ADVOCACY WORKSHOP WCN 2015

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Disclosures

- AAN Palatucci graduate, Advisor, Faculty
- Member, Public education and Advocacy committee, WFN
- Member, Advocacy and Public policy committee, RACP, Australia
- Research grants from Victoria University, National Stroke Foundation, Australia

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Goals

- To provide participants with:
  - An understanding for when and how to use the legislative system to achieve Action Plan goals
  - Why it's important to form relationships with decision makers
  - The best ways to make your point and educate decision makers
  - How and when to use grassroots advocacy

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Greetings From Melbourne

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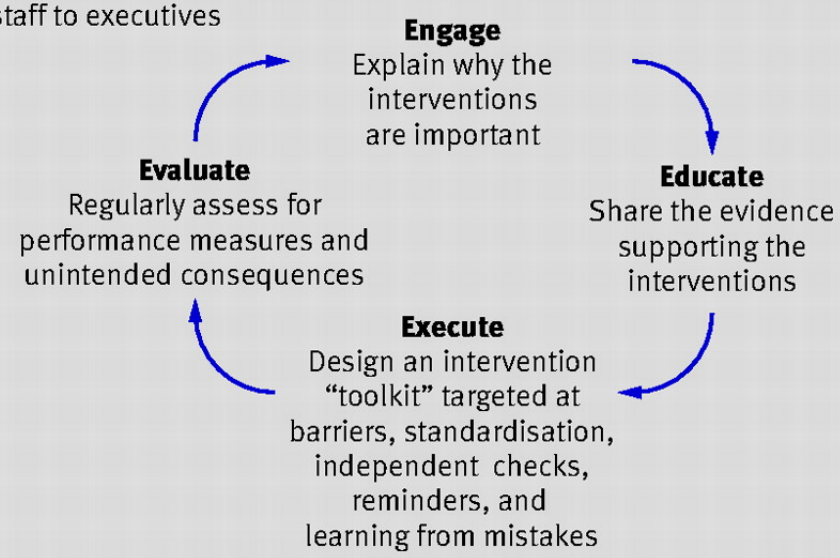
Overall concepts
Envision the problem within the larger healthcare system
Engage collaborative multidisciplinary teams centrally (stages 1-3) and locally (stage 4)

1. Summarise the evidence
Identify interventions associated with improved outcomes
Select interventions with the largest benefit and lowest barriers to use
Convert interventions to behaviours

2. Identify local barriers to implementation
Observe staff performing the interventions
"Walk the process" to identify defects in each step of implementation
Enlist all stakeholders to share concerns and identify potential gains and losses associated with implementation

3. Measure performance
Select measures (process or outcome)
Develop and pilot test measures
Measure baseline performance

4. Ensure all patients receive the interventions
Implement the "four Es" targeting key stakeholders from front line staff to executives



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A simple score (ABCD) to identify individuals at high early risk of stroke after transient ischaemic attack

P M Rothwell, M F Giles, E Flossmann, C E Lovelock, J N E Redgrave, C P Warlow, Z Mehta

Abstract

Background Effective early management of patients with transient ischaemic attacks (TIA) is undermined by an inability to predict who is at highest early risk of stroke.

Methods We derived a score for 7-day risk of stroke in a population-based cohort of patients (n=209) with a probable or definite TIA (Oxfordshire Community Stroke Project; OCSP), and validated the score in a similar population-based cohort (Oxford Vascular Study; OXVASC, n=190). We assessed likely clinical usefulness to front-line health services by using the score to stratify all patients with suspected TIA referred to OXVASC (n=378, outcome: 7-day risk of stroke) and to a hospital-based weekly TIA clinic (n=210; outcome: risk of stroke before appointment).

Results A six-point score derived in the OCSP (age [≥60 years=1], blood pressure [systolic >140 mm Hg and/or diastolic ≥90 mm Hg=1], clinical features [unilateral weakness=2, speech disturbance without weakness=1, other=0], and duration of symptoms in min [≥60=2, 10–59=1, <10=0]; ABCD) was highly predictive of 7-day risk of stroke in OXVASC patients with probable or definite TIA ($p<0.0001$), in the OXVASC population-based cohort of all referrals with suspected TIA ($p<0.0001$), and in the hospital-based weekly TIA clinic-referred cohort ($p=0.006$). In the OXVASC suspected TIA cohort, 19 of 20 (95%) strokes occurred in 101 (27%) patients with a score of 5 or greater: 7-day risk was 0·4% (95% CI 0–1·1) in 274 (73%) patients with a score less than 5, 12·1% (4·2–20·0) in 66 (18%) with a score of 5, and 31·4% (16·0–46·8) in 35 (9%) with a score of 6. In the hospital-referred clinic cohort, 14 [illegible] stroke before their scheduled appointment, all with a score of 4 or greater.

