



Georgia Coverdell Acute Stroke Registry Quarterly Newsletter

Georgia Coverdell Acute Stroke Registry Participating Hospitals



SPRING 2015

Coverdell Partners:

Georgia Department of Public Health (DPH)

Emory University School of Medicine

Alliant Health Solutions-Georgia Medical Care Foundation (GMCF)

American Stroke Association (ASA)

Georgia Hospital Association (GHA)

If you have anything you would like included in an upcoming newsletter or have achieved recent recognition in the area of stroke, contact:

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or

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The Future- One Dot at a Time

A message from our QI Director- James Lugtu



The late visionary and tech guru Steve Jobs once stated "You can't connect the dots looking forward; you can only connect them looking backwards. So you have to trust that the dots will somehow connect in your future. You have to trust in something - your gut, destiny, life, karma, whatever. This approach has never let me down, and it has made all the difference in my life". This quote rang in my ears as I contemplated the future of the Georgia Coverdell Acute Stroke Registry (GCASR). But like Mr. Jobs stated we can't connect dots looking forward but we can connect those behind us, the history of GCASR. The history and story of GCASR is a rich story, worthy of any storyteller.

As we celebrate the future and look intently to what it brings, it would be wise to take some time and celebrate our past. Please allow me to take a moment and brag about the great work each and every one of you has been doing because without you there would not be a GCASR. The Georgia Coverdell Acute Stroke Registry has been funded by the Centers for Disease Control and Prevention since 2001, growing in size from the initial 26 hospitals to its current 66 participating hospitals. In 2014, 14,655 stroke patients (including ischemic stroke) were treated at participating GCASR hospitals. The percentage of stroke patients who received defect-free care increased from 37% in 2008 to 76% in 2014, highlighting improvement in all ten performance measures. For example, intravenous tissue plasminogen activator (tPA) administration among ischemic stroke patients increased from 4.8% in 2008 to 9.5% in 2014, and among eligible ischemic stroke patients, tPA administration increased from 34.9% in 2008 to 89.1% in 2014. The percentage of those who received IV tPA within 60 minutes of their arrival increased from 23.9% to 60.7%. The average time to administer tPA (door-to-needle time) was shortened from 80 minutes in 2008 to 53 minutes in 2014, a reduction of 33.8%. Based on a study conducted by DPH GCASR epidemiologists, patients who are seen at GCASR hospitals are 1.4 times more likely to receive tPA than patients in non-GCASR hospitals. These few but significant statements are just a small sampling of what **YOU** have accomplished in stroke care in the state of Georgia. Your dedication and commitment to your patients, your community and GCASR has not just improved care in Georgia but has impacted the nation. I am so proud to be a Georgian and to be surrounded by an awesome team of professionals.

Despite the progress we have achieved in our state more work remains ahead of us. As we look into the horizon, future challenges lay ahead of us. The next steps for GCASR include strengthening our core relationships with our participating hospitals and partners. We will continue to develop and reinforce our relationship with our pre-hospital EMS partners. As we strive to improve the entire Stroke System of Care in Georgia a new challenge has arisen, post-hospital care or the Transition of Care (TOC) from hospital to home or rehab. This new challenge will be an additional focus area for GCASR.

Based on US estimates, one in four stroke survivors will have another stroke within 5 years. The risk of stroke within 90 days of an ischemic stroke attack may be as high as 17%, with the greatest risk during the first week. Georgia residents face similar risks post stroke. A 30 day readmission analysis of patients discharged with the diagnosis of Acute Ischemic Stroke (excluding those transferred to another facility within 24hrs) found that 9.5% of Georgia stroke patients were readmitted within 30 days and 28.4% of these readmissions were stroke related. In light of this, treating the underlying causes of stroke, including heart disease, high blood pressure, atrial fibrillation, high cholesterol, and diabetes, is important, as well as encouraging changes in lifestyle habits such as diet, exercise, smoking, and alcohol consumption. This teaching is initiated during the hospital but needs to continue post discharge. This would require future collaboration with

Rehabilitation facilities, home health agencies, private physicians, case managers, other post hospital care professionals and your continued support.

The GCASR team is optimistic of the future. We realize that many challenges lay ahead of us and many dots will need to be connected. We are confident with the continued support of our Georgia partners there is no challenge past and future that we cannot overcome, our proven history is a strong indicator of our successful future.

