1. Committee Purpose and Responsibilities

1.1. The purpose of the Stroke Committee shall be to facilitate the collaboration and advancement of a regional system of stroke care for TSA-E that is based on accepted standards of care. The Stroke Committee will solicit participation from health care facilities, organizations, entities and professional societies involved in health care. NCTTRAC Stroke Committee will encourage regional participation in providing and outlining quality stroke care that is patient-focused, complies with state and national guidelines and seeks to expeditiously triage stroke patients to the most appropriate level of care. The Stroke Committee shall develop a plan for a regional system of stroke care.

1.2. The Stroke Committee is responsible for the development of an acute stroke care system for TSA-E, including the development of guidelines for acute stroke care in Level I, II, and III Stroke Centers as specified in the Regional Stroke Plan. The committee will provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans and treatment guidelines, and the committee SOP. Additionally, the committee will interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC)

1.3. Promotes collaboration and commitment among EMS providers, hospitals and members of the NCTTRAC committees.

1.4. Develops uniform stroke system standards that addresses patients' needs, outcomes and opportunities for improvement.

1.5. Promotes stroke algorithms and protocols that facilitate early triage of stroke patients to the most appropriate level of care.

1.6. Promotes educational opportunities that are focused on increasing public and stakeholders (EMS and facilities) awareness about stroke.

1.7. Establishes system coordination for access, protocols/procedures and inter-hospital transfers. These structures will establish continuity and uniformity of care among the providers of stroke care.

2. Sub-Committees and Work Groups

2.1. *Not Applicable*

3. Committee Chair/Chair Elect Responsibilities

3.1. Chair

3.1.1. The Committee Chair serves as the principal liaison between the committee and the Board of Directors with responsibilities that include, but are not limited, to:

3.1.1.1. Knowledge of the Bylaws.
3.1.1.2. Scheduling meetings.
3.1.1.3. Meeting agenda and notes.
3.1.1.4. Providing committee report to the Board of Directors.
3.1.1.5. Annual review of Stroke System Plans, Guidelines, committee SOP, and SPI indicators.
3.1.1.6. Provide or arrange for knowledge and dissemination of appropriate liaison group activities to committee members and the Board of Directors.

3.1.2. The Chair must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.

3.1.3. The Chair will serve a one-year term of office, beginning at the start of the Fiscal year, and be succeeded by the Chair Elect at the end of the Fiscal Year.

3.2. Chair Elect

3.2.1. The Committee Chair Elect assists the Chair with committee functions and assumes the Chair responsibilities for committee activity and meeting management in the temporary absence of the Chair. The Chair Elect may serve in lieu of the Stroke Committee Chair for Board of Directors responsibilities.

3.2.2. The Chair Elect must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.

3.2.3. The Chair Elect automatically ascends to the Chair position at the end of the current Chair's term or if the Chair position is otherwise vacated.

3.2.4. The Chair Elect position will be voted on by the Stroke Committee annually or when the incumbent has vacated this position.

4. Committee Medical Director

4.1. The elected Stroke Committee Medical Director is responsible for

4.1.1. Participating directly with their service line committee

4.1.2. Establishing and maintaining a standing coordination method with their service line peers

4.1.3. Maintaining availability for coordinating with other committees' Medical Directors to recommend a minimum standard of care for providers participating in the trauma, acute, emergency healthcare and disaster response systems of TSA-E

4.2. The Stroke Committee Medical Director provides current physician insight and involvement in support of the Stroke Committee and its responsibilities, including:

4.2.1. Identifying and assessing regional performance improvement standards, formulating strategies and making recommendations to the committee to ensure that the best possible standards of healthcare can be met within TSA-E.

4.2.2. Active partnership in the coordination and support of the following service line committee products (see appendix A for the Coordination Flow Chart):

4.2.2.1. Service Line Regional Plans

4.2.2.2. Guidelines

4.2.2.3. Texas Department of State Health Services (DSHS) Rules Reviews

4.3. The Stroke Committee Medical Director must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.

4.4. The Stroke Committee Medical Director position will be voted on by the Stroke Committee annually, with each Fiscal Year, or if otherwise vacated.

4.5. The Stroke Committee Medical Director should be prepared, with NCTTRAC staff assistance, to facilitate a peer group of Stroke medical directors (by email or meeting) in support of Stroke Committee efforts, as appropriate.

4.6. The Stroke Committee Medical Director will be seated as a voting representative on the NCTTRAC Medical Directors Committee.

