends department access aggregated stroke data for the purpose of statewide benchmarking and quality improvement. The board is exploring ways to align with the department of Health Care Policy and Financing (HCPF) for possible statewide reporting through healthcare quality improvement programs to avoid additional data collection burdens on facilities. 	<p>The department would need to be granted statutory authority and resources to access data, create reports, and provide reports for the board to review.</p>

Future Priorities

- Request and review reports from the Get With The Guidelines GWTG-Stroke registry.
- Determine sources for desired data and a process for data collection, analysis and reporting.
- Refine and disseminate the data template with measures and validation tools for facilities that are not nationally certified as a stroke center.
- Consider telemedicine participants as a unique group for benchmarking.

Public access to data

Legislation instructs the board to address whether access to data would be appropriate or beneficial. The board acknowledges that health literacy is a barrier to risk factor management, recognition of stroke and appropriate response to stroke. The data that is currently available includes stroke-specific metrics that are not appropriate for statewide benchmarking and do not appear to be meaningful or beneficial for public reporting purposes. As the board reviews additional information, the board will consider what information would be appropriate for public reporting. Information that would be appropriate for public reporting should be in language that is understandable to the general public and have evidence that public reporting of the information improves risk factor management, stroke identification, timely activation of 911, and recovery from stroke.

Appendix 1: Recommended Data Measures

Recommended stroke metrics	Source of metric
911 dispatch date/time	EMS data
Provider primary impression of stroke	EMS data
Stroke scale	EMS data
Stroke scale score	EMS data
Stroke severity assessment	EMS data (not currently available)
Stroke severity assessment score	EMS data (not currently available)
Prehospital stroke alert Y/N	EMS data
Date/time of last known well	EMS data
Arrival at destination facility date/time	EMS data
Facility arrival Date/time	Hospital data (Available in facility dataset but no central repository)
Mode of arrival	Hospital data (Available in facility dataset but no central repository)
Thrombolytic therapy (also known as alteplase, tPA or clot dissolving medication): Yes/No If yes: date/time	Hospital data (Available in facility dataset but no central repository)
Symptomatic hemorrhage after tPA?	Hospital data (Available in facility dataset but no central repository)
Endovascular therapy for ischemic stroke: Yes/No	Hospital data (Available through national registry, the department does not have access)
Date/time skin puncture?	Hospital data (Available through national registry, the department does not have access)
Final diagnosis of stroke Y/N	Hospital data (Available through national registry, the department does not have access)
Patient transferred for higher-level care? Yes/No	Hospital data (Available in facility dataset but no central repository)
Date/time patient left for destination hospital	Hospital data (Available in facility dataset but no central repository)
Discharge disposition	Hospital data (Available in facility dataset but no central repository)
Facility defined longitudinal outcome measure that measure function and change in function	Hospital data (Available in facility dataset but no central repository)

Appendix 2: Concepts for the EMS toolkit

The board has developed the following evidence-based recommendations and is developing a toolkit to provide additional guidance to meet the current recommendations. The concepts to improve stroke care in the prehospital setting are outlined below.

The board intends to be a resource to help RETACs and agencies revise existing stroke triage protocols to address the following:

- A specified stroke assessment tool- Current recommendation is BE FAST (Balance Eyes Face Arms Speech Time) and consider sudden, severe headache with unknown cause.
- A specified stroke severity assessment tool- Current recommendation is FAST ED (Field Assessment Stroke Triage for Emergency Destination).
- Notification from the field of a stroke alert based on prehospital provider assessment and clinical judgement.
- Include a last known well date and time, ideally in conjunction with stroke alert.
- Provide contact information for a family member or friend for consent and history.
- Identify criteria for ground/air transportation.
- Specify criteria where transport with lights and sirens is beneficial.
- Patient transport plans that avoid unnecessary bypass and multiple transfers.