I conclude with one final quote from Abraham Lincoln- "The best thing about the future is that it comes one day at a time". We look forward to tackling the challenges of each day with you by our side.

From all of us at Coverdell, thank you for making Coverdell what it is today and what it will be in the future.

Hot Topics from ISC

Upon my return from the International Stroke Conference (ISC) with three jam-packed pre-symposia including the State-of-the-Science Nursing Symposium, the opportunity to network with colleagues from around the world with interest and expertise in stroke prevention, diagnosis, treatment and rehabilitation, and the chance to address nursing issues across the continuum of care, I faced a dilemma. My assignment was to take the week of learning and discovery and pare it down into a 30 minute talk for the AHA/ASA Georgia Stroke Boot Camp.

ISC is home to 22 abstract categories, specialty luncheons, awards and honors, plenary sessions, the Mobile Meeting Guide, the Science and Technology Exhibit Hall capped off with professor-led and regular poster sessions. The State-of-the-Science Nursing Symposium included nearly 900 attendees, plenary session, and four break-out opportunities to hear invited speakers and abstracts on advances in clinical research, essentials of standard and advanced clinical practice, rehabilitation and recovery, and evidence-based practice and quality.

The nursing symposium did not disappoint with plenary sessions on bridging the divide between nursing and EMS, the burden of post-stroke fatigue, stroke center certification, telemedicine, hyper-acute stroke care, HOB studies, and reducing door-to-needle times. Ideas were exchanged for expedited EMS handoff and how to think like STEMI systems of care. We learned that some EMS are using scales or syndrome acronyms such as the NIHSS, LAMS, BEFAST, FASTER to recognize and communicate large vessel occlusions in the field.

Perhaps the most pivotal moment of the conference for me was the announcement of the outcomes of four interventional trials, all positive and stopped early for efficacy. How did we manage to get there? Some best practices included a focus on decreasing picture to puncture time (P to P), provider proficiency, improved devices including stent retrievers, and advanced imaging for better candidate selection. Across studies it was evident that mechanical thrombectomy is safe, with low risk and minimal symptomatic intracerebral hemorrhage rates, the same or even better than with IV tPA. Avoiding general anesthesia and shortening last-known-well to treatment times were also instrumental in this success. Estimates indicate the United States needs approximately 300 Comprehensive Stroke Centers (CSC) but currently there are only 85 certified by The Joint Commission. MR CLEAN, ESCAPE, SWIFT-PRIME, and EXTEND-IA all exhibited improved outcome with average number needed to treat (NNT) of three. Right here in Georgia, Grady Memorial Hospital was a busy study site for SWIFT-PRIME, which demonstrated thrombectomy with the Solitaire device resulted in good functional outcome at 90 days at a rate of 60.2% vs 35.5% tPA alone! By day three, 80% of EXTEND-IA patients had ≥ 8 point reduction in NIHSS vs 37% in tPA alone.

The next big thing session highlighted what's coming on the horizon for this new era in stroke prevention, care, treatment and recovery. The National Institutes of Health's Stroke Net is a new network structure to facilitate research in stroke prevention, treatment, and recovery. There are 25 regional centers across the U.S. with >200 hospitals involved. The Stroke Net provides the infrastructure and pipeline for potential stroke treatment, high quality multi-site clinical trials, and an educational platform for stroke physicians and clinical trial coordinators. The Georgia Stroke Net grant was awarded to Emory University School of Medicine at Grady Memorial Hospital, Emory University/ Emory Midtown Hospitals with Michael R. Frankel, MD as Lead Investigator. Senior Co-Principal Investigators are David W. Wright, MD, FACEP and Steven L. Wolf, PhD, with Clinical Coordinator- Kiva Schindler, RN, CCRC.

Other innovations to watch include large bore catheters with suction for clot extraction, neuroprotectives including laboratory research investigating cold saline injected in mice in space left beyond stent retriever and nitric oxide to be administered in the ambulance. Flat Panel CTs will enable triage in the IR suite, allow plain head CT, contrast CT, perfusion imaging, and reduced time-result CT angiography. Recommendations were made based on studies for blood pressure lowering in type 2 diabetes for a target less than 130/80 to reduce mortality and stroke. Stem cells administered to a stroke injured brain secrete growth factors that enhance endogenous brain repair and provide immunomodulation that cuts brain inflammation. Clinicians may be able to improve delivery of tPA with Transcranial Doppler or NTG.

