



Testimony of Mark J. Alberts, MD, FAHA, FAAN
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Submitted to the Public Health Committee on Monday, March 29th, 2021 regarding
Section 68 of HB 6666, An Act Concerning the Department of Public Health's Recommendations
Regarding Various Revisions to the Public Health Statutes.

Sen. Daugherty Abrams, Rep. Steinberg, Sen. Hwang, Sen. Somers, Rep. Petit and members of the Public Health Committee:

Thank you for the opportunity to testify on section 68 of House Bill 6666, which would require the Department of Public Health to maintain and operate a statewide stroke registry using the American Heart Association's Get with the Guidelines-Stroke (GWTG) program's dataset platform to include data that aligns with the stroke consensus metrics approved by the American Heart Association (AHA) and American Stroke Association (ASA).

Under the bill, stroke centers and acute stroke-ready hospitals would be required to report data in accordance with AHA/ASA stroke consensus measures on a quarterly basis to DPH beginning January 1, 2022. In addition, the bill would require stroke centers and hospitals to provide DPH access to relevant records in order to ensure data accuracy, enable case finding, and engage in quality improvement. If stroke centers fail to comply, DPH is required to levy a civil penalty of up to \$500 "for each failure to disclose a stroke care data." Finally, the bill requires DPH to establish a stroke registry data oversight committee, in consultation with the existing Connecticut Stroke Advisory Council.

HHC supports the development of a statewide stroke registry, but respectfully requests that this bill provide for stakeholder input before prescribing the tools that will be used to build the registry. Stroke is the fifth leading cause of death in Connecticut residents. A statewide registry would pool data across Connecticut's hospitals and stroke centers so that providers can track, measure and improve their performance across various demographics.

However, we have significant concerns that the bill requires stroke providers use a particular platform without first gathering the input of those who are already collecting this data and who would be required to purchase and use a new platform or reconcile interoperability issues. There are many platform options that can be used to build a registry, including free platforms. The AHA platform costs several thousand dollars per hospital and once data is submitted to that platform, accessing the data is controlled by the AHA. The prescribed platform also does not include patient-reported outcomes and is weak in its data collection around certain types of strokes that require very specialized treatment

In addition, the bill appears to require DPH to levy a fine of up to \$500 for each missing data element. The AHA stroke platform requires collection of data on a great number of elements, some of which may not be relevant or clinically meaningful for some hospitals. Plus, the fine is unnecessarily punitive for what might amount to a minor or clerical error.

We would recommend convening a stakeholder group of stroke providers to work with DPH and reach a consensus on the objectives of a registry, identify which common data elements should be reported and what platform(s) align with these goals, rather than taking the one-size-fits-all approach outlined in the bill.

Before moving forward with a statewide stroke registry, we hope the Committee and DPH will engage in a robust stakeholder engagement process. For additional information, contact Cara Passaro at cara.passaro@hhchealth.org. Thank you for your kind consideration.

The HHC system includes seven acute care hospitals, the state's most extensive behavioral health network, a physician group, a clinical care organization, a regional home care system, an array of senior care services, and a large physical therapy and rehabilitation network.