1. Executive Summary of Committee 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 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. The 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 (SSOC).

1.2. The authority and responsibility for regional quality improvement (QI) rests with the Regional Advisory Council (RAC). This will be accomplished in a comprehensive, integrated manner through the work of the EMS Medical Directors Committee as well as the Stroke and EMS Committees.

1.2.1. The NCTTRAC Stroke Committee will organize a multidisciplinary QI Work Group to review and monitor stroke care quality benchmarks, indicators, evidence-based practices, and outcomes within the region. Integrating prehospital records, including National EMS Information System (NEMSIS) data elements, into the stroke registries should enhance the total system performance. It is recognized that continuous QI processes, implemented by each component of a SSOC and the NCTTRAC system, can help improve patient care and outcomes.

1.3. The Stroke Committee is responsible for developing an acute stroke care system for TSA-E, including developing guidelines for acute stroke care at Level I, II, III and IV Stroke Centers as specified in the Regional Stroke Plan (RSP). The committee will guide 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).

1.4. The Stroke Committee shall promote collaboration and commitment among EMS providers, hospitals, and members of the NCTTRAC committees.

1.5. The committee shall develop uniform stroke system standards that address patients' needs, outcomes, and opportunities for improvement.

1.6. The committee shall promote stroke algorithms and protocols that facilitate early triage of stroke patients to the most appropriate level of care.

1.7. The committee shall promote educational opportunities to increase public and stakeholders (EMS and facilities) awareness about stroke.

1.8. The committee shall establish system coordination for access, protocols/procedures, and interfacility transfers. These structures will establish continuity and uniformity of care among stroke care providers.

2. Sub-Committees and Work Groups

2.1. Stroke System of Care Workgroup
2.2. Stroke Triage and Transport Workgroup
2.3. Stroke Research Workgroup
2.4. Stroke Education Workgroup
2.5. Stroke Quality Workgroup

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 at least quarterly.

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.

3.1.1.7. Attend Board of Directors meetings in accordance with the Bylaws.

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.

3.1.4. In the event the Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair. The term of the new Chair shall be the remainder of the unfulfilled term of the previous Chair.

3.1.5. The Chair may only vote in the event of a tie; however, the Chair's organization may assign an appropriately documented voting delegate to fill their committee core group position during the Chair's term

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 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.

3.2.5. The Chair Elect is encouraged to attend Board of Directors meetings in accordance with the Bylaws.

3.2.6. In the event the Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair in accordance with the NCTTRAC Bylaws.

4. Committee Medical Director/Co-Director

4.1. The Committee Medical Director / Co-Director is responsible for participating directly with their service line committee, establishing and maintaining a standing coordination method with their service line peers and availability for coordinating with other committees' Medical Directors / Co-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 Committee Medical Director / Co-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:
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 Committee Medical Director / Co-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 Committee Medical Director / Co-Director position will be voted on by the Stroke Committee Biennially, with each Fiscal Year, or if otherwise vacated.
4.5. The Stroke Committee Co-Medical Directors will be required to collaborate to meet 50% of attendance for committee meetings and/or workgroup meetings.
4.6. The Committee Medical Director / Co-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.
4.7. The Stroke Committee Co-Medical Directors shall represent stroke care issues at the EMS Medical Directors' Committee. Likewise, the Stroke Committee Co-Medical Directors shall facilitate Stroke Medical Directors' meetings as a focus group, as appropriate.
4.8. The Stroke Committee Co-Medical Directors may serve as chair of stroke work groups.
4.9. Committees with Medical Directors may consider establishing an Alternate or Co-Medical Director position, who meets the same criteria above, to assist as desired.

5. Committee Representation

5.1. In accordance with the NCTTRAC Bylaws Article IX, no voting core group is identified within the Stroke Committee. The absence of an identified core group opens voting rights at the committee level to all NCTTRAC Members in good standing.
5.2. Virtual attendees are highly encouraged to utilize video capabilities where available to facilitate meaningful discussion and participation in NCTTRAC meetings and events.