Carotid artery dissection is on the rise. The CADISS trial results indicated there is only a 2% recurrence rate at 3 months. Dissection causes 10-25% of strokes in young and middle-age adults. There was no difference in outcomes or recurrence based on treatment with antiplatelets versus anticoagulants. Elevated blood pressure pre-hospital may differentiate stroke from mimics. Inpatient rehabilitation facility care decreases death and re-hospitalization over skilled nursing facilities.

The economics of stroke care ranged from the large investment in CT in the ambulance to the cost of devices, building and staffing CSC's 24/7 and caring for unfunded patients. CT in the ambulance is being used to enable tPA administration pre-hospital thereby decreasing time to treatment, and increasing patients eligible for treatment. There are three in operation currently in Berlin, Germany, at the University of Texas Health Science Center at Houston, and in Cleveland, Ohio.

Next year, ISC is Los Angeles. February 16 will be the Nursing State-of-the-Science symposium, and February 17-19 will be ISC. Abstract Submission opens from May 20 until August 11, 2015. Thank you for your dedication and passion. Because of you, stroke has dropped from the 3rd to the 5th leading cause of death in the United States in just 10 years!

Submitted by: Karen B. Seagraves, Executive Director-Marcus Stroke and Neuroscience Center-Grady Health System

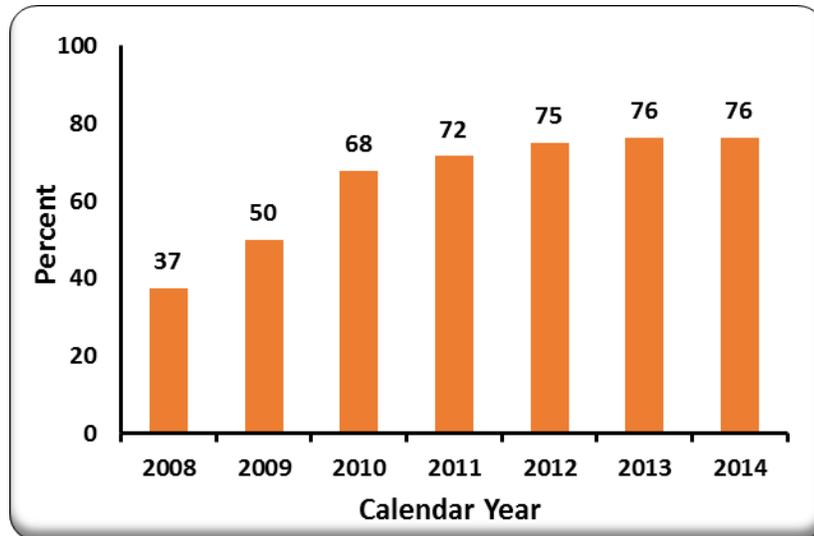
Quality Improvement Never Ends!

The 2014 GCASR data quality analysis showed that GCASR participating hospitals have collectively and through time, registered remarkable achievements in providing a quality care for stroke patients in the state of Georgia. This improvement is documented in the increase in the proportion of patients receiving defect-free care through time. GCASR hospitals improved defect-free care from 37% in 2008 to 76% in 2014 for all eligible patients.

Quality improvement never stops-- One sign of a strong quality improvement program at any level is ensuring that it is data-driven. Data need to be of high quality to be a reliable source of information for decision making. GCASR hospitals have made a huge stride in data quality assurance through regular and continuous training of their data abstractors and assessing accuracy of the information entered to their database. This is really highly commendable and benefits not only the hospitals who are the direct users of their own data but also patients, researchers and policy makers. Besides reliability, data have to be complete; incomplete information in some cases is equivalent to no information. GCASR staff encourage hospitals to complete all the information that are deemed relevant for measuring and monitoring their quality improvement efforts.