The board encourages EMS personnel to report the following information in the Patient Care Report (PCR) into discrete National EMS Information System (NEMSIS) fields and not into narrative fields:

Field name	NEMSIS field code	Recommended selection
Provider impression	eSituation.e.11, e.12	CVA/Stroke
Stroke screening tool and score	eVital.30, eVitals.29	FAST or BE FAST (not available)
Stroke alert from the field	eDisposition.25	Yes/No
Last known well date/time	eSituation.18	
Symptom onset date/time	eSituation.01	
Stroke severity tool and score	eVitals.30- available in NEMSIS 3.5	FAST ED

To improve care coordination and quality improvement, the board recommends EMS and hospitals work together to:

- Perform quality improvement initiatives that track the following. When the provider suspects a stroke:
 1. CVA/Stroke is selected for provider primary impression.
 2. Stroke assessment is performed.
 3. Stroke score is documented.
 4. Hospital is alerted and the alert is documented in the Patient Care Report (PCR).
- Educate hospital and EMS providers together on stroke pathophysiology.
- EMS is encouraged to provide the recommended measures in the PCR to hospitals. Hospitals are encouraged to provide feedback to EMS using the hospital feedback template, found in the hospital toolkit.
- Timely reporting (as agreed by EMS and hospitals) of EMS stroke metrics to the hospital.
- Timely feedback (as agreed by EMS and hospitals) to EMS on each stroke patient.

Appendix 3: Concepts for the hospital toolkit

The board has developed the following evidence-based recommendations and is developing a toolkit to provide additional guidance to meet the current recommendations. The concepts to improve stroke care in the hospital setting are outlined below.

To improve care coordination and quality improvement, the board recommends EMS and hospitals work together on the following initiatives.

- EMS to report recommended metrics in the PCR to hospitals (see EMS toolkit).
- Hospitals to provide feedback to EMS (see the feedback template below).
- Report timely information as agreed between EMS and hospitals.

The following feedback template is for the purpose of education and quality improvement.

Date:

EMS Agency:

Dear EMS provider, thank you for participating in the Stroke Alert Program at [FACILITY NAME] Your patient [PATIENT GENDER AND BIRTHDATE] was brought to the Emergency Department on [DATE OF EVENT] with symptoms of a possible stroke. EMS report feedback, clinical findings and ultimate diagnoses were as follows:

EMS: Prehospital notification	[YES OR NO]
EMS: Accurate last known well time provided	[VALIDATE EMS LKW TIME OR PROVIDE FEEDBACK ON ACTUAL TIME]
EMS: Family/friend contact for consent/history	[YES OR NO]
EMS: Stroke assessment tool utilized	[CPSS or FAST ED or other LVO screening tool]
Facility: Initial NIHSS	[ACTUAL SCORE]
Facility: Diagnosis and interventions	[INCLUDES DOOR TO NEEDLE (tPA) AND DOOR TO SKIN PUNCTURE TIMES TIMES, IF APPLICABLE OR SIMPLY TREATED/NOT TREATED. IF NOT TREATED, GIVE REASON]
Facility: Discharge disposition	[HOME, SNF, REHAB, ETC.]
EMS and Facility: Best Practices	[FEEDBACK AND SHARING OF GOOD INFORMATION]

What went well?

Any educational opportunities identified?

The Emergency Medicine services at [FACILITY NAME] wish to thank you for transporting your patient to us, it is our goal to provide excellent treatment to all of our patients. We value the trust you place in our hearts. If you have any further questions about this case, please do not hesitate to contact your EMS Liaison, [CONTACT INFORMATION]

Sincerely,

Stroke coordinator

Recommendations for facilities that do not have intravenous thrombolytic therapy capabilities (also known as alteplase, tPA, clot dissolving medication, etc.)

- Educate community to recognize stroke using the BE FAST scale and call 911.
- Educate staff to recognize signs and symptoms of stroke (BE FAST and FAST ED).
- Promote a standardized stroke assessment tool for staff, such as the National Institutes of Health Stroke Scale (NIHSS).
- Develop a scope of care for stroke.
- Have an emergency transfer plan that includes destination options and patient representative contact information (e.g., a family member).
- Have a plan for quality monitoring and improvement.
- Have a plan to connect stroke survivors returning to the community with services and/or equipment per best-practice guidelines before hospital discharge.



Appendix 3: Concepts for the hospital toolkit

Recommendations for facilities that can treat acute ischemic stroke with intravenous thrombolytic therapy (also known as alteplase, tPA, or clot dissolving medication) but do not provide inpatient care for stroke patients include the previous criteria in addition to following items.

- Create a facility-defined response plan for prehospital notification of stroke developed in conjunction with emergency medical services to expedite care from facility arrival to brain imaging, interpretation and treatment in the most efficient manner for:
 - > Stroke alerts within the facility-defined IV thrombolytic treatment window.
 - > Stroke alerts outside of the facility-defined IV thrombolytic treatment window.
- Have IV thrombolytic therapy readily available.
- Have brain imaging readily available for interpretation and expert consultation.
- Have a plan for access to expert consultation in person, by phone, telestroke, etc.
- Have a goal for door to IV thrombolytic therapy time consistent with national best-practices.

