7.i. GETAC Stroke Committee

Chair: Robin Novakavic-White, MD

Vice-Chair: Sean Savitz, MD

Stroke Committee

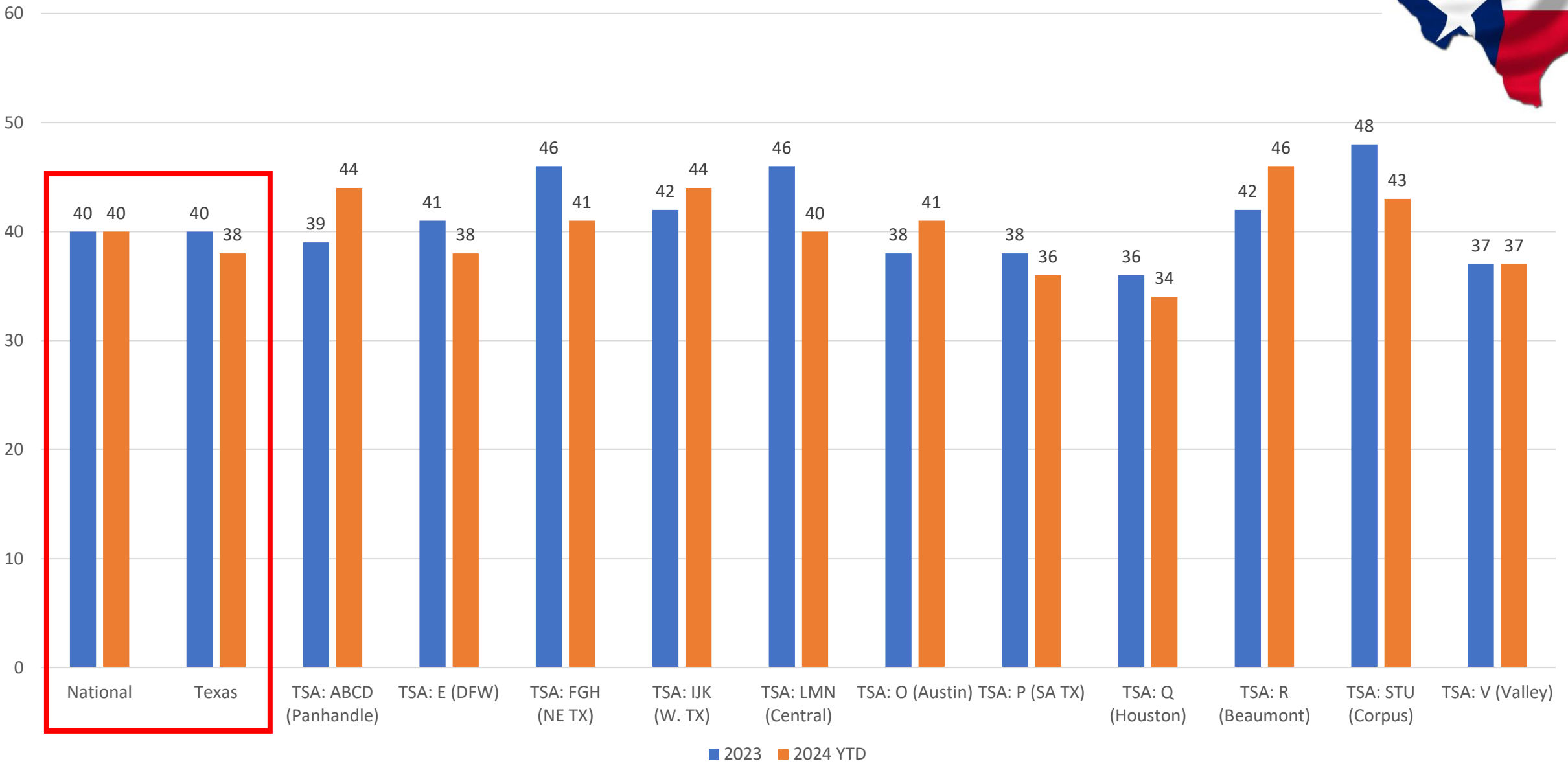
Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
GETAC Stroke Committee Purpose	• Reviewed and approved Stroke Committee purpose 03/2024	
Report and share quarterly Texas Stroke Quality Performance Report	• **Review and disseminate Texas Stroke Quality report.** • **Share with TCCVDS.** • **Use the quality report to identify barriers to stroke care and opportunities for improvement.**	
GETAC Stroke Committee Performance Measures	• **Approved: Median DTN, Median DIDO, Percentage Stroke Screening Tool Performed and Documented submitted** • **Review data from NEMSIS on EMS stroke screen performance.**	
NEMSIS/EMSTR Stroke Collaboration	• **GETAC Council approved 06/2024** • **The Stroke Committee PI Work Group worked with Jia on reviewing the data.** • **Jia presented the initial results**	

GETAC Stroke Metrics

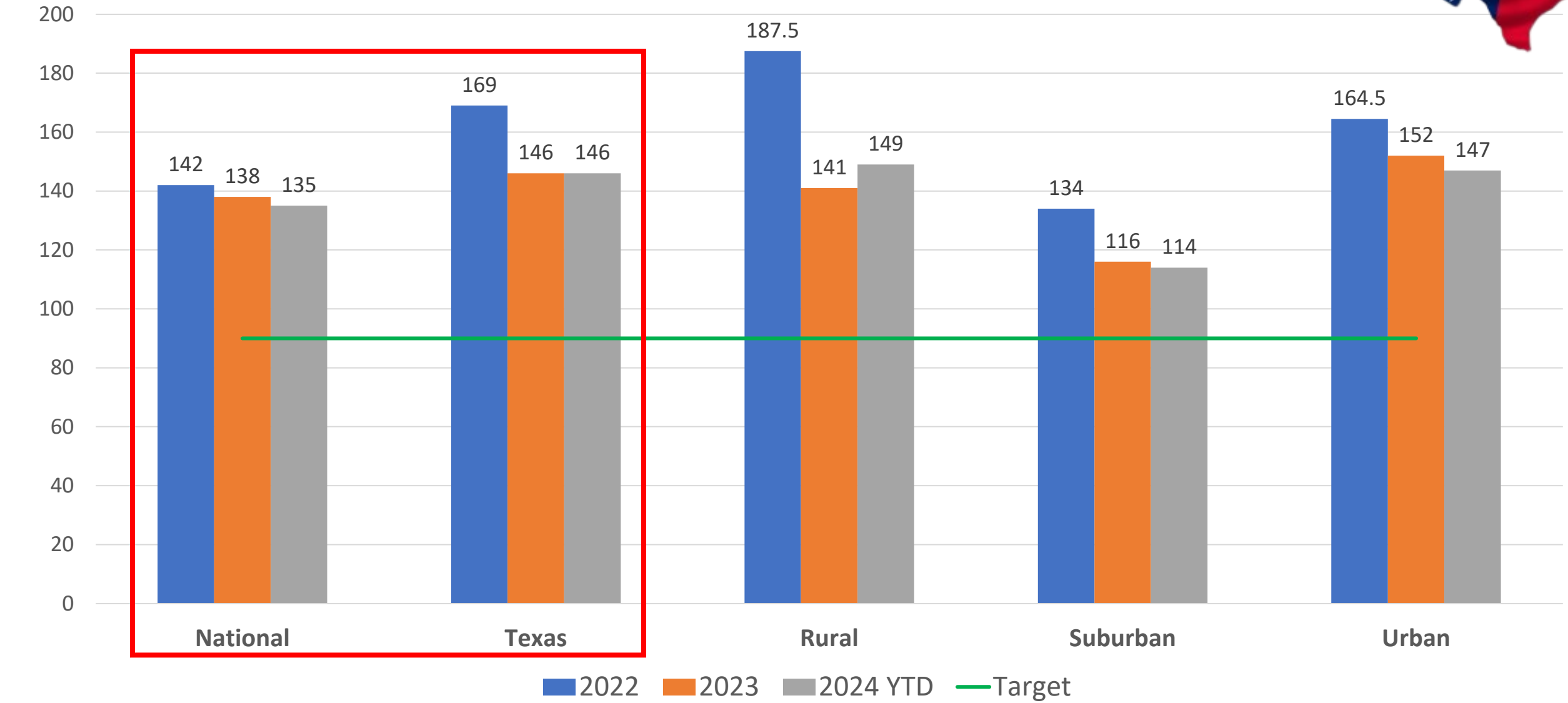
- Median Door to Needle
- Median DIDO for Acute Therapy Eligible Patients
- EMS Stroke Severity Screening for LVO
- EMS Pre-arrival Notification

Median DTN by RAC (minutes)



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/31/24.