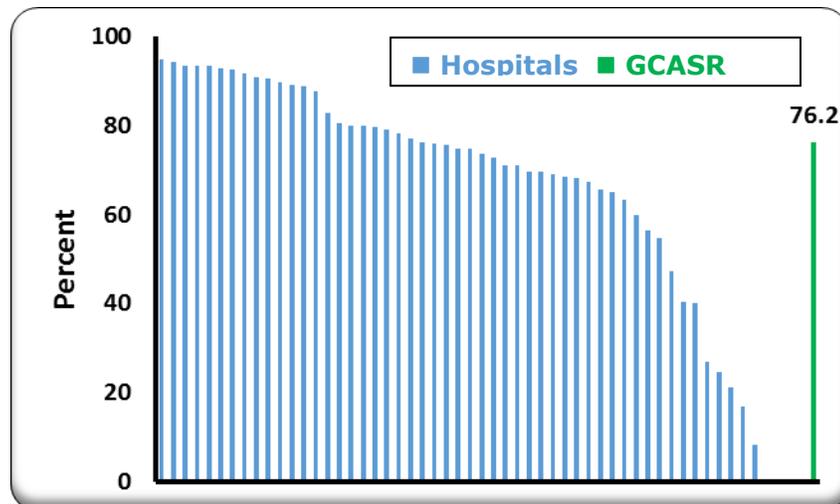
Additionally, it is time to take a much closer look at our defect-free care trend (Figure 1.) Data suggest that since 2013 our progress stayed the same at 76%. Thus GCASR staff and hospitals, particularly stroke coordinators, ought to look into their data to identify barriers and implement interventions to improve our defect-free care.

Figure 1. Trend in defect-free care, GCASR 2008-2014



The 2014 data quality report also highlighted differences in defect-free care among participating hospitals. GCASR realizes that there are several components to care delivery, and that defect-free care by itself may not adequately reflect the quality of care hospitals are providing to their stroke patients. Nevertheless, the defect-free care and its 10 performance indicators are what we are measured on by national organizations. Therefore, it is important for hospitals with a defect-free care less than 76% (Figure 2) to seek assistance from GCASR staff, other participating hospitals and actively identify ways to improve on their 10 performance indicators.

Figure 2. Defect-free care in participating hospital, GCASR 2014



Submitted by: Dr. Moges Ido, MD, MS, MPH –Epidemiologist-Georgia Coverdell Acute Stroke Registry

Upcoming Remote Treatment Stroke Center Workshop

On May 14th, the Georgia Hospital Association, in conjunction with the Georgia Coverdell Acute Stroke Registry and the Georgia Department of EMS, will be hosting an all day workshop on Remote Treatment Stroke Center Designation and the importance of becoming one. This workshop is open to all Coverdell Hospitals that are not a Primary Stroke Center. For more information, please contact Joyce Reid at: jreid@gha.org or Kerrie Krompf at: kkrompf@emory.edu

Thank you from Our Coverdell QI Consultant

On behalf of the Georgia Coverdell Acute Stroke Registry Quality team, I would like to thank each of you for your dedication and support to Georgia's stroke patients. We strive to deliver evidence based care by committing to the delivery of quality care and innovative stroke interventions.

We set extraordinary standards for ourselves and as dedicated stroke professionals meet opportunities every day in anticipation of reducing death and incapacity due to stroke. Each member of Coverdell is dedicated to providing defect-free care, irrespective of the undertaking and circumstances, and often surpasses our patients' expectations. These results are delivered while preserving a solid commitment to patient safety.

Our Quality Improvement team strives to help each facility deliver improved outcomes while utilizing data to make evidence based decisions. Some of the initiatives facilitated by our Quality Improvement staff include preparation planning for Joint Commission certification and readiness; development of stroke protocols including revision of stroke order sets; efficient methods of data diving and scrubbing; customized Plan-Do-Study-Act worksheets and training on the data tool's reporting system and data definitions. Each facility has different requirements that will help cultivate their stroke programs and we desire to help drive change appropriate to the health care institution.

I have been a part of the GCASR for a little over four years and have immensely enjoyed every initiative we have partnered on. Let's continue to collaborate and address the challenges of stroke care that your health care institution may be facing. I look forward to connecting with each of you. If you have any questions or need assistance with any area of stroke care, I encourage you to call or email me at: Sanita.Floyd@dph.ga.gov.

Submitted by: Sanita Floyd, Georgia Coverdell Acute Stroke Registry, QI Consultant

Educating Everyone on FAST

A stroke also known as a cerebrovascular accident or CVA, occurs when part of the brain loses its blood supply and the part of the body that the blood-deprived brain cells control stops working. This loss of blood supply can be ischemic because of lack of blood flow, or hemorrhagic because of bleeding into brain tissue. A stroke is a **Medical Emergency** because strokes can lead to death or permanent disability, plus there are now opportunities to treat ischemic strokes but the treatment needs to be started in the first few hours after the signs of stroke begin.