[illegible] troke during the 7 days after TIA seems to be highly predictable. Although further validations [illegible] needed, the ABCD score can be used in routine clinical practice to identify high-risk individuals [illegible] investigation and treatment.

Lancet 2005; 366: 29–36

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Stroke Prevention Research Unit, Department of Clinical Neurology, University of Oxford, Radcliffe Infirmary, Oxford, OX2 6HE, UK (Prof P M Rothwell FRCP, M F Giles MRCP, E Flossmann MRCP, C E Lovelock FRACP, J N E Redgrave MRCP, Z Mehta DPhil); **and Department of Clinical Neurosciences, University of Edinburgh, [illegible] Hospital, E[illegible]** (Prof C P W[illegible]

Correspond[illegible] Prof Peter M[illegible] **peter.rothv[illegible] ac.uk**

Start with self education

- **Identify key decision makers**
  - Draw a governance chart - a dynamic document which requires frequent updating given personnel movement and governance restructuring.
- **Identify clinical colleagues that are stroke advocates and non-advocates**.
  - Dealing with the latter can be difficult although avoidance of utilisation of their resources usually works best.
- **Learn the proposal endorsement process.**
  - Who do you need to educate to achieve endorsement?
- **Learn the proposal implementation process.**
  - This is often neglected and usually defaults back you.

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Getting your proposal through

- Prioritize your availability for endorsement process
- Ensure support from all local governance managers
- Consult/educate all key decision makers
- Give a “half baked” endorsement <u>considerable</u> thought
  - Consult key stakeholders before commitment
    - Pros: “foot in the door” – staged approach
    - Cons: additional workload absorbed into existing resource - intra/inter departmental friction

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Implement your proposal

- **Streamline the implementation process**
  - Recruitment of good personnel
  - Ensure transparency of funding, gain signing rights to budget expenditure
  - Communication to all key stakeholders
- **Write a protocols and procedures document**
  - Ensure that this document is readily available (i.e. intranet)
- **Mock runs before starting**
- **Be available and quickly address teething problems**
  - Not a good time to go on leave
- **Avoid protocol violation**
  - You want wins initially, not disasters

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Promote a feel good state

- **Showcase wins**
  - Stakeholders - reinforces commitment
  - Opponents - induces global aphasia (& resistance agnosia)
  - Administrators - increases probability of endorsement of future proposals
  - Colleagues/public – promotes service development by passive diffusion in other centres
- **Do this via**
  - Email – thankyou to all
  - Patient letters of commendation – if a patient/family commends your service request that they put it in writing and send to your general manager
  - Public forums
  - Departmental meetings
  - Media
- **Always acknowledge support of administrators**
  - Public endorsement for administrators by clinicians generates political currency
    - The more you generate the more you will be accommodated with future proposals.
    - (opposite holds true for inflammatory comments)

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Ensure Longevity

- **Collate and feed back KPI's to administrators**
  - Administrator relevant
- **Reward key stakeholders**
  - lunches, feedback sessions, acknowledgement, sponsor PD activities to key staff
- **Audit and refinement**
  - Patient focussed to ensure best practice.
  - Often leads to further resource request and thus the cycle begins

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The key to success

- It's not complicated
- Like any long range plan it includes:
  - Setting goals
  - Gathering resources
  - Outlining an action plan

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When to Use These Skills

- To resolve the Issue identified in an Action Plan, legislation/ education may be needed
- To create a new law or rule
  - modify an existing law or rule
  - request new funding or direct existing funding
- The state, local, and national legislative processes often play a big role in most advocacy objectives

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Preparation

- Do your homework
  - Know what interests the decision maker has and what committees they serve on
  - Know what relevant decisions he/she has made
  - Know what your Request will be
  - Know if there are others that support your Request

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Conversation Tips

The Big 3

- 1– Introductions
  - Your name, what you do & specifically where you live/ work
- 2 – Key Messages & Local Stories
  - Stay on message
- 3 – The Request
  - What can he or she do for you?
  - Be specific

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Your Story

Communication approaches:

- 1. Formal Argument
  - Facts, figures, data
  - Logic
  - Indexing power
- 2. Personal Story (always more effective)
  - Talk about your patients
  - Emotional connection
  - Anecdotal power

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Apply Your Media Skills

- Keep it simple
  - Avoid jargon, acronyms, clinical terms
- Don't ask a decision maker if he/she is familiar with your Issue
  - Opens the wrong door; assume they aren't
- Stay cordial
  - Never get defensive
  - Avoid partisanship
- If you don't have an answer say, "I don't know but I'll get back to you" (then promptly follow up)

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More Tips

- **Beware of Traps & Distractions:**
  - Don't go off message – bridge back to key points
  - Turn off cell phones
  - Don't answer questions you don't know the answer to
  - Don't be ambiguous
  - Don't waste time or lose track of time
  - Don't show up late or miss a meeting
  - Don't forget to thank him or her for their time and follow up on all requests

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Building Relationships

- Invest the time in building a personal relationship
  - Everyone wants to help their friends
- Generate positive relationships
  - Credibility is essential but takes time
- Position yourself
  - As a credible, reliable, and timely source of information

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Grassroots Advocacy

- Grassroots Advocacy happens when you act in unison with others seeking the same Request

Examples:

- Coordinated Legislative Office visits
- Letter-writing and email campaigns
- Online Blogs & website articles
- Editorials and letters to the editor
- Media coverage

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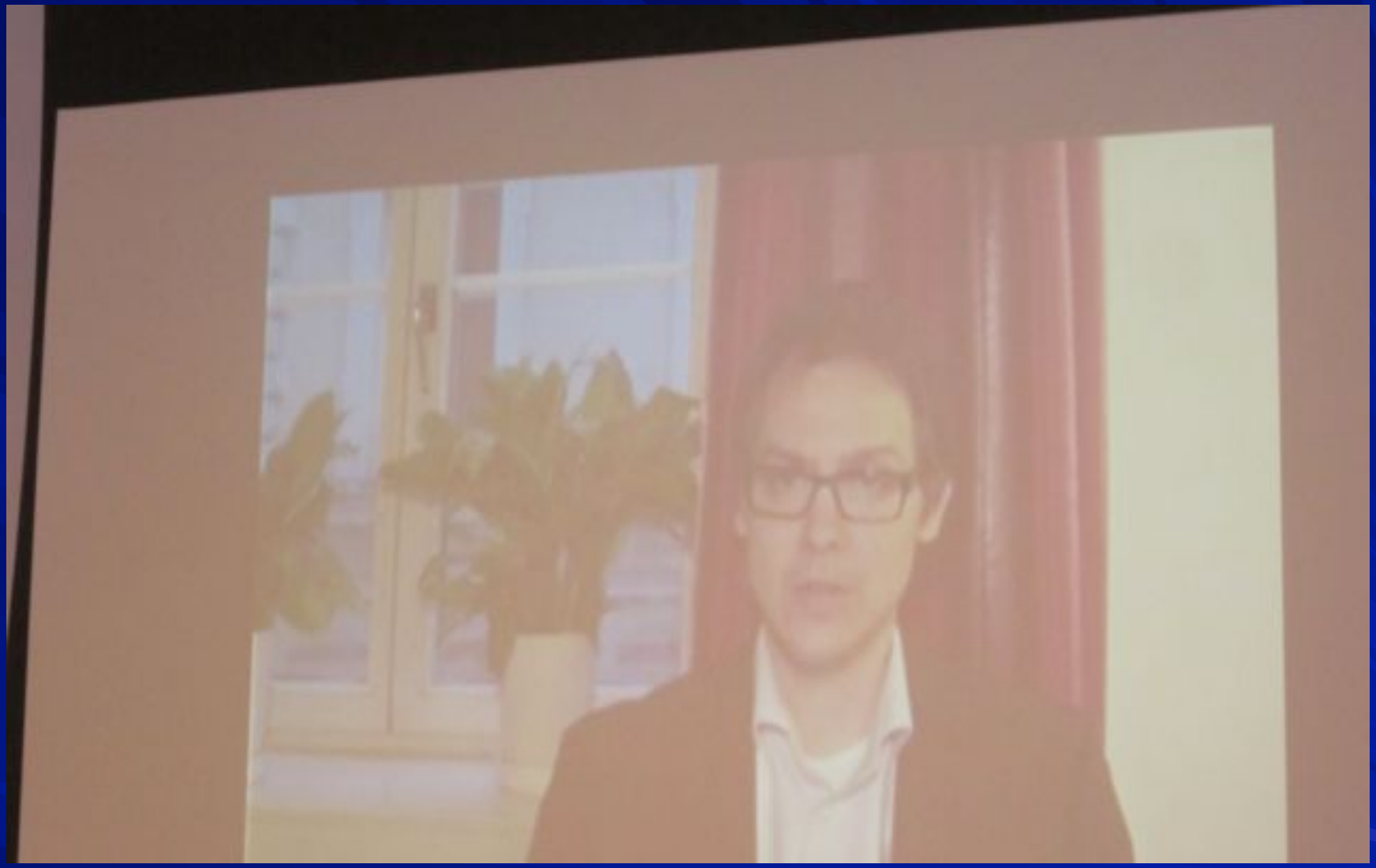