Median DIDO for Acute Therapy Eligible Patients



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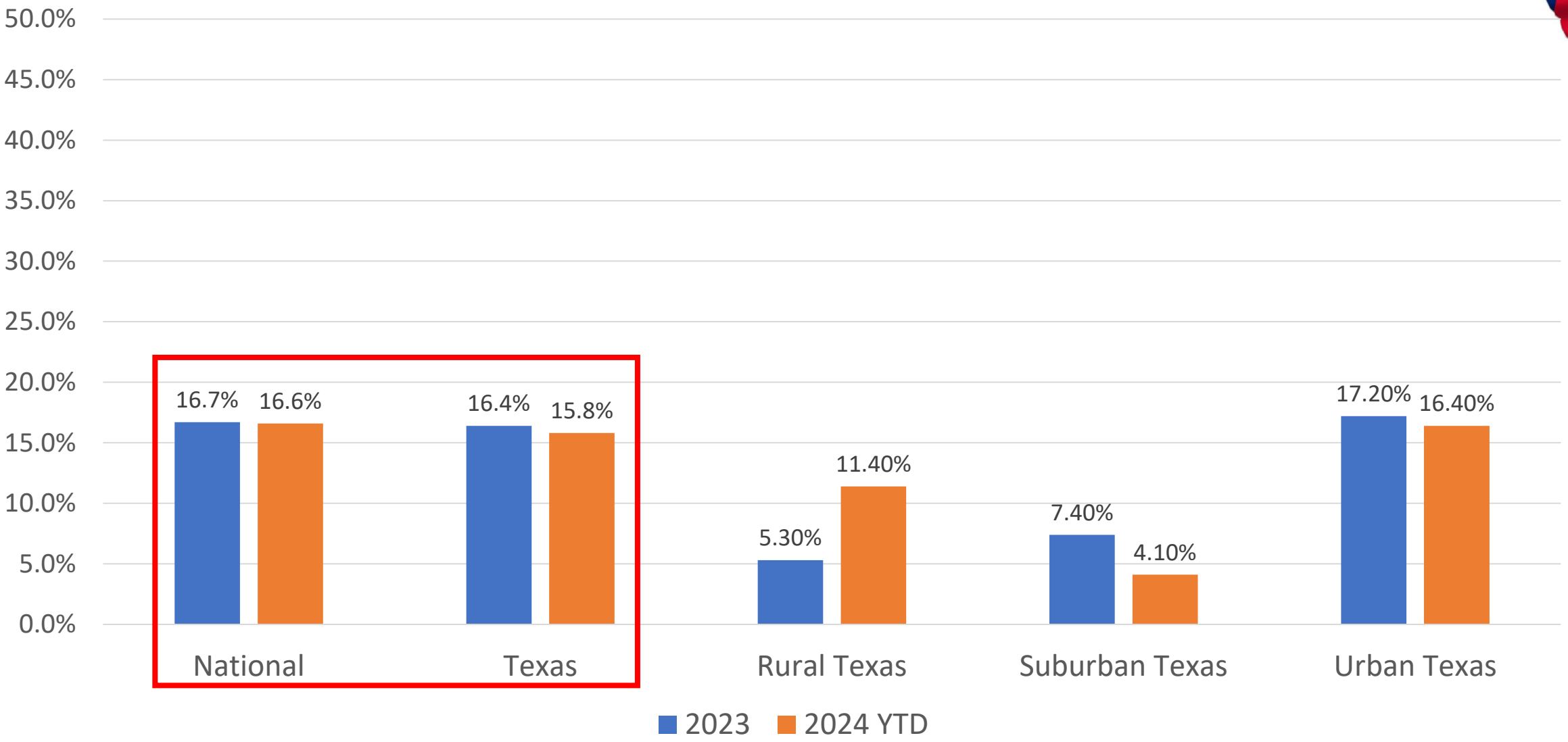
EMS Stroke Severity Screening by Geographic Classification



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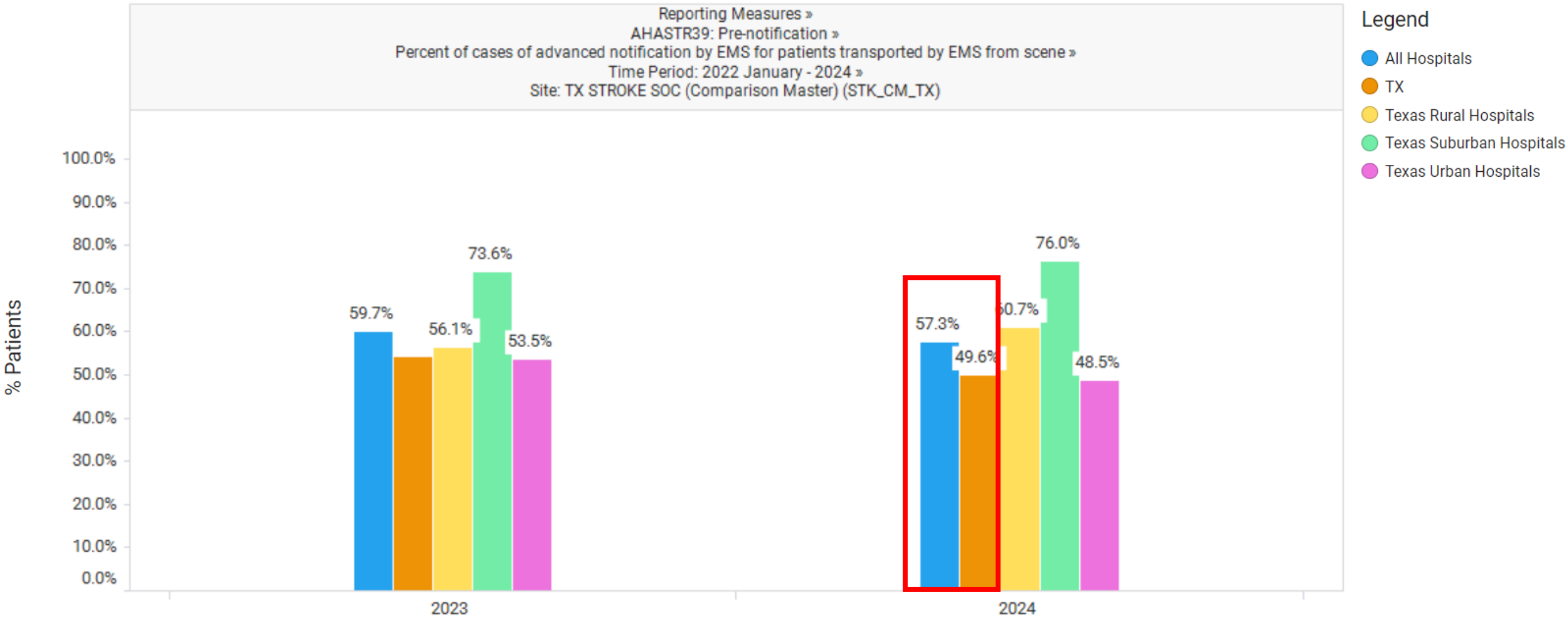
AHASTR39: Pre-notification

Percent of cases of advanced notification by EMS for patients transported by EMS from scene