Recommendations for facilities that treat, admit or transfer ischemic stroke patients include all previous criteria in addition to the following items.

- Develop a formal plan for feedback to EMS. See the feedback template as an example.
- Provide the following inpatient rehabilitation services.
 - > Perform physical, occupational and speech therapy evaluations to determine impairments and rehabilitative needs for all stroke survivors.
 - > Develop a multidisciplinary care plan to address current impairments, outline the expected progression through the rehabilitation continuum of care and make recommendations for treatment after discharge.
 - > Incorporate the stroke survivor, family and caregiver(s) into the care team as early as possible.
 - > Arrange for access to equipment that improves mobility and protects the patient from further impairment (i.e., wheelchairs, splints, orthotics, etc.).
 - > Perform or schedule a needs assessment of the home before discharge.
 - > Develop a discharge plan for stroke survivors that includes:
 - A current functional score and a goal using a validated functional assessment tool.
 - A multidisciplinary care plan for current and future rehabilitative needs and includes a plan to monitor and address emotional health issues, caregiver burden and self-care.
 - Referrals for appropriate resources available in the stroke survivor's community.
 - Patient, family and caregiver education on:
 - ✓ The stroke continuum of care and the multidisciplinary care plan.
 - ✓ Prevention of falls, secondary impairment and disability.
 - ✓ Provision of equipment to increase independence in Activities of Daily Living (ADLs).
 - ✓ Proper use of equipment to improve mobility.

For facilities that provide endovascular services include all previous criteria in addition to the following items.

- Adopt a time for door-to-recanalization that is consistent with national best-practices.
- Explain the clinical platform for endovascular services including staffing, equipment and education in the scope of care.
- Ensure 24/7/365 capability or develop a plan to communicate with EMS and partner hospital(s) with the following information.
 - > Schedule of endovascular service availability.
 - > Changes in the schedule for endovascular service availability.
- Provide prehospital provider education for stroke assessment and severity assessment.
- Provide NIH stroke scale certification to hospital professionals.

Appendix 4: Stroke Advisory Board Membership

Jeff Beckman, MD

Golden
Term expires 08-01-22
CDPHE designee - ex officio

Christy Casper, AG-ACNP

Centennial
Term expires 08-01-22
Expert in stroke database management

Robert Enguidanos, MD

Windsor
Term expires 08-01-22
Primary care physician

Joseph Foecking, PT

Colorado Springs
Term expires 08-01-20
Stroke rehabilitation facility

Donald Frei Jr., MD

Denver
Term expires 08-01-20
Interventional neuroradiologist

Cindy Giullian ACNP- BC

Denver
Term expired 08-01-19
Urban area hospital administrator

Kathryn Henneman, OTR/L

Loveland
Term expires 08-01-20
Occupational therapist involved in stroke care

Emily Jones

Evergreen
Term expires 08-01-20
Representative of a national cardiovascular ass.

William Joseph Jones, MD

Denver
Term expired 08-01-19
Board-certified vascular neurologist

Lorence Leaming, DHA, FACHE

Estes Park
Term expired 08-01-19
Administrator from a rural hospital

Rick Morris O.D., F.C.O.V.D.