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Western Health Story

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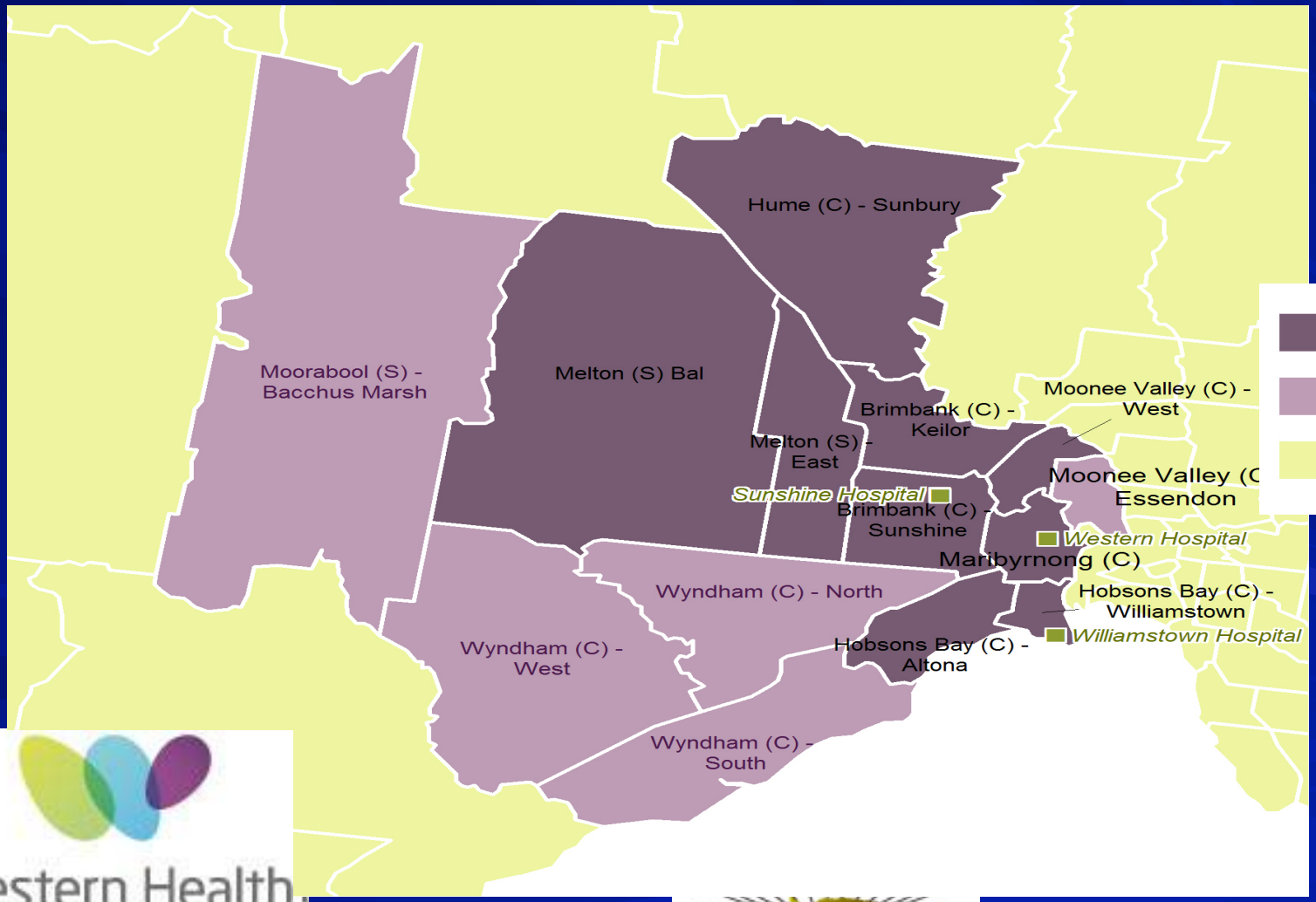
Western Health Catchment