Measure Summary



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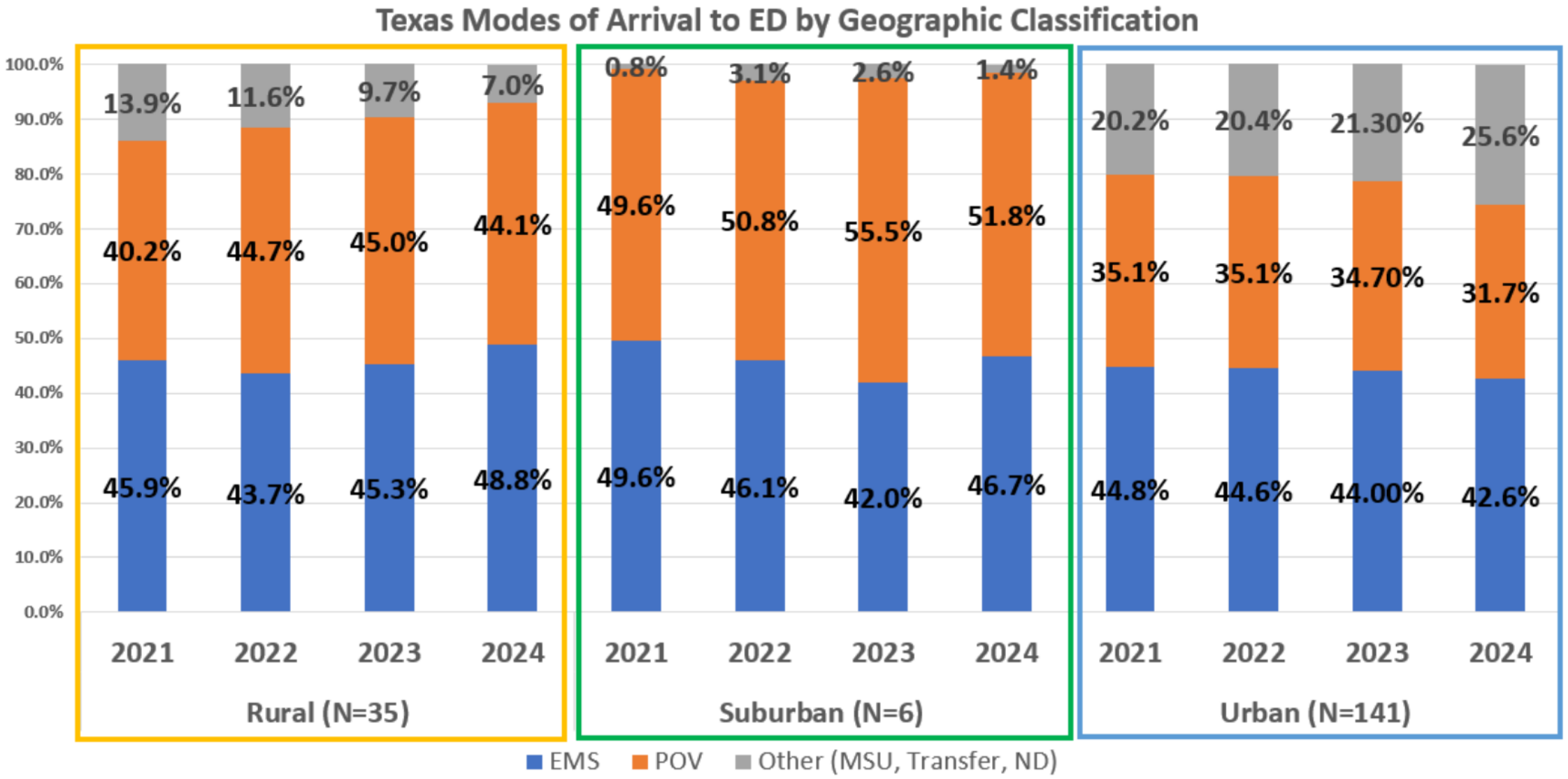
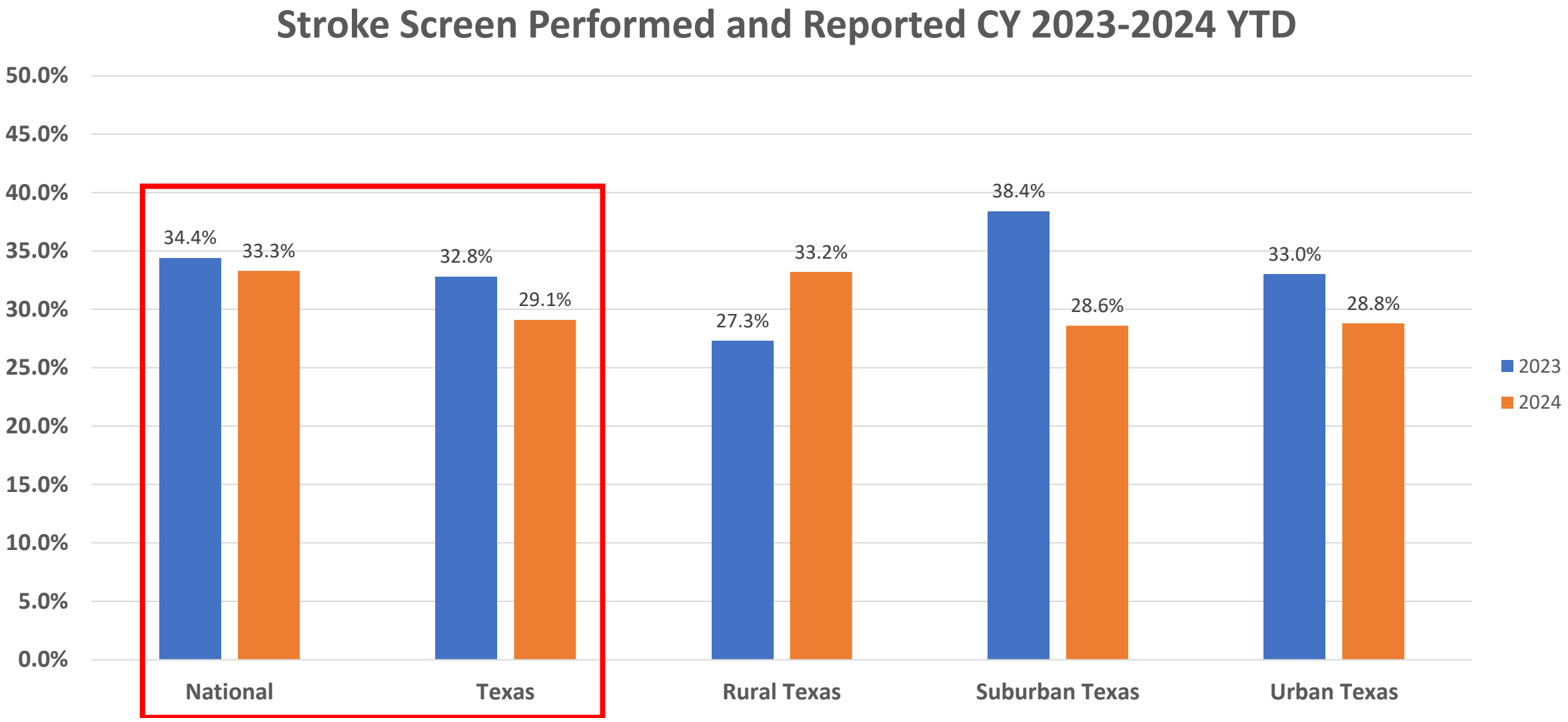
Other Stroke PI Measures

- tPA vs. TNK Usage
- Median Time LKW to Arrival by Geographic Region
- Modes of Arrival by Geographic Classification
- % DTN in 30’, 45’, and 60’ in TX
- DTD in Direct Arrivals vs. Transfers
- EMS Stroke Screen Performed and Reported
  - GWTG vs. NEMSIS data
- EMS On-Scene time <15 min



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 4/12/24.

Percentage of confirmed stroke patients transported to your hospital by EMS and for whom a validated regional or national stroke screen tool was used with documentation of the outcome.



