

Minnesota Stroke Committee* Meeting Minutes September 27, 2005

In attendance:

Sandy Hanson, Maggi Lang, Donna Lindsay, Kathleen Miller, Darcy Olson, Beth Rabeneck, Stan Shanedling, Tess Sierzant, Lyn Steffen, Sharon Torodor, Albert Tsai, Gary Wingrove

Absent:

Donna Brauer, Carol Brown, John Oswald

Notes:

- Professional educational materials (on stroke) were provided to all members of the committee. We have a few extra copies of each available, so if you could use more materials, or know who else could use them, please let Al know.
- Discussion points are summarized in these notes, but do not necessarily appear in chronological order (from the discussion). This was done intentionally in order to capture the key points of the discussion in a logical manner for future reference.

* *Minnesota Stroke Committee will usually be abbreviated to "MSC" in these notes.*

AGENDA TOPIC	KEY DISCUSSION POINTS	DECISIONS	ACTION ITEMS
Introductions and Overview of Minnesota Stroke Committee	<ol style="list-style-type: none"> 1. Al reviewed the history and organization of the Great Lakes Regional Stroke Network (GLRSN). (Please review the fact sheet provided in the meeting folder for more details.) The MSC is one of the key charges of participation in the GLRSN. 2. The mission, organizational structure, and operations of this group are open for modification. These were originally drafted to mirror what was developed for the GLRSN. 3. CDC provides funding of up to \$20,000 per year for supporting the work of this committee (that is, generally speaking, programmatic activities). Other funding sources that could be considered are matching funds from MSC member (or non-member) organizations, foundations (grants), or federal grants. 	None	None

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Operations and Governance	<p>4. Kathleen guided our discussion through the proposed operations of this group. (Please see light green handout.)</p> <p>5. Beth recommended that the mission statement be modified so the “improve stroke care” phraseology reflects our desire to make systems-level changes – both within the discreet areas of stroke care (pre-hospital, acute care in-hospital, sub-acute care, rehabilitation) as well as across the continuum of care. This was affirmed by others.</p> <p>6. The issue of whether American Stroke Association and National Stroke Association should be mentioned specifically in the mission (or somewhere in the fact sheet) was raised by Gary. Beth and Kathleen both agreed that it was not necessary, as they saw this group and its work as a collaboration, and the mission statement should speak to that, and not necessary to single them out (even though they are significant partners to the group).</p> <p>7. Beth raised the question of whether it should be specified in the operations documentation that ASA and NSA should always be represented on this committee.</p>	<p>1. Modify the mission statement to read “improve systems of stroke care”</p> <p>2. ASA and NSA would not be specifically mentioned in the mission statement.</p> <p>3. ASA and NSA would not be specified as standing members of the committee. The group agreed that it was so obvious that these two organizations would be on the committee we didn’t need to specify it.</p>	<p>1. Al will make this change in the fact sheet and use this mission statement in the letterhead, website, and other documents.</p>
Role of Minnesota Department of Health (MDH)	<p>8. Al briefly discussed the roles that he sees MDH playing regarding the MSC. (Please see light-green handout for specifics) In addition, he referred everyone to the yellow handout, which describes the past, current, and planned stroke-related activities of MDH.</p>	None	None

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Projects Discussion	<p>9. Al described the process involved in coming up with the proposed projects came from. A handout with the five proposed projects listed was provided.</p> <p>10. Sandy raised this point: stroke treatment/care in the Twin Cities is generally quite good, with a healthy competition amongst providers from which significant improvement in stroke care has emerged. The problem remains, however, with smaller and rural hospitals that don't necessarily have the capacity or the knowledge for appropriately addressing stroke (either by their staff or care system, or linking to larger care systems).</p> <p>11. In response to the issue of the improving acute stroke care across hospitals (and EMS), Gary suggested (at different times during the discussion) connecting with Stratis Health, with Ira Moscovice (U of M), and with Mark Schoenbaum from Office of Rural Health and Primary Care (MDH).</p> <p>12. After much discussion on this general topic, the group was in general agreement that the major overarching focus area of an acute stroke care system, possibly modeled after the state trauma system.</p> <p>13. The group agreed that there was a significant need to raise public awareness of warning signs and the need to call 9-1-1; in addition, it is important to have a consumer-friendly focus; we need to speak to the issue of not being embarrassed to call the ambulance; we need to communicate that interventions are available, that care can in fact be provided for a stroke (changing the public's nihilism about stroke); keep in mind that we are needing to teach adult-learners; we need to teach stroke survivors and families and friends to know the warning signs and what to do.</p>	<p>4. The group was agreeable to focusing on a) educating the public on stroke (on a variety of issues) and b) improving standards of care in all hospitals, and coordinating acute stroke care across the state. No final decisions were made.</p>	<p>2. Al will provide copies of an article describing the state trauma system to members.</p> <p>3. Connect with Stratis Health on what they are doing and how stroke care issues may be addressed in conjunction with their scope of work this year.</p> <p>4. Connect with Ira Moscovice (U of M), who is developing rural measures for EMS.</p> <p>5. Connect with Mark Schoenbaum from Office of Rural Health and Primary Care.</p> <p>6. A single project should be determined and worked on now; research and a needs assessment for the basis of second and third projects can occur at the same time.</p> <p>7. Al will create a visual aid: a "Chain of events", or a "continuum of care model" for next meeting.</p>

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	<p>14. Other issues that were proposed to address:</p> <p>a. Gary: The new national EMS dataset may or may not be stroke-friendly. Somehow, someone should address this. From experience, making changes at the highest level (i.e., national) is the best strategy to take, rather than address it merely from the state level.</p> <p>b. Donna: Rehabilitation services for all stroke survivors is a pressing need and should be considered for our work.</p> <p>c. Lyn: Possibly there are opportunities to do some research that will help inform our program/intervention planning.</p> <p>15. These questions were raised a couple of times: What are the gaps? What are the true needs? We should get a handle of what those are and decide on our work based on this knowledge. One answer to that question: the issue of <u>bypassing hospitals for appropriate care</u>. (<i>Note: this led into the discussion of a stroke care system, perhaps modeling after the trauma system.</i>)</p> <p>16. The issue of evaluation was raised by Stan. As we address the various projects and interventions, we need to keep Process, Outcome, and Impact evaluation in mind. Sandy recommended that % receiving tPA was an easy measure to collect regarding the impact evaluation piece specifically (<i>Al's additional note: this would be relevant for the <u>acute care intervention(s)/project(s)</u>, whatever they might be</i>).</p> <p>17. The group acknowledged that there are several areas of need, but this group should be ready and willing to take incremental steps (small bites) nonetheless.</p>		

Next Meeting: January 31, 2006, 3 pm – 5 pm at Snelling Office Park, St. Paul, Minnesota.