David Wheeler (00:04):

Hello, and welcome to today's episode of Hemorrhagic Stroke Fireside Chats, where we address unique, rural, and regional barriers to care, the hub and spoke relationships within local health systems, and best practices as patients transfer through their systems of care.

My name is Dr. David Wheeler, I'm a neurologist in private practice in Casper, Wyoming, and I'm the DirectMC ,1 (tM0)-6 (2-92 (q) f3.1 6(tM0)-6 (2-92 1 S)1.4 (int0 Tcr)b T-0.001 Tc 0.003 Tw 0 -1.217 TD[(D)-5.6 (r.)1 (M more about the communities that you're serving as well, and so Dr. Geraghty, I wonder if you could first

We knew that that would also be moving people who had what looked like potentially hemorrhagic strokes into higher levels of care, but we figured that would be appropriate in the catchment system as well. So there is this overall bypass system that's built into law in Washington state.

David Wheeler (07:58):

Good. Thank you, Dr. Geraghty. So as for the ongoing management of the Coverdell Stroke Project in Washington, I imagine there are a number of stakeholders involved. Do you, or members of your team, participate in any regular meetings of this organization or help to set the priorities of the organization going forward?

Nicole West (08:16):

Yes, we are actually both very involved in the state system with the Department of Health and with the EMS systems. We have, from the State Department of Health and then we've got a regional systems that we're involved in as well. So yes, and it's so important to have that connection statewide and for those in the larger facilities that have the ability to care for patients at the highest acuity, to reach out and participate and support.

Madeleine Geraghty (08:56):

Pretty much when I first came here to Spokane, I was befriended by the local MPD, medical program director, for Spokane EMS, who taught me a lot about getting involved with EMS services way back in

have readily available CT, and so it's really an evaluation by the ED provider. And then when they call looking for transfer, it goes through our transfer center and the call is generally put out to neurology, so anything that looks like it's neurology based, the first call is to come through neurology and then if we have scans available, they'll pull in others, like neurosurgery, if needed.

But we have that so that neurology can evaluate the best place and the best next step for that patient coming from the outside facility.

David Wheeler (17:14):

For patients who are presenting with stroke-like symptoms to one of your outlying facilities, is the imaging always readily available to the neurologist who's going to be participating in the care?

Madeleine Geraghty (17:25):

Not always. Sometimes we have to rely on the verbal descriptions from the outlying hospital, but the neurologist is always going to serve as the triage person and try to help decide whether neurosurgery needs to get involved, what the next step is. So we serve as that middle layer.

David Wheeler (17:52):

initially identified, we initially start with the blood pressure control and getting that down urgently to whichever target is appropriate for the subtype of hemorrhagic stroke and assessing whether or not there's going to be an emergent neurosurgical need.

Our neurosurgeons are incredibly responsive, and I'm very proud to say that we've worked with our neurosurgery department with recurrent, casual, after hours get togethers with evidence-based