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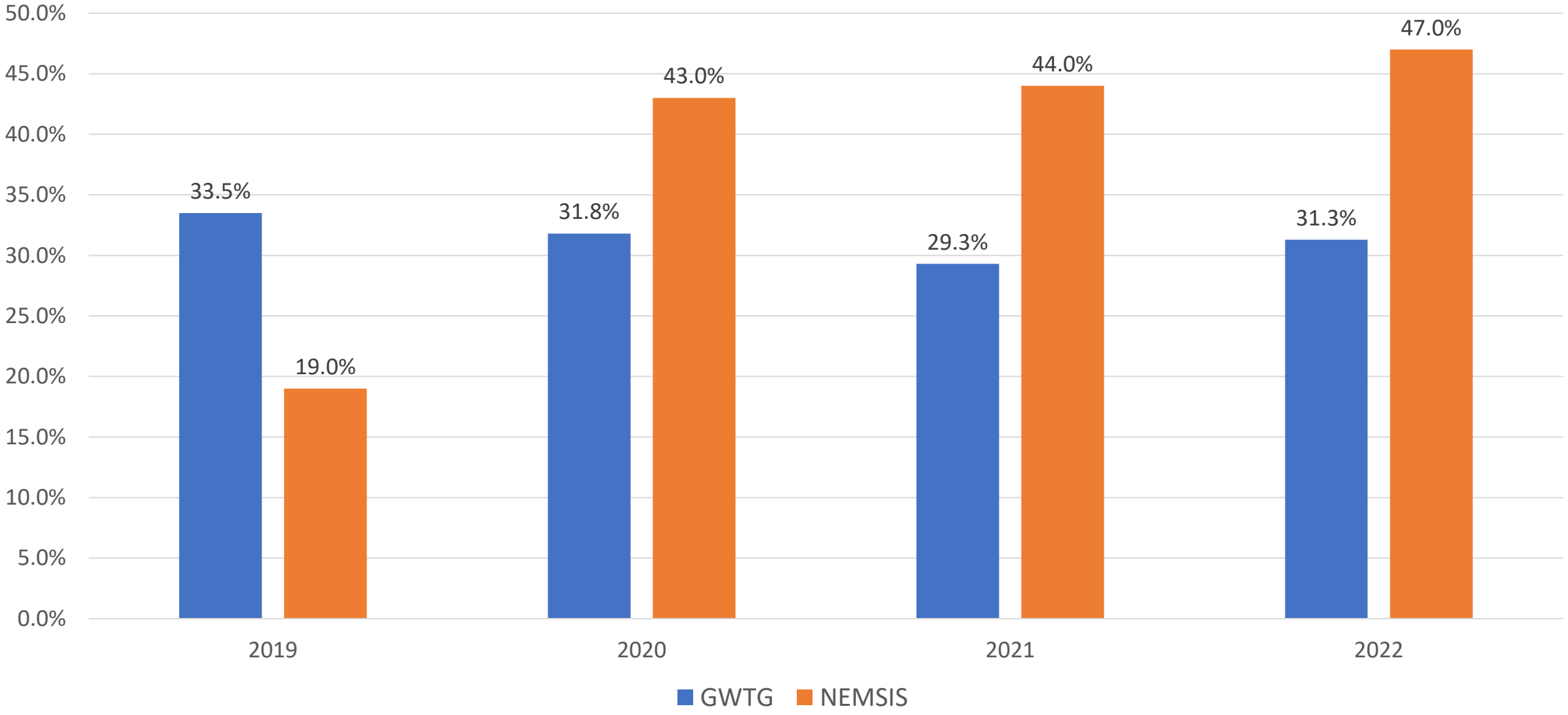
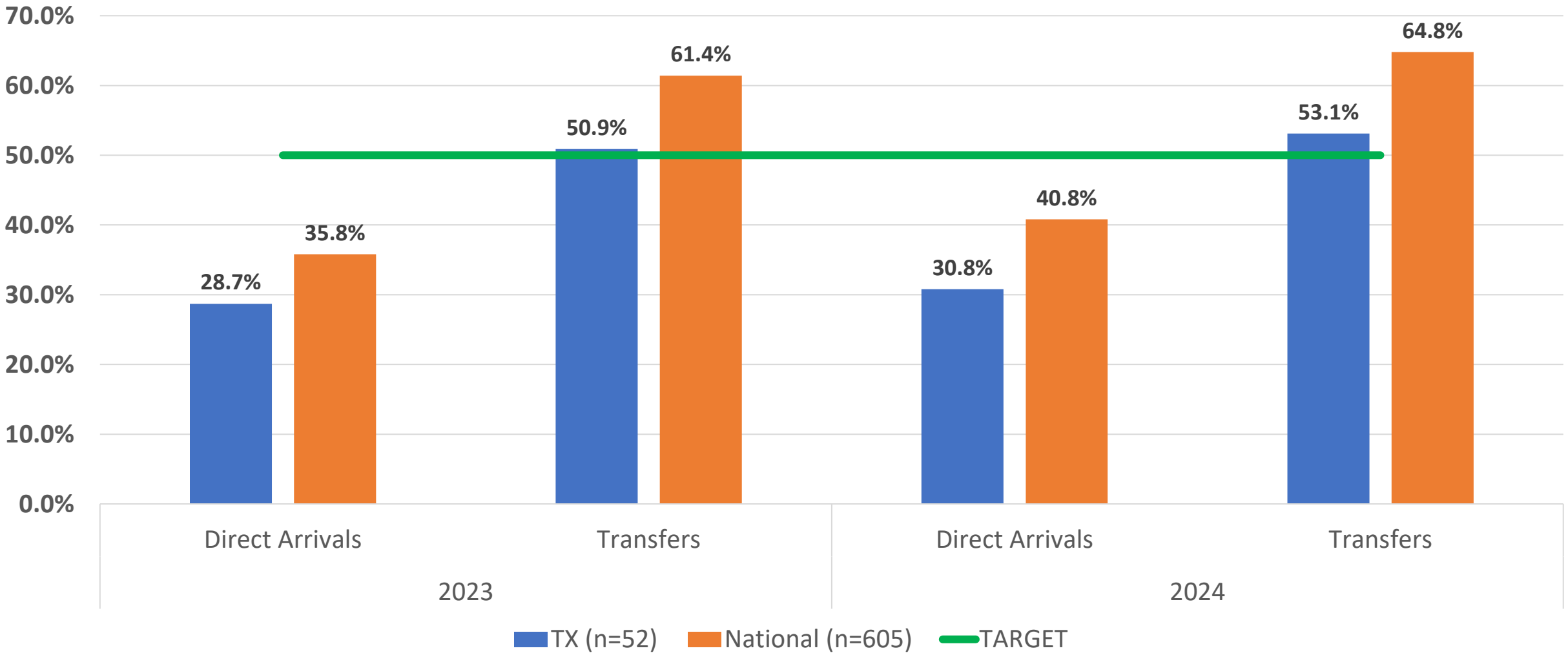
GWTG vs. NEMSIS: EMS Stroke Screen Performed and Reported



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 8/20/24.

DTD <60 min. for Transfers; DTD <90 min. for Direct Arrivals (LKW w/i 24 hours)



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Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prehospital Stroke algorithm – Recommendation	• **Approved by Stroke, EMS and Air Medical Committees.** • **Presented to EMS Medical Directors, revisions recommended.** • **Dr. Winkler, Dr. Fagan and myself will meet to review initiatives. Plan to present 11/2024 for approval.**	
Stroke facility infrastructure and requirements	• The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee. • SSOC Work Group will review BAC guidelines and alternatives, make recommendation to the Stroke Committee 08/24.	
Pediatric Task Force	• Reviewed and approved latest revisions to prehospital best practices for management, transport and interfacility transfers approved by stroke committee and Pediatric Committee. • Submitted to EMS, Air Medical, EMS MD committees, RAC. Seek approval 11/2024. If approved GETAC Council. • Next steps, minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke.	

EMS ACUTE STROKE ROUTING RESOURCE DOCUMENT

EMS Dispatch

Per regional stroke protocol

EMS on Scene:

1. Obtain vitals and provide ABC interventions

2. Interview witnesses & obtain phone number

3. Perform physical exam and validated **PREHOSPITAL STROKE SCREEN**

4. Obtain POC blood glucose

STROKE SUSPECTED?

YES → **Initiate Stroke Protocol**

NO → Treat and transport as indicated per patient presentation

Perform validated **STROKE SEVERITY TOOL** to screen for large vessel occlusion (LVO)

Determine last known well (LKW)and time of symptom discovery

LVO SUSPECTED?

YES → **LKW <24 Hours?**

NO → **LKW <24 Hours?**

NO → **1.** Transport to nearest certified stroke center

2. Provide prehospital prenotification

YES → **Transport to Level I or II Stroke Center possible within thrombolytic window?**