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- Catchment area of one million population
- 900-1000 strokes
- 300 – 400 TIAs
- Stroke 84% managed by Neurology
- TIA 62% managed by Neurology – Admit 93% of all TIA's
- 25 bed neurology unit with four part time neurologists (1.7 EFT)
- No formal stroke thrombolysis service

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•Characteristic	Element	Level 1	Level 2	Level 3
•SERVICES: •*Medical / Nursing*	•Neurosurgery services	-	-	•-
•Onsite = +	•Interventional neuroradiology	-	-	-
•Offsite Access = -	•Stroke physician	+/-	+	+
	•Stroke nursing – Stroke Care Coordinator	-	+	+
•*Allied Health*	•Neuropsychology	-	+/-	+
	•Occupational therapy, speech pathology & dietician	-	+	+
	•Physiotherapy & Social work	+/-	+	+
•SPECIALISED DIAGNOSIS / TREATMENT	•Rapid triage of stroke/TIA	+	+	+
	•Computerised Tomography	-	+	+
•Yes = +	•Magnetic Resonance Imaging or Digital Subtraction Angiography	-	-	+/-
•No = -	•Capacity to deliver stroke thrombolysis	-	+	+
	•Outpatient TIA/neurovascular clinic	-	+/-	+
•SERVICE/CARE ORGANISATION & PHYSICAL FACILITIES	Acute stroke care co-located in an inpatient ward	+/-	+	+
	•Interdisciplinary Team	-	+	+
•Yes = +	•Specified Director, Stroke Services	-	+	+
•No = -	•Intensive Care/High Dependency Unit	-	-	+
	•Stroke Care Facilitator	-	-	
	•Telemedicine facilities for clinical & professional support	+	+	
	•Leading education and research initiatives	-	-	
	•Participating in education and research initiatives	+	+	

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Governance Framework

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Acute Stroke Unit Achievements

- Establishment of Acute Stroke Unit - 4 Acute Stroke beds - Signage erected!
- Relocation ward: 2C → 3A (Gym)
- Development & Implementation - ASU Admission/Discharge/Transfer Policy

- ASU Interdisciplinary Team – Function & Structure
- Family Meeting – Structure & Function
- ASU - Equipment Audit
- ASU – Clinical Pathway

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Western Health Acute Stroke Unit

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Acute Intervention Achievements

- Rapid Triage Protocol established – Cat 2 for Thrombolysis & Cat 3 for Acute stroke & TIA
- Thrombolysis Protocol established & implemented April 09 – just more than 300 patients had thrombolysis
- TIA – Clinical Practice Guidelines endorsed Oct 2009 – nearly 1000TIA patients were managed in the clinic with very few stroke recurrence

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Stroke Workforce Achievements

- Recruitment - Head of Neurology
- Recruitment – 1.4 EFT Stroke Neurologists
- Recruitment - Stroke Nurse Coordinator
- Increase 1.0 - 1.5 EFT Social Work
- Collaborative Physio / OT assessment policy
- Stroke Nurse Practitioner – just completed her Msc

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Clinical Practice

- Stroke Care Pathway
- Patient / Carer Information Working Party
- Continence Working Party
- NSF - Organisational & Clinical Audit

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Sub Acute Achievements

- Sub Acute Referral – Criteria (Inclusion & Exclusion) policy
- Sub Acute Referral Form
  - Document development & trial
  - Sub Acute Access – Team Meetings
- Continence & Patient Information

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Workforce Education Achievements

- Western Health Stroke Workforce Survey
- Western Health Stroke Education Seminar – Annual
- Stroke Continuing Professional Development Program
- Stroke Learning Packages & Competency

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Stroke Self Management Program

Sex	Male	Female				
	3	2				
Age	<34	35-44	45-54	55-64	65-74	75+
			2	2		1
Ethnicity	Aust	Ab/TSI	Eng Speak	European	Asian	Other
	2			3		
Living arrangements	Alone	Shared	Hostel	Other		
		5				
Employment	No	Yes				
	5					
Year of most recent stroke	<2004	2005	2006	2007	2008	2009
					1	4
SSG member	No	Yes				
	5					
nding	No	Yes				
	3	2				

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