4.7. The Stroke Committee Medical Director represents Stroke care issues at Medical Directors Committee.

4.8. The Stroke Committee Medical Director can facilitate Stroke Medical Directors meeting as a focus group of Medical Directors Committee.

4.9. The Stroke Committee Medical Director may chair stroke work groups.

4.10. The Stroke Committee will call for eligible nominees for Stroke Committee Medical Director, followed by an election process or electronic poll to identify the person that will serve in the position.

5. Committee Representation

5.1. In accordance with NCTTRAC Bylaws Article IX, there is a voting core group identified within the Stroke Committee.
5.2. The Stroke Committee core group shall be comprised of delegated representatives from Stroke Designated hospitals that are NCTTRAC member organizations in good standing.

6. Committee Attendance

6.1. While attendance is highly encouraged in support of meaningful participation, there are no specific attendance requirements for this committee.

7. Committee Active Participation

7.1. *Not Applicable*

8. Procedures (Meeting, Agenda and Notes)

8.1. The Stroke Committee shall perform its responsibilities with an organized approach utilizing the following procedure:
- 8.1.1. The date, time and location of all scheduled meetings will be posted at least ten (10) days in advance on the NCTTRAC website calendar.
- 8.1.2. The committee will meet at least quarterly.
- 8.1.3. All meetings are held as open meetings.
- 8.1.4. Agendas will be provided and be prepared by the Committee Chair.
- 8.1.5. A sign in sheet will be provided at each meeting.
- 8.1.6. Each meeting will have notes.
- 8.1.7. Agendas and meeting notes will be forwarded to NCTTRAC office and administrative staff within 20 days after the meeting for posting. The attendance will be turned in at the end of the meeting.
- 8.1.8. Copies of meeting agendas and notes will be available on the NCTTRAC website.

9. Committee Liaisons

9.1. American Heart/Stroke Association (AHA/ASA)
9.2. North Texas Stroke Coordinators Group
9.3. Governor's EMS and Trauma Advisory Council (GETAC) Stroke Committee
9.4. Texas Department of State Health Services (DSHS)
9.5. Texas EMS Trauma and Acute Care Foundation (TETAF)
9.6. Dallas Fort Worth Hospital Council Foundation (DFWHC)

10. Standing Committee Obligations

10.1. Annual Review of the Stroke Committee SOP
10.2. Annual Review of Regional Stroke Plans & Guidelines
- 10.2.1. Inter-Facility Stroke Transfer Guideline
- 10.2.2. Inter-Facility Transfer EMS Documentation

10.3. DSHS "Essential Criteria", Rules and/or contractual deliverables, as applicable

10.4. GETAC Strategic Plan objectives and strategies, as applicable

11. Projected Committee Goals, Objectives, Strategies, Projects

11.1. Regional Quality Stroke Measures Survey
11.2. Annual Stroke Symposium
11.3. NCTTRAC's "Accountability Scorecard" spreadsheet will be used to document commitments and progress with associated efforts.
11.4. Annual Committee Goals
  11.4.1. Monitor regional quality measures quarterly: median Door-to-Needle within 60 minutes; median Door-In-Door-Out 90 minutes for patients receiving IV Alteplase; median Door-In-Door-Out 60 minutes for patients not receiving IV Alteplase; and median Door-to-Skin Puncture 90 minutes.
  11.4.2. Community Outreach: Participate in and support two stroke awareness public education events within TSA-E.
  11.4.3. Regionally supported research or quality improvement projects, with the goal to improve stroke care within TSA-E.
  11.4.4. Encourage EMS pre-hospital notification to receiving ED of potential stroke patient with critical information to include (but not limited to) last known well, vitals, stroke screening score and large vessel screening tool score.
  11.4.5. Offer one educational opportunity to Stroke Committee per quarter.
  11.4.6. At least 20% of NCTTRAC stroke designated hospitals will participate with stroke registry data submission to the RAC Data Collaborative (RDC).

12. System Performance Improvement (SPI)

12.1. The Stroke Committee will support Stroke SPI responsibility by establishing a standing meeting agenda item and corresponding accountability (e.g. appoint individual facilitator, workgroup or sub-committee).
12.2. At minimum, the Committee will review, evaluate, and report Stroke EMResource utilization and make recommendations to the Executive Committee of the Board of Directors for appropriate designation/accreditation of hospitals related to initial or changes to designation/accreditation as requested/required by the Department of State Health Services (DSHS).
12.3. Closed Stroke SPI meetings support detailed reviews of Performance Improvement (PI) Indicators and referred PI events as afforded by Texas Statute and Rule.
  12.3.1. Representation:
    12.3.1.1. Stroke Committee Chair
    12.3.1.2. Stroke Committee Chair Elect
    12.3.1.3. Stroke Committee Medical Director
    12.3.1.4. Two elected Stroke Committee representatives
  12.3.2. Closed Stroke SPI meeting participants will sign a confidentiality statement prior to the start of each closed meeting.