6. Quorum & Voting

6.1. Standing Committees/Subcommittees voting may be conducted by the following methods:
6.1.1. In person or virtually during the meeting.
6.1.2. Electronically (e.g., email, fax, website) for unscheduled votes between meetings.
6.1.3. The outcome of each action item will be recorded in the meeting minutes or notes.

6.2. As an alternative to a consensus vote at a Stroke Committee Meeting, electronic votes may be employed. A record of responses and results must be maintained in the Meeting Notes or Minutes.
6.2.1. Electronic Votes may be called via:
6.2.1.1. Polls
6.2.1.2. Surveys
6.2.1.3. Ballots
6.2.1.4. Other technologies

6.3. The Stroke Committee Group (Chair, Chair Elect, and Co-Medical Directors) may convene on an ad hoc basis to represent the committee in matters necessary to maintain contractual compliance, execute deliverables, develop regional SPI indicators, review Committee-

relevant data products, and/or endorse emergency, off-cycle purchases for regional benefit. The actions taken will be reported at the next scheduled committee meeting.

6.4. The Chair shall manage voting issues in accordance with existing NCTTRAC Bylaws and procedures. While the Chair will generally facilitate routine activity by consensus, non-routine or electronic voting activity will normally be facilitated and documented by supporting staff.

6.5. The Chair may only vote in the event of a tie; however, the Chair's organization may assign an appropriately documented voting delegate to fill their committee core group position during the Chair's term.

7. Committee Active Participation

7.1. The Stroke Committee identifies the following to be creditable for active participation at the committee level:

7.1.1. Attendance is a prerequisite to meaningful participation and as such, the Stroke Committee requires documented attendance of 75% of committee meetings by the primary or identified alternate organization/agency representative. Virtual attendees are highly encouraged to utilize video capabilities where available to facilitate meaningful discussion and participation in NCTTRAC meetings and events.

7.1.2. NCTTRAC regional facilities participating in the SSOC must have a separate performance improvement system for stroke patients. Continuous QI processes implemented by the stroke system as a whole will provide a means of improving patient care and outcome.

7.1.3. Each Stroke facility shall demonstrate a written stroke QAPI plan as outlined by the Texas Administrative Code, Rule §157.133 Requirements for Stroke Facility Designation (Texas Administrative Code (state.tx.us)). Additionally, stroke facilities shall actively participate in the RAC Stroke Committee and transport plan; and submit data to the DSHS department as requested.

7.1.4. The NCTTRAC Stroke Committee strongly encourages standardized data collection and reporting from healthcare entities and data sharing between them consistent with the exceptions to privacy laws governing routine healthcare operations and QI.

7.1.5. Stroke facility participation in the RAC Data Collaborative is strongly recommended to promote consistent adherence to current regional treatment guidelines, allow continuous QI, and improve patient outcomes.

7.1.6. NCTTRAC may set minimum standards for what is considered active participation for the purposes of a Letter of Participation:

7.1.6.1. **Silver Star Stroke Facility** status is awarded to stroke facilities sharing Lite performance measures monthly with the RAC Data Collaborative, as part of the NCTTRAC quality initiative to improve regional stroke care in the NCTTRAC SSOC.

7.1.6.2. **Gold Star Stroke Facility** status is awarded to stroke facilities sharing Full performance measures monthly with the RAC Data Collaborative, as part of the NCTTRAC quality initiative to improve regional stroke care in the NCTTRAC SSOC.

7.1.6.3. **Gold Star Stroke Facility Plus** status is awarded to stroke facilities providing Full, transparent performance measures monthly with the RAC Data Collaborative, as part of the NCTTRAC quality initiative to improve regional stroke care in the NCTTRAC SSOC.

7.1.6.4. These systems should include elements from the provision of stroke care

from stroke detection and 911 activation through hospital discharge. Outcomes should be used to assess the effectiveness of the care systems.