NO → **1.** Transport to nearest TSC if within 30 minutes

2. If no CSC or TSC within time frame transport to nearest highest level stroke facility

3. Provide prehospital notification

YES → **Total Transport Time (scene to CSC by air or ground) is ≤30 Minutes?**

NO → **1.** Transport to nearest CSC

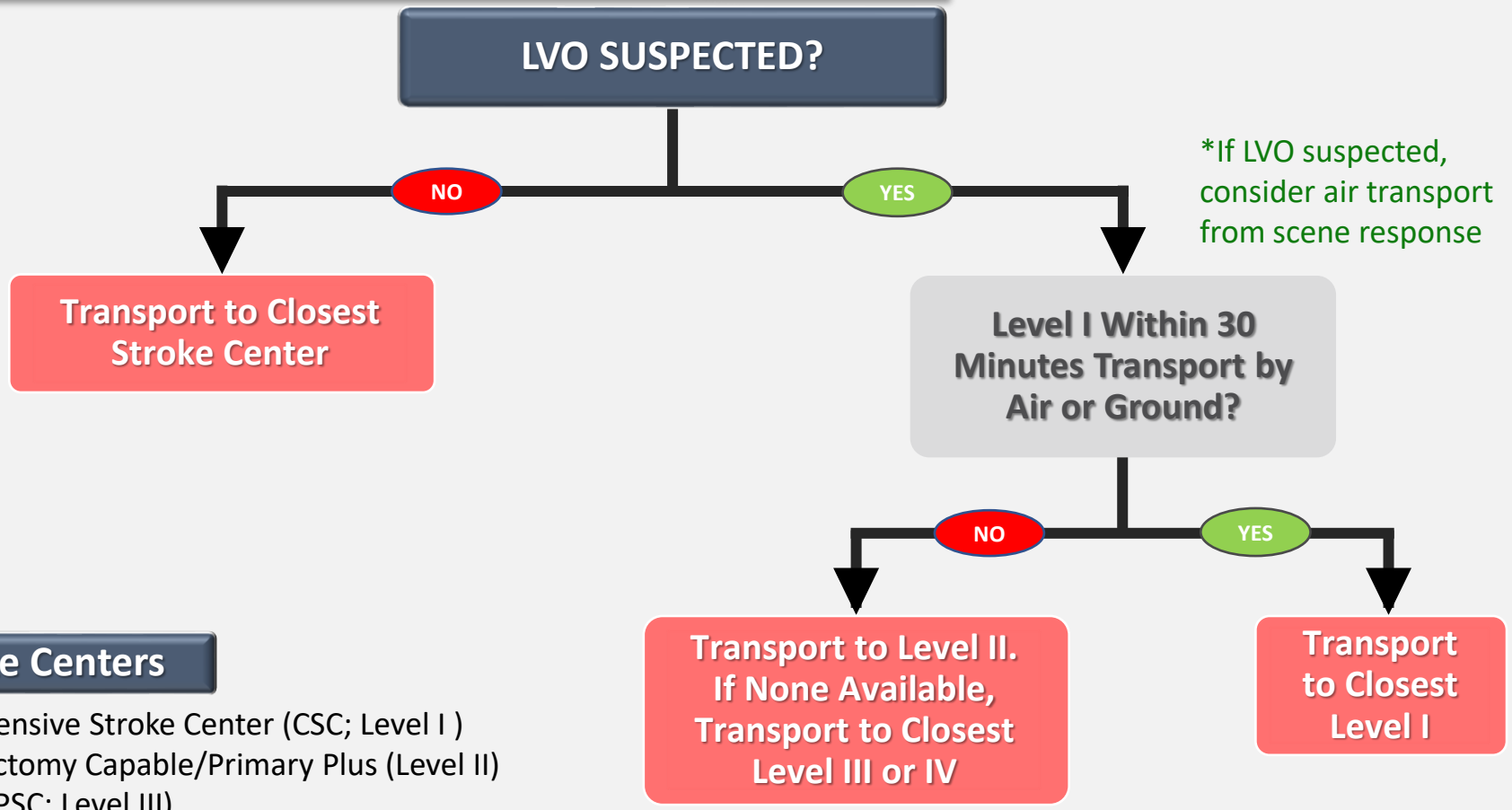
2. Provide prehospital notification

YES → **1.** Transport to nearest CSC

2. Provide prehospital notification

Disclaimer: Regional stroke protocols are developed and implemented based on local guidelines, medical directors' recommendations, and Regional Advisory Councils (RACs). Variations in protocols may exist between different regions. For the most accurate and applicable guidelines, please consult the specific protocols established by your local health authorities and medical professionals.

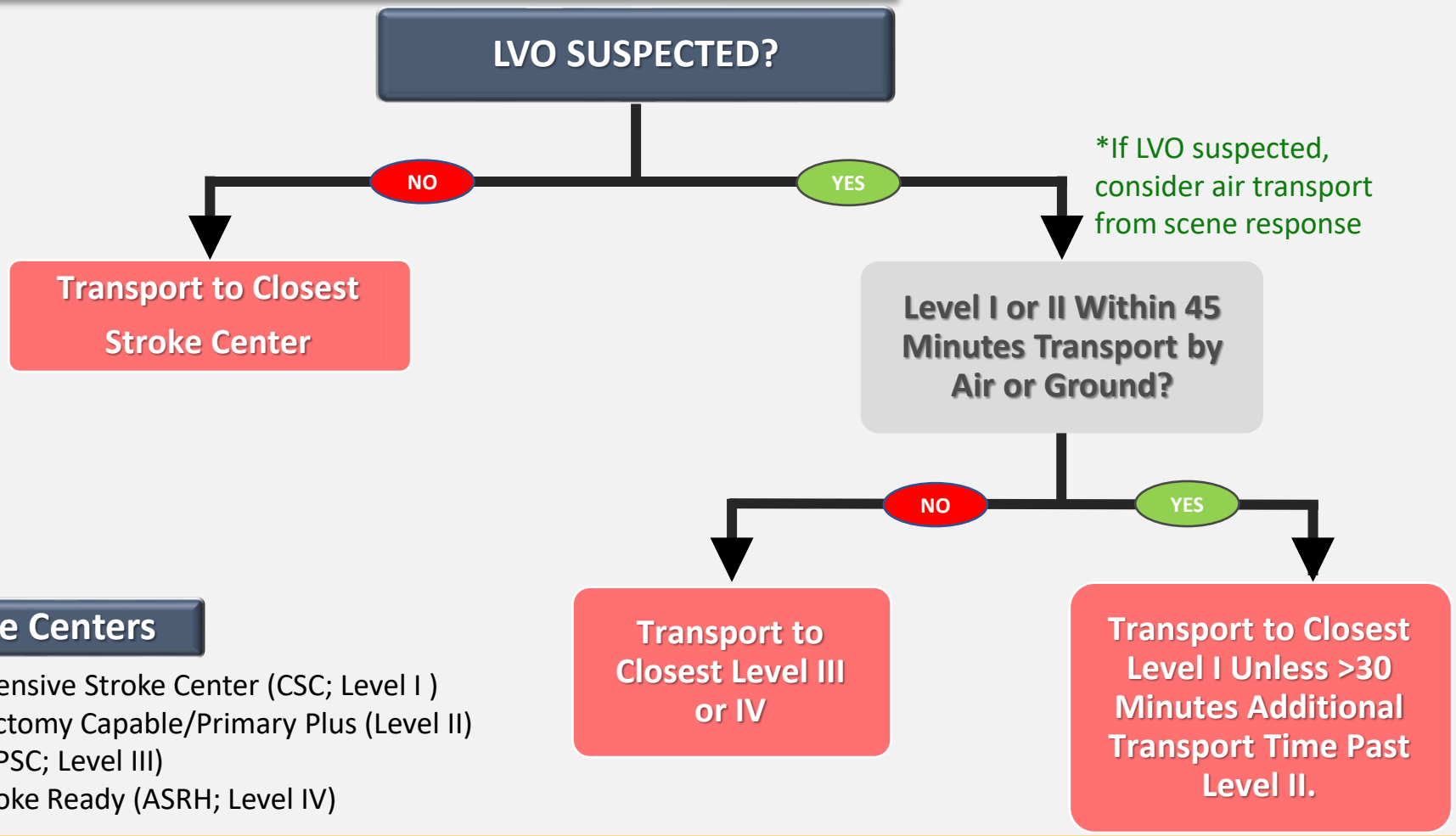
Stroke Urban Transport Recommendation



Stroke Centers

Comprehensive Stroke Center (CSC; Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (PSC; Level III)
Acute Stroke Ready (ASRH; Level IV)

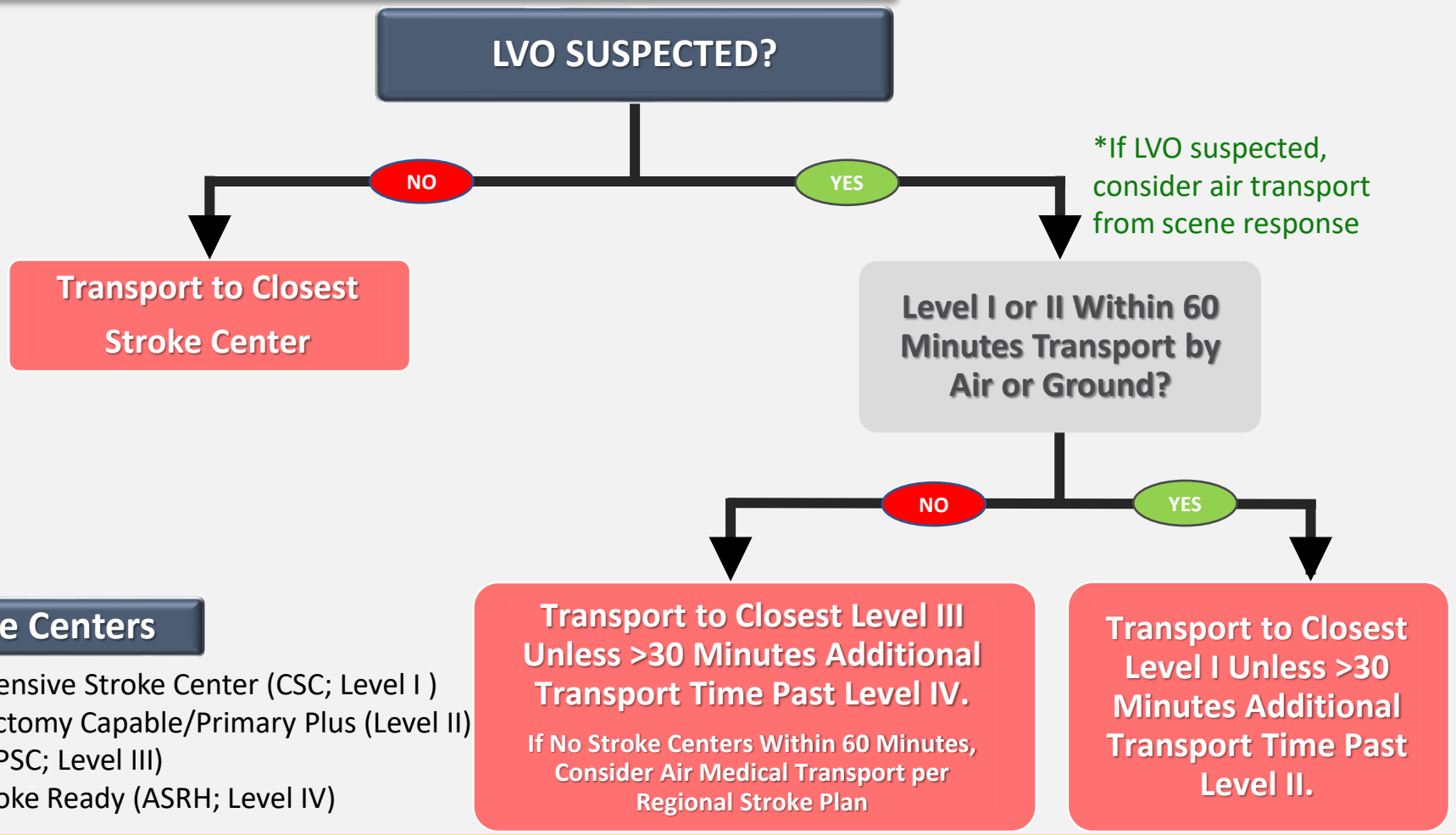
Stroke Suburban Transport Recommendation