Any one of these signs could mean a stroke:

Face: Look for an un-even smile

Arm: Check if one arm is weak

Speech: Listen for slurred speech

Time: Call 911 right away

Act FAST Call 911 visit stroke Call911.com to learn more

Here is my story:

I had a few extra FAST magnets in my office; I gave one to each of my co-workers and the temp that was in the office at the time. The temp asked if I had any more because she wanted to give them to her neighbors as well. I gave them to her and the next day, she told me that when she gave it to one of her neighbors, the wife expressed that her husband had been having some of the listed symptoms for several days. They immediately brought him to the hospital and he was admitted to our Neuroscience Unit with an Ischemic Stroke. This shows that we **ALL** have more work to do in getting the word out that Stroke is an Emergency to all our *communities*. *To act FAST, call 911* and get to the hospital for care and treatment.

Submitted by: Ora D. Williams, RN BC BSN MHCA-Northside Hospital Medical Staff/Quality Improvement Coordinator



Piedmont Newnan Receives Remote Treatment Stroke Center Designation

Piedmont Newnan Hospital has been designated as a Remote Treatment Stroke Center, just the third in Georgia.

The designation recognizes Piedmont Newnan's quality care of stroke patients, as the hospital provides state-of-the-art diagnostics and emergency treatment. The recognition of quality stroke care is especially important in an area known as the "stroke belt." The southeast, except Florida, has the highest rate of strokes in the country.

More than 50 percent of stroke patients in Coweta County were having to be rushed to Emory University Hospital or Grady Memorial Hospital in Atlanta – or to Piedmont Fayette – but with the designation, Piedmont Newnan can treat almost any stroke victim in the county.

"This certified designation is really great for the community. We're really excited about the fact that you can be treated without having to leave Coweta," said Deborah Camp, stroke program manager. With the recent designation, Piedmont Newnan will no longer have to "drip and ship," which is where stroke patients receive initial treatment at the emergency department of a community hospital, followed by transfer within 24 hours to a comprehensive stroke center. Instead, Piedmont Newnan will be able to provide 24/7 CT scans for round-the-clock treatment. Specialized stroke care is still routed to Grady, Emory and Atlanta Medical Center, but now the majority of local stroke patients will be able to be fully treated at Piedmont Newnan.

By becoming the third Remote Treatment Stroke Center in Georgia, Piedmont Newnan joins University Hospital McDuffie in Thomson and St. Mary's Good Samaritan Hospital in Greensboro. According to Camp, Piedmont Newnan is also working on partnering with HealthSouth Rehabilitation Hospital to keep local stroke victims local with comprehensive rehabilitation services often needed.

Strokes are the fifth-leading cause of death in the United States according to the Centers for Disease Control and Prevention. By being able to stay local, stroke patients can receive full care as quickly as possible, which alleviates stress on the patient's loved ones.

"Us being a Regional Treatment Stroke Center takes the burden off the patient's family, because they're able to stay local. It's traumatic to travel downtown or even to Fayetteville," said Camp.

"When we got our certified designation, families won," she added. "In Atlanta, there are excellent programs for stroke care, but it's such a burden to go to downtown Atlanta to be treated. We'll be able to do a lot for more for the community and provide the best care for the people of Coweta County."

This article appeared in the Times-Herald.com Local Section on April 10, 2015 and was written by: Bradley Hartsell

Wellstar Kennestone Regional Medical Center Breaks Down Barriers to Delivering IV t-PA in the Acute Ischemic Stroke Patient

Wellstar Kennestone Hospital is committed to providing the highest quality care available for the acute stroke patient. During the acute phase of the stroke, two million neurons die each minute blood and oxygen is not able to flow to the brain. Time is an essential factor for the long term outcomes of these patients. Tissue plasminogen activator (t-PA) is the gold standard of care for patients suffering from an acute ischemic stroke within a 0-4.5 hour time frame of their last known well. The American Heart Association (AHA) recommends patients "arrive by two and treat by three hours from onset of symptoms". The "golden hour of stroke treatment" suggests thrombolytic therapy begin within 60 minutes of hospital arrival. Intravenous t-PA reduces long-term disability and complications when administered early to patients who suffer from ischemic stroke. Through the journey to become a comprehensive stroke center (CSC), the physicians, nurses, and entire stroke team at Kennestone closely examined every aspect of patient care from field to entry through the emergency department all the way to discharge.