Golden
Term expires 08-01-20
Member of the public who has suffered a stroke

Shaye Moskowitz, MD, Chair

Colorado Springs
Term expires 08-01-21
Board-certified neurosurgeon

David Scott Miner, MD

Denver
Term expired 08-01-19
Statewide chapter of emergency physicians

Chris Mulberry

Henderson
Term expires 08-01-22
Emergency medical service provider

Wesley Reynolds, MD

Denver
Term expires 08-01-21
Rural area board-certified neurologist

John Savage, CMPE, PMP, Co-Chair

Aurora
Term expires 08-01-20
Representative of a statewide hospital association

Richard Smith, MD

Denver
Term expires 08-01-20
Resident and member of a stroke association

Michelle Leppert, MD

Englewood
Term expires 08-01-22
Board-certified in vascular neurology

Kerri Jeppson

Golden
Term expires 08-01-22
RN involved in stroke care

Brian Thomas

Denver
Term expires 08-01-22
Urban area hospital administrator

Paul Sykes, MD

Lyons
Term expires 08-01-20
Statewide association of physicians

Michelle Whaley, RN

Castle Rock
Term expired 08-01-19
RN involved in stroke care

2017



SENATE JOINT RESOLUTION 17-027

BY SENATOR(S) Guzman and Tate, Aguilar, Baumgardner, Cooke, Coram, Court, Crowder, Donovan, Fenberg, Fields, Garcia, Gardner, Hill, Holbert, Jahn, Jones, Kagan, Kefalas, Kerr, Lambert, Lundberg, Marble, Martinez Humenik, Merrifield, Moreno, Neville T., Priola, Scott, Smallwood, Sonnenberg, Todd, Zenzinger, Grantham;
also REPRESENTATIVE(S) Duran and Beckman, Arndt, Becker J., Becker K., Benavidez, Bridges, Buck, Buckner, Carver, Catlin, Coleman, Covarrubias, Danielson, Esgar, Everett, Exum, Foote, Garnett, Ginal, Gray, Hamner, Hansen, Herod, Hooton, Humphrey, Jackson, Kennedy, Kraft-Tharp, Landgraf, Lawrence, Lebsack, Lee, Leonard, Lewis, Liston, Lontine, Lundeen, McKean, McLachlan, Melton, Michaelson Jenet, Mitsch Bush, Navarro, Neville P., Nordberg, Pabon, Pettersen, Rankin, Ransom, Rosenthal, Saine, Salazar, Sias, Singer, Thurlow, Valdez, Van Winkle, Weissman, Willett, Williams D., Wilson, Winter, Wist, Young.

CONCERNING RECOGNITION OF THE NEED TO EXPAND ACCESS TO EFFECTIVE TREATMENT FOR STROKE PATIENTS.

WHEREAS, Strokes are a leading cause of death and long-term disability in the United States, costing more than 130,000 lives annually, including an average of 1,600 victims in Colorado alone; and

WHEREAS, A stroke can affect anyone at any age and at any time and can have devastating long-term effects if the victim is not treated immediately; and

WHEREAS, A stroke occurs when blood flow to an area of the brain is blocked by a clot or aneurysm, but certain specialized care has been proven to give stroke patients an excellent chance of survival and even full recovery; and

WHEREAS, Advancements in medical innovation have produced revolutionary treatments such as the tissue plasminogen activator and

Appendix 5: Senate Joint Resolution

neuroendovascular surgery in which highly trained stroke surgeons, in conjunction with neurologists, treat patients suffering from a severe form of ischemic stroke by removing or dissolving the blood clot and ensuring the patients' survival while greatly reducing long-term disabilities; and

WHEREAS, When emergency medical technicians (EMTs) and other first responders are properly trained to assess stroke severity and then transport stroke patients to neuroendovascular-ready stroke centers capable of performing a mechanical thrombectomy twenty-four hours per day, seven days per week, 365 days per year (24/7/365), stroke patients who undergo neuroendovascular surgery can live up to five years longer than patients who do not receive this specialized treatment, while also saving up to up to \$23,000 over their lifetime from shorter hospital stays and fewer required therapies; and

WHEREAS, Only an estimated 10% of those stroke victims who would benefit from this specialized care are currently being properly assessed, triaged, and transported to these specialized 24/7/365 neuroendovascular-ready stroke centers to receive this lifesaving treatment; now, therefore,

Be It Resolved by the Senate of the Seventy-first General Assembly of the State of Colorado, the House of Representatives concurring herein:

That we, the Colorado General Assembly:

(1) Hereby recognize and applaud the significant progress being made by Colorado's medical community, including physicians, nurses, EMTs, and hospitals, to embrace new, effective treatments for stroke victims, including specialized care that involves the performance of neuroendovascular surgery;

(2) Continue our support of improvements for the emergency medical response time and transport of stroke victims for appropriate medical care because we believe this type of care is an urgent priority and recognize that further efforts are needed to improve these services;

(3) Strongly encourage the Department of Public Health and Environment to provide EMTs and first responders with the tools needed

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Appendix 5: Senate Joint Resolution


for the proper pre-hospital assessment and triage of stroke patients, which may include education about identifying stroke patients who may have an emergent large vessel occlusion that would necessitate transport to 24/7/365 neuroendovascular-ready stroke centers and for which geographic considerations can be designated by regional emergency medical services entities; and

(4) Encourage EMTs and other first responders to receive the proper education and training for the assessment and triage of stroke patients, along with being familiarized with 24/7/365 neuroendovascular-ready stroke centers and the Colorado Community College System to incorporate such education and training curricula into its existing program for the education and training of EMTs and other first responders so that this needed education and training is readily available.