Stroke Centers

Comprehensive Stroke Center (CSC; Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (PSC; Level III)
Acute Stroke Ready (ASRH; Level IV)

Stroke Rural Transport Recommendation



Stroke Centers

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EMS Pediatric Stroke Recommendations

PEDIATRIC STROKE SCREEN POSITIVE

Sudden Onset/Wake from Sleep:

- Numbness
- Weakness
- Difficulty speaking or understanding
- Loss of vision/double vision
- Altered mental status
- Loss of balance or coordination
- New onset focal seizure
- Severe headache without cause

Stabilize – ABCDEs Pediatric Guidelines

Airway - Ensure airway patency with suctioning and OPA or NPA, as needed.
Breathing – goal O2 sat > 94% (may be lower in congenital heart disease)
Circulation – Evaluate and treat for shock
Disability – GCS, pupillary size/reactivity, blood glucose
Exposure – evidence of traumatic injury

Pediatric Patient Stable

YES / NO

Transport to Nearest Pediatric Facility

Exam:

- Blood pressure
- Rate
- Rhythm
- Respiratory Rate
- Oxygen Saturation
- Assess for seizures
- Hypoglycemia
- Shock

History to Obtain:

- Last Known Well
- Time of Symptom Discovery
- Seizure at onset
- Head trauma
- Recent surgery
- Possible drug ingestion
- Pre-existing disability
- Device/implant history
- Medical Problems with High Stroke Risk
  - Heart Disease
  - Blood vessel problems in the brain (e.g., aneurysms, moyamoya)
  - Stroke
  - Sickle cell disease
  - Cancer
  - Blood clots

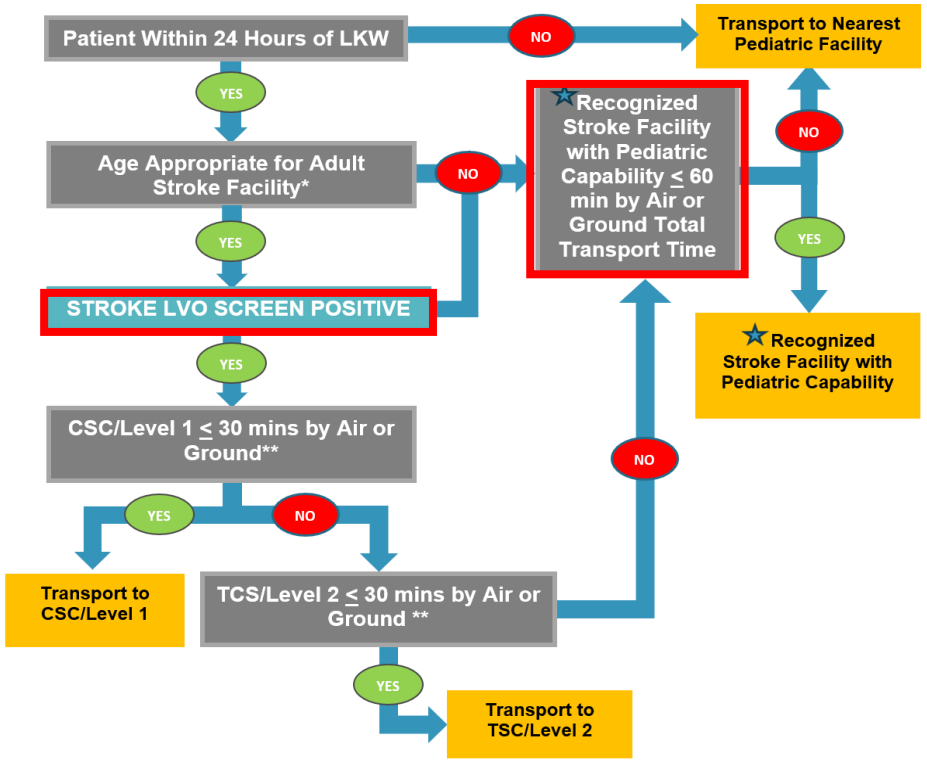
Management:

- Position head of bed to 30 degrees
- Continuous cardiac monitoring
- Place two PIV's if possible
- Avoid Hypotension
- SBP goal >50%-ile for age[1]

SBP Parameters[1]

Female		Male	
Age	50%-ile	Age	50%-ile
1-4 years	90mmHg	1-4 years	90mmHg
5-10 years	96mmHg	5-10 years	96mmHg
11-17 years	105mmHg	11-17 years	110mmHg

EMS Pediatric Stroke Recommendations



*Each Regional Advisory Council (RAC) should outline the patient age appropriate for adult stroke facility admission based on regional facility resources or hospital policies: ** Within ≤ 30 minutes past the nearest Recognized Stroke Facility with Pediatric Capabilities and no more than 60 minutes total transport time by air or ground: CSC; ★A pediatric hospital with recognized capability to care for pediatric patients with stroke. Comprehensive Stroke Center: TSC; Thrombectomy Capable Stroke Center: LVO; large vessel occlusion

Reference

1. Rivkin MJ, Bernard TJ, Dowling MM, Amlie-Lefond C. Guidelines for Urgent Management of Stroke in Children. Pediatr Neurol. 2016 Mar;56:8-17. doi: 10.1016/j.pediatrneurol.2016.01.016. Epub 2016 Jan 21. Erratum in: Pediatr Neurol. 2016 Nov;64:105. PMID: 26969237.

Last Updated 08/21/2024

EMS Pediatric Stroke Triage GuidanceRecommendations

Pediatric Stroke is a rare disease that is, nevertheless, included among the top ten causes of **death** in pediatrics.[11] However, rapid recognition and appropriate treatment of pediatric stroke can profoundly improve outcomes for these children, sparing them from decades of disability.[2,32,3] This guidance document is designed to help EMS providers recognize and triage pediatric stroke patients quickly to facilitate improved outcomes throughout the state.

Goal:
To enhance EMS identification of strokes in the pediatric population (infants and children less than 18 years of age), as well as to increase rapid triage and transport to the nearest appropriate facility.

Purpose:
In consultation with EMS, ER, stroke, pediatric neurology, and pediatric leaders from around the state and current American Heart Association recommendations, we have developed the below EMS guidelines for pediatric patients with a known or suspected stroke.[4,54,5]

General Information on Pediatric Stroke

Pediatric stroke can present with focal neurologic signs, as well as non-specific signs like seizure or altered mental status.[6–106–10]

Sudden onset of any of the following suggests the possibility of acute stroke:

- Numbness or weakness of face, arm and/or leg (especially on one side of the body)
- Confusion
- Trouble speaking or understanding language
- Trouble seeing in one or both eyes or double vision
- Altered Mental Status
- Trouble walking
- Dizziness
- Loss of balance or coordination
- Severe headache with no known cause (suggests hemorrhagic stroke), especially with altered mental status

❖ For patients with any of the above neurological signs, especially with the listed conditions below, consider triaging as an acute stroke.