During this evaluation, the Code FAST process was born. The term Code FAST activates the comprehensive stroke response team that includes a pharmacist, emergency room physicians, emergency room nurses, radiology, neuro ICU, patient registration, and the in-house stroke neurologist. This team expedites the diagnoses and treatment of patients presenting to the emergency department with stroke like symptoms and a last known well time between 0 and 4.5 hours. FAST stands for **f**acial droop/asymmetry, **a**rm/extremity weakness (unilateral), **s**lurred speech/speech difficulty or **s**udden onset, and **t**ime. Pre-hospital providers are crucial to this process as they provide the emergency room with early notification of the arrival of a potential stroke patient. Patients exhibiting stroke symptoms within the prescribed time period are met by a team of doctors, nurses, and a pharmacist at their point of entry. After a quick assessment of their stability, including vital signs and blood sugar at the door, patients are rushed to radiology for an immediate head CT scan. Neuro-radiologists are notified of a Code FAST when the image is sent to the reading room and the scan is read within minutes. Once a hemorrhagic event is ruled out, and inclusion/exclusion criteria are reviewed, IV t-PA is given immediately – many times while still in the CT scanner. Additionally, immediate CT scans aid in the identification of hemorrhagic strokes and allows patients to be expedited to the Vascular Institute for an interventional procedure to halt bleeding if necessary.

Prior to implementation of our Code FAST process, door to t-PA administration times averaged 60 minutes from patient arrival in the emergency department. The goal of this project was to streamline the care of these patients and reduce our door to needle times (DTN) by 25 percent using a rapid identification process and a structured comprehensive stroke team. With the implementation of the Code FAST process, the emergency department was able to reduce our door to needle times to 31 minutes in September, 25 minutes in October, 22 minutes in November, and 26 minutes in December, representing about a 50% reduction. During the month of October, two different patients received IV t-PA within 9 minutes of arrival, a department record! Additionally, multiple patients received IV t-PA in less than 15 minutes. Thirty-three doses of IV t-PA have been administered between September 1, 2014 and December 31, 2014, with an average DTN of 26 min.

The Code FAST process represents an interdisciplinary effort to improve patient care at Wellstar Kennestone hospital. This process change did not happen overnight and provided many challenges to the team. A commitment to high quality patient care acted as the driving force for all those involved in the Code FAST process from its conception to its implementation. The following are the keys to the success of this pathway:

1. Emergency physicians and nurses, a pharmacist, a neurologist, and patient registration greet the stroke patient based on a pre-notification call from emergency medical system (EMS).
2. Patients travel directly to CT for STAT imaging.

3. IV access is established and laboratory studies are collected in CT
4. The neurologist accompanies the patient to CT and a pharmacist arrives with t-PA in hand.
5. IV t-PA is mixed immediately upon physician order.
6. The pharmacist documents any delays in administration or reason for thrombolytic not given.

The primary focus of our new process is to improve quality of life and reduce long-term disability for patients who suffer from strokes in the community. The emergency department clinical nurses and the neurology team continue their commitment to stroke patients and timely t-PA administration, ensuring the highest quality care available. The stroke team under the direction of the stroke coordinator has broken down every barrier in order to deliver the Gold Standard of Care to patients at Wellstar Kennestone Hospital.

Submitted By: Jamie Threatt, MSN, RN, CCRN, CEN, Leslie Busby, RN, SCRNP, & Susan Zimmermann MSN, RN, CNRN-Wellstar Kennestone Hospital

What Coverdell Has Meant To Me

If you believe, like I do, that for every Bad there is a Good, then you get the jest of The Georgia Coverdell Acute Stroke Registry (GCASR). When Paul Coverdell died from a stroke, his death highlighted how little this country knew about stroke and from his death emerged the GCASR. It gave all of us some care maps to follow. Guidance, resources and what quality stroke care is.

Close relationships were formed as a result of the GCASR and due to these relationships, the Georgia Stroke Professional Alliance (GA-SPA) emerged. I have been proud to be a member the GA-SPA for some years now.

Going to a GA-SPA meeting is like going home. Not only is the Coverdell team there but you walk into a room filled with the only group of people that truly understand what a stroke manager does. They understand the issues you are having and the concerns you may have in getting staff to embrace stroke. They know because they too have been there.