8. Committee Liaisons

8.1. American Heart/Stroke Association (AHA/ASA)
8.2. North Texas Stroke Coordinators Group
8.3. Governor's EMS and Trauma Advisory Council (GETAC) Stroke Committee
8.4. Texas Department of State Health Services (DSHS)
8.5. Texas EMS Trauma and Acute Care Foundation (TETAF)
8.6. Dallas Fort Worth Hospital Council Foundation (DFWHC)

9. Standing Committee Obligations

9.1. Annual review of all documents and/or products identified in *Appendix A: Stroke Committee Annual Review Product List*
9.2. DSHS Rules (e.g. Essential Criteria) and/or contractual deliverables
9.3. GETAC Strategic Plan objectives and strategies, as applicable
9.4. Annual review of Program Guidance and Regional Initiatives

10. Projected Committee Goals, Objectives, Strategies, Projects

10.1. Quarterly quality reviews using third party outsource data systems
10.2. Biennial Stroke Symposium
10.3. NCTTRAC's "Accountability Scorecard" spreadsheet will be used to document commitments and progress with associated efforts.
  10.3.1. Annual Committee Goals: Documentation of EMS Prenotification
  10.3.2. Use of Prehospital Stroke Screening and Stroke Severity Tools
  10.3.3. Door-to-Needle – 75% within 45 minutes and 50% within 30 minutes
  10.3.4. DIDO – 50% < 90 minutes
  10.3.5. Door-to-Device - 50% within 60 minutes for transfers and 90 minutes for direct arriving patients
10.4. Community Outreach: Participate in and support one stroke awareness public education event within TSA-E.
10.5. Regionally supported research or quality improvement projects, with the goal to improve stroke care within TSA-E.
10.6. Encourage EMS pre-hospital notification to receiving ED of potential stroke patients with critical information to include (but not limited to) last known well, vitals, stroke screening score and large vessel screening tool score.
10.7. Offer one educational opportunity to Stroke Committee per quarter.
10.8. At least 10% of NCTTRAC stroke designated hospitals will participate with stroke registry data submission to the RAC Data Collaborative (RDC).

11. System Performance Improvement (SPI)

11.1. Regional EMS Trauma Systems requires "a performance improvement program that evaluates processes and outcomes from a system perspective." The direction for the development of an NCTTRAC Regional QI program is derived from the Texas EMS Rules: 25 TAC: Rule §157.123 (b)(2)(B)(XIV). Additional support and direction for regional performance improvement program development specific to stroke facility designation can be found in 25 TAC: Rule §157.133 (d), Requirements for Stroke Facility Designation.

11.2. The Stroke Committee, Stroke Committee System Performance Improvement (SPI) subgroup (within the Stroke Committee) and the EMS Medical Directors Committee serve as the oversight committee for regional performance improvement.

11.3. The Stroke Committee SPI subgroup, in consultation with the Stroke Committee, will determine the type of data and manner of collection, set the agenda for the PI process within the regularly scheduled meetings of the committee, and identify the events and indicators to be evaluated and monitored. Indicator identification will be based on high risk, high volume, and problem prone parameters. Indicators will be objective, measurable markers that reflect stroke resources, procedural/patient care techniques and/or systems/process outcomes.

11.4. The functions and effectiveness of NCTTRAC QI process will be evaluated on an annual basis in conjunction with the annual evaluation of the NCTTRAC Bylaws.

11.5. All PI activities and committee proceedings are strictly confidential. Individuals involved in performance management activities will not be asked to review cases involving their facility or affiliated healthcare system.

11.6. Prior to submitting an SPI event, the referring/requesting agency is expected to first contact the involved agencies/facilities in an attempt to satisfactorily resolve the issue or concern. Only after appropriate attempts have been made to satisfactorily resolve an SPI event should the referring/requesting agency formally submit an SPI event notification/request via the NCTTRAC secured ticket system.

11.7. Closed Stroke SPI functions support detailed reviews of Performance Improvement (PI) Indicators and referred PI events as afforded by Texas Statute and Rule.

11.7.1. Representation:

11.7.1.1. Stroke Committee Chair

11.7.1.2. Stroke Committee Chair Elect

11.7.1.3. Stroke Committee Medical Director

11.7.1.4. Two (2) elected Stroke Committee representatives

11.8. Closed Stroke SPI function participants will sign a confidentiality statement prior to the start of each closed meeting.