Patients with any of the following are at higher risk for acute stroke:

- Heart disease
- History of blood vessel problems in the brain
- History of stroke
- Sickle cell disease
- Cancer
- History of blood clots

Common pediatric stroke mimics:

- Alcoholic intoxication
- Cerebral infections
- Drug overdose
- Hypoglycemia
- Hyperglycemia
- Genetic/metabolic disorders
- Atypical migraines
- Neuropathies (e.g. Bell's palsy)
- Seizure
- Post-ictal state
- Tumors

Prehospital Triage of Stroke Patients

Basic Level – in suspected stroke cases, as with all other pediatric patients, assess and treat ABCDEs per universal pediatric recommendations:

- **A (Airway):** Airway support and ventilation assistance are recommended for patients with acute stroke who have decreased consciousness or who have compromised airway. Ensure airway patency with suctioning and OPA or NPA, as needed.
- **B (Breathing):** Supplemental oxygen should be provided to maintain oxygen saturation > 94% (continuous monitoring).
- **NOTE:** some patients with congenital heart disease have a different goal saturation level (80-90% in some cases). Confirm normal level with parents/caretakers if unsure.
- **C (Circulation):** Evaluate and treat signs/symptoms of shock according to the Shock Clinical Practice Guidelines
- **D (Disability)**: Assess and document GCS, pupillary size and reactivity.
- **E (Exposure/Environmental):** Assess for evidence of traumatic injury, especially head injury.

Stabilization and initial management:

- If there is evidence of shock, treat according to the Shock clinical practice guidelines.
- If there is hypoglycemia (POC glucose < 60 mg/dL), treat according to diabetic emergencies clinical practice guidelines.
- If there are seizures, treat according to the seizure clinical practice guidelines.
- Place the patient in a supine position, head of the bed elevated 30 degrees.
- Cardiac monitoring during transport is recommended.

Cardiovascular examination:

- Record blood pressure, rate, rhythm, respiratory rate and oxygen saturation.
- Obtain an EKG if it will not delay transport.

Neurological assessment for pediatric stroke:

- Weakness of face, arm and/or leg (especially on one side of the body)
- Numbness on one side of the face or body
- Confusion
- Trouble speaking or understanding language
- Trouble seeing in one or both eyes or double vision
- Altered Mental Status
- Trouble walking
- Dizziness
- Loss of balance or coordination
- Severe headache with no known cause (suggests hemorrhagic stroke), especially with altered mental status
- Seizure with post-ictal focal deficit (like weakness) that does not resolve quickly (~15 minutes)

❖ **NOTE - There are no validated pre-hospital screening tools for pediatric stroke.**

History:

Interview patient, family members and other witnesses to determine symptoms, time of symptom discovery and last known well (LKW), or last time patient was without symptoms. Ask about seizure at onset, head trauma, history of recent surgeries, history of bleeding problems, and signs of possible brain hemorrhage (severe headache of sudden onset, nausea/vomiting with headache or loss of consciousness). Obtain mobile number of next of kin and witnesses.

❖ **NOTE:** For "wake up strokes" the last known well time is the last time that they were witnessed to be at their baseline, which may be the night before. The time they are found is not the last known well time.

Additional History:

- Obtain past medical history and history of past and recent surgeries.
- Allergies (e.g., iodinated contrast)
- Pre-existing substantial disability (e.g., unable to walk independently)
- Device and implant history (e.g., left ventricular assist device, pacemaker, valve replacement, VP shunt)

Medications:

- Obtain a list of all medications including antiplatelet agents (e.g. aspirin, clopidogrel [Plavix]) and blood thinners (direct thrombin inhibitors, factor Xa inhibitors, low molecular weight heparin [enoxaparin/ Lovenox], unfractionated heparin, warfarin [Coumadin], rivaroxaban [Xarelto], dabigatran [Pradaxa], apixaban [Eliquis], edoxaban [Savaysa]).

- If possible, record when the last dose was taken.

Management:

EMS personnel should address ABCDEs per universal pediatric guidelines. Additional initial management steps include:

1. Prevent aspiration, HOB > 30. Ensure airway patency with suctioning and OPA or NPA as needed.
2. Provide supplemental oxygen if needed to keep oxygen saturation > 94%.
   a. (Adjust if the patient has known congenital heart disease with a different goal oxygen saturation)
3. Avoid hypotension. Maintain systolic blood pressure ≥50%ile for age.

Systolic Blood Pressure Parameters[11]

Female			**Male**		
Age	50%ile	20% above the 95%ile	Age	50%ile	20% above the 95%ile
1-4 years	90mmHg	133mmHg	1-4 years	90mmHg	134mmHg
5-10 years	96mmHg	145mmHg	5-10 years	96mmHg	145mmHg
11-17 years	105mmHg	157mmHg	11-17 years	110mmHg	168mmHg

4. Call online medical control for severe hypertension (persistent systolic BP that is ≥20% above the 95th percentile).
5. Hypoglycemia (blood glucose < 60 mg/dL) should be treated in patients suspected of acute ischemic stroke.
6. To facilitate expedited stroke workup in the ED, place two peripheral IVs so long as it does not delay transport time.

System Triage:

Goal on-scene time is 10-15 minutes or less. Encourage the family to go directly to the ED if not transported with the patient.

Destination Decision-Making for Pediatric Suspected Stroke in Rural, Urban and Suburban Areas

Each Regional Advisory Council (RAC) should outline the patient age appropriate for adult stroke facility admission based on regional facility resources or hospital policies.

1. Pediatric patient suspected of stroke and last known well **≤ 24 hours**; triage based on following criteria:

Age appropriateness for adult stroke facility:

- Pediatric suspected stroke, **age < appropriate:**
  - Transport suspected stroke patients to the nearest **Recognized Stroke Facility with Pediatric Capabilities.**
    - **Recognized Stroke Facility with Pediatric Capabilities** – a pediatric hospital with recognized capability to care for pediatric patients with stroke.
  - If no **Recognized Stroke Facility with Pediatric Capabilities** is within **60-minute** by air or ground **total transport time** or the patient is unstable, transport to the nearest **Pediatric Facility**.
- Pediatric suspected stroke, **age ≥ appropriate:**
  - **Perform Validated Stroke Severity Screening Tool** to access for potential large vessel occlusion (LVO), such as RACE score.[12]
  - **If LVO Screening Tool Positive:**
    - Transport suspected stroke patients to the nearest adult **Comprehensive Stroke Center (CSC/ Level 1)** if within ≤ **30 minutes from** the nearest **Recognized Stroke Facility with Pediatric Capabilities** and no more than **60-minute total transport time** by air or ground**.**
    - If no **CSC is available within 30 minutes**, transport to nearest **thrombectomy capable stroke center (TSC/ Level 2)** if within ≤ **30 minutes** from the nearest **Recognized Stroke Facility with Pediatric Capabilities** and no more than **60-minute total transport time** by air or ground.
    - If neither a CSC nor TSC is available within ≤ **30 minutes**, transport to the nearest **Recognized Stroke Facility with Pediatric Capabilities.**
    - If no **Recognized Stroke Facility with Pediatric Capabilities** is available within ≤ **60 minutes** or the patient is unstable, transport to the nearest **Pediatric Facility.**
  - **If LVO Screening Tool Negative:**
    - Transport suspected stroke patients to the nearest **Recognized Stroke Facility with Pediatric Capabilities.**
    - If no **Recognized Stroke Facility with Pediatric Capabilities** is within **60-minute** by air or ground **total transport time** or the patient is unstable, transport to the nearest **Pediatric Facility**.

2. Pediatric patient suspected of stroke and last known well **> 24 hours**, triage based on following criteria:
   - Pediatric suspected stroke, **for all ages:**
     - Transport suspected stroke patients to the nearest **Recognized Stroke Facility with Pediatric Capabilities.**
     - If no **Recognized Stroke Facility with Pediatric Capabilities** is within **a 60-minute total transport time** or the patient is unstable, transport to the nearest **Pediatric Facility**.

❖ **For all ages,** consider air medical if prolonged transport time > 60 minutes.

❖ **Stroke Prenotification**, alert receiving facility that a suspected pediatric stroke patient is in route prior to arrival. A stroke alert prior to arrival will mobilize appropriate resources before patient arrival.
  - Prenotification should include: Age, last known well, current vital signs, stroke screening tool score (if performed) and symptoms (weakness on one side, altered mental status, etc).

❖ **Hand-off Goal**: 120 seconds for EMS to ED triage nurse hand-off.

(Note – Plan is adapted from 2022 Pediatric Stroke North Central Texas Regional Stroke Plan)

References:

1. National Center for Injury Prevention and Control, CDC. 10 leading causes of death by age group. [Internet]. 2018 [cited 2022 May 10];Available from: https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2015-a

2. Bhatia KD, Briest R, Goetti R, et al. Incidence and Natural History of Pediatric Large Vessel Occlusion Stroke: A Population Study. JAMA Neurol 2022;79(5):488–97.