There's an aura in the room. As soon as you arrive you feel it. Everyone's happy to be speaking about the one topic they all have in common, improving stroke care. The visions may differ slightly, but the cause is the same.

In my entire nursing career, there has never been a collaborative with facilities that have shared so much about any topic, including cardiac. This is where stroke care must differ. Because of the GCASR and GA-SPA and the people in it, stroke care in Georgia is moving aggressively forward. That sharing of information is invaluable to new as well as seasoned stroke managers. You ask a question or post a need to a protocol and immediately get responses from people that have done just what you're trying to do. No reinventing any wheels. Just dot the I's and move forward. You need Guideline information; you will most likely get a message from Dr. Frankel, the stroke Guru, himself. I know of no one else, in such a high level position that responds like he does. I am grateful that he does and has many times, given me the needed information to move appropriately with our program.

Submitted by: Carol Smith-Peters, Retired Stroke Program Manager, Piedmont Fayette Hospital

Georgia-Stroke Boot Camp 2015

On March 31, 2015 the American Heart Association/American Stroke Association (AHA/ASA) and the Georgia Coverdell Acute Stroke Registry (GCASR) partnered along with member's from GA-SPA to put on the first Stroke Boot Camp in Georgia. There were attendees from across the Southeast Affiliate that included Alabama, Tennessee, and Florida with Georgia members traveling from as far south as Valdosta to participate in the conference.

The facilitator for the program was Dr. Diadra Biles, Director of Quality/systems Improvement for AHA. She spent months planning and organizing the event with the support from Coverdell and GA-SPA members. This boot camp has proven to be extremely successful being offered in a few states across the country. Diadra was able to obtain the agenda from the other programs and tailor the GA-Boot camp to what was needed specifically for the SE-Affiliate.

The morning session was filled with major topics that included the Traditional and Emerging Roles of the Stroke Coordinator, QI and Data Analysis, Legislative Updates and Hot Topics from 2015 ISC. Susan Gaunt from Gwinnett Medical Center and Teri Newsome from Habersham Medical Center did a superb presentation on Validating a Stroke Program: Return on Investment (ROI) at large and small facilities. The details of how they are able to demonstrate to Administration the value of a Stroke Program was exceptional. The afternoon was filled with breakout sessions for Primary, Comprehensive, and Stroke Ready/Telemedicine sessions along with Stroke Nursing Research, Engaging Physicians as Partners, Best Practices in Stroke Education and Multi-tasking for Dual Roles in Small and Midsized Facilities. The group reconvened for an enlighten presentation of Professional Development and Self-Preservation of the Stroke Coordinator by Alexis Thomas from Saint Francis Hospital in Columbus. She delighted the audience with her fresh, perspective and how she has mastered the stroke coordinator role in just a few years. It ended with a panel discussion from Dr. Frankel and several of the speakers answering a multitude of questions from the audience. There was plenty of time for networking and sharing experiences between the attendees.

The ultimate goal was achieved. Each participant left with a toolbox of resources that would assist them in providing best practice guidelines and quality care to all patients that enter into our hospital doors. If you weren't able to attend you truly missed a great conference. We hope there will be enough interest to offer Boot Camp again in the future for you and your Team and that you will be able to attend and continue to develop the strategies for maintaining a quality stroke program.

A very special thank you to the AHA/ASA Team, Mary Robichaux, Diadra Biles, Kay Johnson, Krystle Richards and Sherelle Waters that sponsored the program and made sure all went well and we had a great time, fantastic networking, along with an excellent educational opportunity.

Submitted by: Debbie Camp, Stroke Manager-Piedmont Newnan Hospital

Coverdell Highlights

March Abstraction Training Workshop

On March 18th, the GCASR sponsored a full day abstraction training workshop. The morning session was devoted to general abstraction and the afternoon session offered advanced reporting for the attendees. We are proud to say that the class was full to capacity and we plan to offer this again in the fall. Thanks to the American Heart Association for working with us on the advanced reporting session.

April Conference Call

Thank you to Dr. Raul Nogueira, Director of Neuroendovascular Service and Director of Neurocritical Care Services at the Marcus Stroke and Neuroscience Center at Grady Memorial Hospital. Dr. Nogueira presented on "Endovascular Stroke Therapy: Now Proven so What is Next"? It was an extremely informative presentation