12.3.3. Meeting notes, attendance rosters, and supporting documents of Closed Stroke SPI meetings must be provided to NCTTRAC staff within 48 hours following each meeting to be secured as a confidential record of committee activities.

12.4. SPI Products
- 12.4.1. Stroke SPI Indicators
- 12.4.2. Stroke SPI Referral Form

12.5. SPI Indicators
- 12.5.1. Regional hospitals accepting stroke patients for higher level of care will accept the transfer within a mean of 15 minutes.
- 12.5.2. Regional hospitals transferring stroke patients to a higher level of care, for the purpose of Endovascular Revascularization Therapy (ERT), an urgent neurosurgical procedure or other urgent treatment, should establish goal Door-In-Door-Out (DIDO) time for patients arriving to the emergency department, as well as Picture-to-Door-Out time for inpatients (recommended times outlined in the Regional Stroke Plan).
- 12.5.3. Regional hospitals transferring stroke patients to a higher level of care will establish well delineated protocols for triage and transportation
- 12.5.4. NCTTRAC stroke designated hospitals will maintain stroke management protocols throughout the continuum of care.
- 12.5.5. NCTTRAC stroke designated hospitals will maintain a stroke performance improvement process to review all aspects of stroke care.
- 12.5.6. NCTTRAC stroke designated hospitals will submit data for the quarterly regional quality measure survey.
- 12.5.7. NCTTRAC stroke designated hospitals will have appropriate stroke specific training and access to specific educational needs. The NCTTRAC Stroke Committee should be considered a resource for training and educational opportunities.
- 12.5.8. EMS transport teams will complete vital sign documentation, blood pressure management, appropriate IV Alteplase documentation and procedures (labelling, drug completion), as well as appropriate neurological assessments and documentation on all drip and ship patients as defined in the Regional Stroke Plan.
- 12.5.9. EMS transport teams will establish last known well when possible, complete vital signs, and apply a stroke screening and severity tool as defined in the Regional Stroke Plan.
- 12.5.10. EMS transport teams that identify a pediatric stroke patient will transfer the patient to the closest pediatric stroke hospital or contact Medical Control for guidance.
- 12.5.11. EMS goal for on-scene time in the field, 10-15 minutes or less.
- 12.5.12. EMS goal for on-scene time at bedside in the ED for inter-hospital transfers, 15-20 minutes or less.
- 12.5.13. When a receiving hospital's feedback letter requests a follow-up on care or timeliness issue, the transferring hospital should respond within thirty days of receiving the letter.

13. Illness Prevention / Public Education

13.1. The Stroke Committee will support Stroke Illness Prevention and Public Education responsibility by establishing a standing meeting agenda item and corresponding accountability (e.g. appoint individual facilitator, workgroup or subcommittee).

13.2. Focus on injury prevention and education of the public health needs.

13.3. Create a broad stakeholder representation working to provide an opportunity to share resources leading to the development, operation, and evaluation of public education and illness prevention efforts within TSA - E.
13.4. Base decisions on current Stroke trends and data, facts and assessment of programs and presented educational opportunities.
13.5. Organize; support and/or coordinate community evidenced based education and illness prevention programs.
13.6. Recommend/support prevention priorities for TSA-E according to the illness, geographic location, cost, and outcome.
13.7. Serve as a resource to identify prevention programs, events and other prevention resources available in TSA-E to members and community members.
13.8. Establish Ad Hoc Task Forces, as necessary, to address specific issues.

14. Professional Development

14.1. The Stroke Committee will support the Stroke Professional Development responsibility for all levels of providers by establishing a standing meeting agenda item and corresponding accountability (e.g. appoint individual facilitator, workgroup or subcommittee).
14.2. At minimum, the Stroke Committee will:
14.2.1. Participate in the development of the Annual NCTTRAC Needs Assessment.
14.2.2. Sponsor at least two classes annually based on needs assessment results.

15. Unobligated Budget Requests

15.1. Recommendations from the Stroke Committee, coordinated through the Finance Committee, seeking approval from the Board of Directors for financial backing and execution authority in support of related initiatives, projects, and/or education efforts within TSA-E.

Appendices follow

Appendix A – Coordination Flowchart