11.9. 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.

11.10. Occurrences will be evaluated from a system outcomes perspective and sentinel events will be evaluated on a case-by-case basis. Sentinel events will be used to focus attention on specific situations/occurrences of major significance to patient care outcomes and be reviewed by the Stroke Committee SPI subgroup.

11.10.1. Activities and educational offerings will be presented to address knowledge deficits and case presentations, or other appropriate mediums will be designed to address systems and behavioral problems. All actions will focus on the opportunity to improve patient care and systems operation. The results from committee activities will be summarized and communicated to the RAC membership. Problems identified that require further action will be shared with the persons and entities involved for follow-up and loop closure. Committee follow-up and outcome reports will be communicated on a standard format.

11.11. 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).

11.12. At minimum, the Committee will review, evaluate, and report Stroke EMResource utilization.

11.13. The Stroke Committee will 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).

11.13.1. SPI Products

11.13.1.1. Stroke SPI Indicators

11.13.1.2. Stroke SPI Referral Form

11.14. SPI Indicators

11.14.1. Regional hospitals accepting stroke patients for higher level of care will accept the transfer within a mean of 15 minutes.

11.14.2. Stroke Centers will provide individual follow-up on acute stroke transports directly to the EMS agency transporting the patient.

11.14.3. Regional hospitals transferring stroke patients to a higher level of care, for the purpose of Endovascular Revascularization Therapy (EVT), 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 RSP).

11.14.4. Regional hospitals transferring stroke patients to a higher level of care will establish well delineated protocols for triage and transportation.

11.14.5. NCTTRAC stroke designated hospitals will maintain stroke management protocols throughout the continuum of care.

11.14.6. NCTTRAC stroke designated hospitals will maintain a stroke performance improvement process to review all aspects of stroke care.

11.14.7. 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.

11.14.8. EMS transport teams will complete vital sign documentation, blood pressure management, appropriate IV Thrombolytics 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.

11.14.9. 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.

11.14.10. EMS transport teams will notify receiving hospitals of a possible stroke patient as soon as possible and prior to arrival. EMS transport teams that identify a pediatric stroke patient (<18 years old) will transfer the patient to the nearest Pediatric Stroke Center: Children's Health or Cook Children's Medical Center or contact Medical Control for guidance.

11.14.10.1. EMS goal for on-scene time in the field, 10-15 minutes or less.

11.14.10.2. EMS goal for on-scene time at bedside in the ED for inter-hospital transfers, 15-20 minutes or less.

11.14.11. 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.

12. Data Initiatives

12.1. The Stroke Committee will identify data submission requirements/goals/projects and include the following:

12.1.1. The committee currently identifies the following projects as the main data initiatives:

12.1.1.1. Door-to-needle time for patients with acute stroke

12.1.1.2. Percent of EMS patients with primary impression of "stroke" who have a documents stroke screening scale

12.2. Performance Indicators – As stated above

12.3. Registry Information and enrollment process is outlined in Appendix B: *Regional Stroke Registry Program Overview*

13. Injury and Illness Prevention / Public Education

13.1. The Stroke Committee will support Stroke Injury/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 Annual NCTTRAC Self-Assessment.

14.2.2. Sponsor educational events based on potential committee requests within annual budgetary limits.

14.2.3. Biennial Stroke Symposium

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.

Appendix A: Stroke Committee Annual Review Product List

Additional Appendices follow (as appropriate)

1. Purpose

1.1. The Stroke Committee Annual Review Product List serves as the list of all documents, guidelines, flowcharts, processes, or other products that the Stroke Committee will review each fiscal year.

1.2. Each product identified in Section 2 will be distributed to the Committee via email upon its approval and can be found on the Stroke Committee webpage on the NCTTRAC Website.

2. List of Products

2.1. Stroke Committee Standard Operating Procedures (SOP)
2.2. Regional Stroke System Plan & Guidelines
2.3. Interfacility Stroke Transfer Guideline
2.4. Interfacility Stroke Transfer EMS Documentation