3. Lauzier DC, Galardi MM, Guilliams KP, et al. Pediatric Thrombectomy. Stroke 2021;52(4):1511–9.

4. Ferriero DM, Fullerton HJ, Bernard TJ, et al. AHA / ASA Scientific Statement Management of Stroke in Neonates and Children. 2019.

5. Jauch EC, Schwamm LH, Panagos PD, et al. Recommendations for Regional Stroke Destination Plans in Rural, Suburban, and Urban Communities From the Prehospital Stroke System of Care Consensus Conference: A Consensus Statement From the American Academy of Neurology, American Heart Association/American Stroke Association, American Society of Neuroradiology, National Association of EMS Physicians, National Association of State EMS Officials, Society of NeuroInterventional Surgery, and Society of Vascular and Interventional Neurology. Stroke 2021;52(5).

6. Elbers J, Wainwright MS, Amlie-Lefond C. The Pediatric Stroke Code: Early Management of the Child with Stroke. J Pediatr 2015;167(1):19-24.e4.

7. Phelps K, Silos C, De La Torre S, et al. Establishing a pediatric acute stroke protocol: experience of a new pediatric stroke program and predictors of acute stroke. Front Neurol 2023;14.

8. Harrar DB, Benedetti GM, Jayakar A, et al. Pediatric Acute Stroke Protocols in the United States and Canada. In: Journal of Pediatrics. Elsevier Inc.; 2022. p. 220-227.e7.

9. Wharton JD, Barry MM, Lee CA, Massey K, Ladner TR, Jordan LC. Pediatric Acute Stroke Protocol Implementation and Utilization Over 7 Years. In: Journal of Pediatrics. Mosby Inc.; 2020. p. 214-220.e1.

Last Updated – 08.21.24

Stroke Committee

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Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• **Approved revisions by Stroke, EMS and Air Medical.** • **Presented to EMS Medical Director, and RAC leadership in past.** • **EMS Medical Directors deferred approval until 08/2024. Did not have time to review.** • **Will seek approval 11/2024 from EMS MD and RAC, then GETAC Council**	
DIDO performance recommendations	• Approved revisions by Stroke, EMS and Air Medical. • Plan to present to EMS MD 08/2024. Did not have time to review. • Will seek approval 11/2024 from EMS MD and RAC, then GETAC Council • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO	
Establish research opportunity in the state of Texas to help advance stroke care in the state	• Working on Texas study evaluating if providing standardized stroke education improves performance. • Dr. Savitz resented on opportunities for IRB approval for statewide study.	

Current
INTERFACILITY STROKE TERMINOLOGY

1

Level 1 Stroke = Patient with an ischemic or hemorrhagic stroke in need of an emergent intervention

2

Level 2 Stroke = Patient with an ischemic or hemorrhagic stroke in need of an urgent transfer for higher level of care but without emergent need of an intervention

3

Level 3 Stroke = Patient with an ischemic or hemorrhagic stroke in need of transfer but without emergent or urgent needs

- **Level 1 and 2 Stroke**- time from ***agency notification*** to transportation ***arrival at the transferring hospital*** ≤ 30 minutes.
  Level 1 Stroke- if ground transportation to transferring facility or transport time to receiving facility > 30 minutes consider air transport.

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New Proposal Breaking Down DIDO

DIDO Median Time Metrics for patients with LVO in need of thrombectomy Goal 90 minutes	
Transferring Facility Door to Notification of receiving facility and ground or air medical transport	**30 minutes or less** **(call as soon as possible)** *Consider early activation if auto-accept with receiving facility is not in place.
Receiving Facility to Notification of acceptance or not	**15 minutes or less**
EMS arrival	**50% at goal 30 minutes by air or ground urban/suburban and 45 minutes rural**
EMS arrival to Door out	**15 minutes or less**

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• Approved revisions by Stroke, EMS and Air Medical. • Presented to EMS Medical Director, and RAC leadership in past. • EMS Medical Directors deferred approval until 08/2024. Did not have time to review. • Will seek approval 11/2024 from EMS MD and RAC, then GETAC Council	
DIDO performance recommendations	• Approved revisions by Stroke, EMS and Air Medical. • Plan to present to EMS MD 08/2024. Did not have time to review. • Will seek approval 11/2024 from EMS MD and RAC, then GETAC Council • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO	
Establish research opportunity in the state of Texas to help advance stroke care in the state	• **Working on Texas study evaluating if providing standardized stroke education improves performance.** • **Dr. Savitz resented on opportunities for IRB approval for statewide study.**	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	• **Approved** • **Joseph assisting with disseminating survey**	
Stroke Committee endorsed stroke education and certification courses	• Ongoing effort identifying stroke educational opportunities for providers.	
Stroke Education Resource for stroke facilities	• Working with DSHS for website access to stroke education • Elizabeth to report back to the Stroke Committee 11/2024	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Ongoing	

Stroke Committee

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Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Stroke Coordinator/Manager Mentorship Survey	• **Stroke Committee Education Work Group developing survey to help pair mentor/mentee** • **Elizabeth and Jorie advising** • **Seek approval GETAC Council 11/2024**	
Rural Stroke Work Group	• Provider QR code for member participation	
BAC Gap Analysis	• SSOC Work Group reviewed BAC guidelines and compared to other options. • Recommendation to use ASA as resource over BAC approved by Stroke Committee	

Stroke Committee

Priority Not Implemented
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Committee Priorities	Current Activities	Status
Stroke Coordinator/Manager Mentorship Survey	• Stroke Committee Education Work Group developing survey to help pair mentor/mentee • Elizabeth and Jorie advising • Seek approval GETAC Council 11/2024	
Rural Stroke Work Group	• **Provider QR code for member participation**	
BAC Gap Analysis	• SSOC Work Group reviewed BAC guidelines and compared to other options. • Recommendation to use ASA as resource over BAC approved by Stroke Committee	

RURAL Stroke Work Group

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Stroke Coordinator/Manager Mentorship Survey	• Stroke Committee Education Work Group developing survey to help pair mentor/mentee • Elizabeth and Jorie advising	
Rural Stroke Work Group	• Provider QR code for member participation	
BAC Gap Analysis	• **SSOC Work Group reviewed BAC guidelines and compared to other options.** • **Recommendation to use ASA as resource over BAC approved by Stroke Committee**	

Vote:

SSOC Meeting Monday August 19th 2024

Objective: The GETAC stroke committee seeks to recommend a different set of stroke standards to the department. The recommendation is to use the AHA/ASA Guidelines.

1. SSOC will serve as the working group to review and discuss the standards to be recommended.
2. Develop a gap analysis of the BAC standards to the current AHA recommendations
   a. Why AHA standards would be best for Texas to follow.
   b. Evidence that the current stroke survey organizations utilize the standards for their certification evaluation.
   c. Are there any conflict of interests or down sides to remaining with the BAC

standards

AHA/ASA standards for their certification evaluation. When considering the various societies that have purview in the field of stroke and cerebrovascular disease, the AHA provides the most comprehensive, current guidelines across the continuum of care for stroke patients. When the BAC publishes a new statement, we could re-evaluate returning to the BAC as our source for standards.

These are a sample of AHA Publications as References

Ideal Foundational Requirements for Stroke Program Development and Growth: A Scientific Statement From the American Heart Association. Stroke
Volume 54, Number 4 https://doi.org/10.1161/STR.0000000000000424

Recommendations for the Establishment of Stroke Systems of Care: A 2019

Gap Analysis

The published Brain Attack Coalition (BAC) guidelines for stroke care are out of date; the BAC have not published updated guidelines. From their website, the BAC have published 1)"Formation and Function of Acute Stroke-Ready Hospitals in 2013; (2)"Revised and Updated Recommendations for the Establishment of Primary Stroke Centers (2011); (3)"Recommendations for Comprehensive Stroke Centers" in 2005.

a new level of care for stroke center certification has also been introduced by several accrediting bodies pertaining to thrombectomy capability. However, the BAC has not published updated standards to incorporate these transformative changes in stroke care. Staying with the outdated BAC publication places Texas more than 10 years behind in standards of care.

What is an alternative neutral party that we could reference as a source?
The proposal is to refer to the American Stroke Association under the American Heart Association as the main source for stroke care guidelines. The AHA has updated its guidelines through multiple publications on the most recent evidence from clinical trials to support best practices in stroke care. Current stroke survey organizations utilize the

GETAC Stroke Committee Item Request for Council August 2024

Robin Novakovic-White, MD

Stroke Committee

Stroke Committee

- Committee items needing council guidance
  1. ASA recommendation to replace BAC

- Stakeholder items needing council guidance
  1. None at this time

- Items referred to GETAC for future action
  1. Near future will seek approval for the adult and pediatric prehospital stroke algorithm, stroke terminology and DIDO performance measures best practice recommendation