Be It Further Resolved, That copies of this Joint Resolution be sent to Dr. Larry Wolk, Executive Director and Chief Medical Officer of the Colorado Department of Public Health and Environment; the nine members of the Colorado Community College System's State Board for

Appendix 5: Senate Joint Resolution

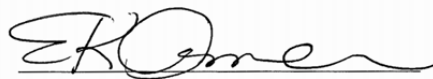
Community Colleges and Occupational Education; Governor John Hickenlooper; and Colorado's Congressional delegation.



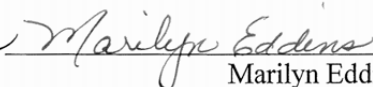
Kevin J. Grantham
PRESIDENT OF
THE SENATE



Crisanta Duran
SPEAKER OF THE HOUSE
OF REPRESENTATIVES



Effie Ameen
SECRETARY OF
THE SENATE



Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

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Appendix 6: Stroke Advisory Board Legislation

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, Hulinghorst, 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;



Appendix 6: Stroke Advisory Board Legislation

(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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Appendix 6: Stroke Advisory Board Legislation

(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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Appendix 6: Stroke Advisory Board Legislation

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

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

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

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

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

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

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

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

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Appendix 6: Stroke Advisory Board Legislation

(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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Appendix 6: Stroke Advisory Board Legislation

(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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Appendix 6: Stroke Advisory Board Legislation

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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Appendix 6: Stroke Advisory Board Legislation

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

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Appendix 6: Stroke Advisory Board Legislation

\$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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COLORADO
Department of Public
Health & Environment



HOUSE BILL 18-1265

BY REPRESENTATIVE(S) Lontine and Beckman, Buckner, Ginal, Kennedy, Roberts, Esgar, Gray, Hamner, Michaelson Jenet, Valdez, Young; also SENATOR(S) Crowder, Aguilar, Kefalas, Martinez Humenik, Merrifield, Moreno, Tate, Todd, Williams A.

CONCERNING THE CONTINUATION OF THE STROKE ADVISORY BOARD IN ACCORDANCE WITH THE RECOMMENDATION IN THE DEPARTMENT OF REGULATORY AGENCIES' 2017 SUNSET REPORT.

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

SECTION 1. In Colorado Revised Statutes, 25-3-115, **amend** (5) as follows:

25-3-115. Stroke advisory board - creation - membership - duties - report - definition - repeal. (5) This section is repealed, effective ~~September 1, 2018~~ **SEPTEMBER 1, 2028**. 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.

SECTION 2. In Colorado Revised Statutes, 2-3-1203, **repeal** (7)(a)(II); and **add** (19) as follows:

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

Appendix 6: Stroke Advisory Board Legislation

2-3-1203. Sunset review of advisory committees - legislative declaration - definition - repeal. (7) (a) The following statutory authorizations for the designated advisory committees will repeal on September 1, 2018:

(II) ~~The stroke advisory board created in section 25-3-115, C.R.S.~~

(19) (a) THE FOLLOWING STATUTORY AUTHORIZATIONS FOR THE DESIGNATED ADVISORY COMMITTEES WILL REPEAL ON SEPTEMBER 1, 2028:

(I) THE STROKE ADVISORY BOARD CREATED IN SECTION 25-3-115.

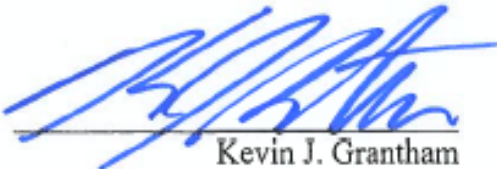
(b) THIS SUBSECTION (19) IS REPEALED, EFFECTIVE SEPTEMBER 1, 2030.

SECTION 3. Act subject to petition - effective date. This act takes effect September 1, 2018; except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within the ninety-day period after final adjournment of the general assembly, then the act, item, section, or part will not take effect unless approved by the people at the general election to be

Appendix 6: Stroke Advisory Board Legislation

held in November 2018 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.


Crisanta Duran
SPEAKER OF THE HOUSE
OF REPRESENTATIVES


Kevin J. Grantham
PRESIDENT OF
THE SENATE


Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES


Effie Ameen
SECRETARY OF
THE SENATE

APPROVED 12:18 PM May 4, 2018


John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

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COLORADO
Department of Public
Health & Environment