Regional Improvement
Stroke Regional Advisory Council Charter

Problem Statement:

Among Arkansans, cerebrovascular disease including acute stroke ranks, one notch above the U.S. as the overall 4th leading cause of death in the state. Arkansas has since strengthened and expanded statewide efforts, with state funds, to mitigate the burden of acute stroke by advancing stroke systems of care through ASR partnerships with acute care hospitals (tele-stroke systems), Emergency Medical Services (EMS), American Heart Association (AHA), and other entities. As a result of these ensuing public-private partnerships, Arkansas lowered its rank for highest cerebrovascular disease mortality among states from 3rd in 2015 to 11th in 2019. Arkansas dropped its nation-wide rank for the highest acute stroke mortality from 5th in 2015 to 7th in 2019. With these successes, disproportionate burdens of acute stroke mortality, among Arkansans, continue to be evidenced as 33% high mortality for African Americans versus Whites, and 13.7% higher mortality for men versus women. Antecedent stroke risk factors: hypertension, hypercholesterolemia, and diabetes trended-up among Arkansas over the past few years, indicating a need for targeted community-level, preventative interventions within the stroke systems of care. GWTG-Stroke state portal in 2020, as compared to 2015, except for 2020 and the Corona virus pandemic affecting patient access to and delivery of care, Arkansas Stroke Registry (ASR) participating hospitals improved the delivery of IV thrombolytic therapy, as well as acute stroke care measures over the past 5 years. ASR data demonstrate the percentage changes below. Although there has been improvement, additional improvement is needed. Adherence highlighted in green are measures that increased; in red, marks a decrease in adherence. The data comparison below are from

2015 to 2020:

- Patients transported and transferred by EMS increased from ⇧**54% to 60.9%.**
- EMS pre-notification of suspected stroke patients to hospitals improved from ⇧**64.5% to 73.5%.**
- Coverdell Defect-free care increased from ⇧**65.2% to 69.7%.**
- IV-Thrombolytics arrive by 2 hours; treat by 3 hours from ⇧**76.1% to 77.4%.**
- IV-Thrombolytics arrive by 3.5 hours; treat by 4.5 hours from ⇧**68.3% to 80.8%.**
- Recording the NIHSS score from ⇧**70.6% to 82.1%.**
- Dysphagia screening ⇧**73.3% to 77.4%.**
- VTE prophylaxis ⇩**93.5% to 92.0%.**
- Antithrombotic therapy by the end of hospital day 2 from ⇩**95.6% to 95%.**
- Assessed for rehabilitation from **97.3% to 97.3%**.
- Smoking cessation counseling from ⇧**94.5% to 97.9%**.
- Stroke education from ⇧**91.8% to 92.3%**.
- Discharged on antithrombotic therapy ⇩**97.6% to 96.6%**.
- Discharged on statin medication from ⇧**90.8% to 93.7%**.
- The inter-rater reliability agreement increased in Arkansas from ⇧**97.6% to 98.3%.**

A. Purpose of the Stroke Regional Advisory Council

Primary Functions

The Stroke Regional Advisory Council (SRAC) was formed to address regional-specific issues as well as to provide guidance and support for hospitals with quality improvement (QI) challenges. The SRAC team is supported by regional leaders (Leaders) selected by vote of SRAC members. The Leaders facilitate the SRAC Team comprised of EMS staff and hospital stroke coordinators (Coordinators). The Leader shares areas of strength and weakness as well as successful strategies. The Leader organizes regional meetings and assigns the team's work to members. Additionally, the Leader makes connections with Leaders from the other regions across the state and bring best practices and other information back to their region. The Leader shares blinded regional data, comparing hospitals to the regional, state and U.S. benchmarks on key stroke care performance measures. The Leaders and members assist with QI efforts to improve regional performance. The Leaders are members of the Regional Leaders Team. Additionally, Leaders provide a progress report, on their region, during the Stroke Task Force meetings (upon request) as well as the Leadership Team, comprised of Arkansas Department of Health (ADH) Stroke Registry staff (refer to the SRAC Leadership Charter).

The primary function of the SRAC Team is to support the local EMS agency providers and the hospital stroke coordinators in improving care to stroke patients. The state has been divided into 7 regions. The Team provides quality improvement (QI) support, resources, and successful strategies. These responsibilities are carried-out by performing the following functions:

- **Providing QI** assistance to the members.
- **Presenting regional, state, and other data** for QI purposes.
- **Giving feedback** on work being done as requested by the member.
- **Reviewing data** to identify improvement/challenges needed to improve adherence.
- **Creating, collating, interpreting, and presenting** short questionnaires to identify issues, education needs and necessary supports.
- **Assessing and sharing up-to-date information** as the initiative is plugged into stroke QI at the national level through AHA and CDC.
- **Linking** other Arkansas hospitals and EMS with a community of providers supporting and networking with each other, facilitating measurement and the improvement of care.
- **Connecting** stroke coordinator mentors with new coordinators and/or coordinators needing support.
- **Requesting and coordinating** and if requested, participating in educational webinars in response to data, questions, and other inputs from the members.

B. Membership

The SRAC Team membership is comprised of EMS staff and stroke coordinators within the region. Others may be added as needed.

The SRAC Team Leader (Leader) is a 3-year term. There is a maximum of 4 Leaders for two regions (Central and Northwest) and a maximum of 3 Leaders for the other five regions. The process of

selecting a Leader is conducted at least 3 months prior to the expiration of the term. The nominees are suggested by the SRAC Team members, self-nominations are accepted as well. Prior to nominating, it is recommended that the member ask the person, to ensure he/she is willing to serve. Once a ballot is completed, the Team members vote for their choices.

C. Role of the SRAC Team

SRAC Team Leader:

- **Maintain a Regional Contact Lists** – Pull the contact names of all hospitals (stroke contacts) and ambulance services for each of the 7 geographic regions in Arkansas. It is important to all ambulance services and acute care hospitals within the region are included.
- **Schedule meetings** – Set up a ZOOM (or other type of tele-meeting application) call inviting all EMS/hospital contacts in the region. The meetings are expected to be at least quarterly. They may be scheduled more frequently if needed. In addition to the primary goal of decreasing the incidence of stroke and improving stroke care, there an opportunity to have a regional voice on the state stroke council. If the Team is willing, an in-person meeting may be held. For in-person meetings, a tele-link is provided for those unable to attend, allowing for a virtual connection.
- **Prepare for the meeting –** Ensure the agenda for the meeting and the minutes from the previous meeting are sent to the team at least 1 week prior to the meeting. This provides time for members with follow-up to be sure the work is completed prior to the meeting. As part of the agenda, send the Zoom link and information need to join.
- **Participate in the SRAC Team meetings –** If more than one leader is planning to attend a meeting, a facilitator is selected at the end of the previous meeting and assigned to run the next meeting. The leader selected to facilitate is responsible for the follow-up to prepare for the next meeting.
- **Assume the Facilitator's Role -** The facilitator's responsibilities are to ensure a member is willing to document the meeting; and keep the meeting on track by adhering to the agenda time frames, removing obstacles, encouraging participation by all members and following-up on questions and requests for others outside the SRAC.
- **Interact with other Leaders –** It is important to discuss challenges, successful strategies as well as other issues to bring information back to the SRAC Meeting.
- **Interact with the Stroke Task Force –** When requested, provide an update on data, challenges, areas of opportunity, strategies that are working well as well as resources/support needed to meet the challenges.
- **Attend the Leadership Team meetings –** All Leaders are member of the Leadership Team Meetings (refer to the Leadership Team Meeting Charter).

SRAC team member:

- **Attend meetings –** It is critical to have full participation in the meetings. There are times when issues arise, and participation is not possible. If that happens, notify the Facilitator as soon as possible. If the team allows substitutes, have a specific and consistent substitute. A substitute isn't always valuable in an ongoing meeting. But, if allowed, a consistent substitute, more familiar with the topics, may have value.

- **Actively participate in meetings** – Review the agenda prior to the meeting. Be prepare to speak to the agenda topics.
- **Participate in the QI process** – Join in with QI team activities and education. A member may be requested to be a QI team. Team members are selected based on the expertise needed.
- **Share responsibilities** – Volunteer when the members are asked to document the meeting; when follow-up is needed; request topics of interest are placed on the agenda.
- **Complete all assignments timely** – When assigned follow-up, be sure the work is completed prior to the meeting. Be prepared to discuss the follow-up at the meeting.
- **Follow the team guidelines** – Many teams set-up guidelines to support a productive meeting. If guidelines are present, follow them.
- **If requested, bring data, specific to the member's service/hospital** – When discussion of data adherence is on the agenda, run and bring appropriate reports to the meeting.
- **Participate in consensus building** – In order to move the work forward, use/participate in strategies to arrive at a decision.
- **Evaluate the meeting** – The final agenda items are to plan the agenda for the next meeting and to evaluate the meeting. This is the member's opportunity to request items of interest to be on the next agenda. The meeting evaluation is an opportunity to discuss what worked well and make suggestions on opportunities for improvement. Each member's time is valuable, by completing the meeting evaluation honestly and respectfully, improvements are made to have a more valuable meeting. The meeting evaluation can be made orally or done in writing and given to the meeting facilitator. The facilitator will provide information on the evaluation method.

D. Regional Meetings Schedule

The meetings are to be scheduled, at a minimum, quarterly. Initially the meetings may be held monthly to expedite the team's work. Once the meetings are up and running, the Team may decide to meet every other month and eventually, quarterly.

E. Meeting Agenda

Standing Agenda Items:

Welcome, Overview and Announcements:

00:00 Introductions and attendance

00:00 Agenda review

00:00 Review of the objectives

Old Business:

00:00 Review minutes from the previous meeting

00:00 List all items pending from previous meeting for discussion

Quality Improvement:

00:00 QI Target

00:00 Measure adherence

New Business:

00:00 Coordinator updates

00:00 Newly introduced topics #1

00:00 Brainstorming topics for next meeting agenda

00:00 Meeting evaluation