

9:30-9:45 am	Partner Pairings (ice breaker interactive socialization)	Gayle Walker-Cillo
9:45-10:00 am	<p>International Stroke Conference Update</p> <ul style="list-style-type: none"> ● Zodiac <ul style="list-style-type: none"> ○ Ischemic stroke thrombectomy patients have less early neurologic deterioration prior to clot extraction with head down versus elevated head positioning. ○ Hyperacute LVO recommendation to keep head of bed flat versus elevating HOB at 30 degrees, until the patient is taken for intervention, showed improved mRS scores at 90 days. ○ “Putting the head down at zero degrees increases the cerebral blood flow by 20%,” Dr. Alexandrov continued. “The longer these patients sit up at 30 degrees with a large vessel occlusion, the worse stroke symptoms get before thrombectomy. Maintaining the head at zero degrees until thrombectomy stabilizes blood flow and minimizes neurologic deterioration compared to 30 degrees.” ○ (ZODIAC), the largest randomized trial exploration of head positioning in acute ischemic stroke thrombectomy candidates to date. Researchers randomized 92 patients across 12 U.S. hospitals newly diagnosed with large vessel occlusion to zero-degree head positioning or the usual 30-degree head elevation until initiation of thrombectomy. ○ RESULTS:In participants with hyperacute large vessel occlusion (LVO) ischemic stroke awaiting thrombectomy, 0-degree head of bed (HOB) positioning resulted in better neurological outcomes compared to participants with 30-degree HOB positioning ● Resilient Extend <ul style="list-style-type: none"> ○ RESILIENT-Extend showed thrombectomy benefit without advanced imaging versus best medical management. ○ Mechanical thrombectomy (MT) is more effective than medical therapy alone to treat ischemic stroke due to large vessel occlusion in limited resource settings with little or no access to MRI. Based on CT and/or CT angiography imaging to confirm large vessel occlusion, MT performed up to 24 hours after last known well has an adjusted odds ratio of 2.56 (95% CI 1.24-5.29, p=0,012) for functional independence at 90 days compared to best medical therapy. ○ “The lack of advanced imaging capabilities should not be a reason not to perform MT,” said Raul G. Nogueira, MD, FAHA, FSVIN, director of the University of Pittsburgh Medical Center Stroke Institute, endowed professor and chief of cerebrovascular medicine, and professor of neurology and neurosurgery, University of Pittsburgh School of Medicine. ○ RESULTS:Patients who underwent mechanical thrombectomy(MT) within 8-24 h from the time last seen well and were selected solely based on a non-contrast tomography angiography/CT angiography, showed significantly higher rates of good (modified Rankin Score 0-2) and excellent (mRS0-1) outcomes at 90 days, suggesting that expanding availability of MT worldwide could benefit more patients. https://isc.hub.heart.org/isc-24/article/22886343/zodiac-resilientextend-and-most-latebreaking-science-presented 	Kim Hollender

<p>10:00-10:30 am</p>	<ul style="list-style-type: none"> • *Several trial presented on SDH hematomas ultimately showed that embolization of MMA was beneficialBenefit of utilizing the FeSS Protocols for stroke (Fever, Sugar, Swallow) on the first 24 hours. <p>Nursing Conference Highlights:</p> <ul style="list-style-type: none"> • Use of the FESS Protocol: <ul style="list-style-type: none"> o Fever: Temp q6 hrs , treated for >37.5 o Sugar: BS q6 hrs , insulin for >180 o SwallowUtilization of escape rooms for nursing education • Value of care plans: should be a patient center. Best practice is to have a nurse navigator. Nurse navigators can help put the patient’s plan of care together to ensure BP management, providing 7 day f/u phone call to ensure the patient is following the plan. (Korum) • Maternity stroke response teams • Transitions of care vendors: their service offers to complete the follow up phone calls for stroke patients • RAPIDO adopted by AHA for spanish speaking patients <p>Report and updates NJ Stroke Care Advisory Panel (SCAP) Update NJ Department of Health Update</p> <ul style="list-style-type: none"> • It was decided that all stroke centers will submit to the state 100% of primary stroke diagnosis inpatient/obs patients. NO TIA. • Deborah is unable to join us today, but she did send an email to Florence and Gayle. • DOH aggregate STK data initial due date was May 15, 2024, has been extended to May 31,2024. • There are currently 67 Stroke centers in New Jersey, of which 62 are nationally recognized and certified by the Joint Commission or DNV. NJ's goal is to have 100%. • If your stroke certification changes, it is your responsibility to notify the state by submitting a CN-74 form Debra instructs everyone requiring assistance with this form to reach out to so she said that if anybody's having issues reach out to Scott Owens from the DOH <p>https://www.nj.gov/health/healthcarequality/documents/Designated_Stroke_Centers_2024.pdf</p> <p>https://www.nj.gov/health/healthcarequality/health-care-professionals/cardiac-stroke-services/stroke-services/index.shtml</p> <p>EMS Updates:</p> <ul style="list-style-type: none"> • Kirsten reports Dr Halperin states NJ EMS education is lacking in stroke care. Trying to incorporate onboarding and continuing education. • Kirsten is collecting data to identify the current practices of the EMS providers; which assessment tools are they currently using and are they transporting the patients to the appropriate stroke center. 	<p>Florence Chukwuneke, Gayle Walker-Cillo</p> <p>Posselt, Kirsten</p>
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10:30-11:00
am

AHA updates

2024 Award recognition data deadline closed on March 31, 2024

- Any data edited/entered after that date will not be taken into consideration for 2024 awards
- Official 2024 awards will be released Summer 2024



GWTG-Stroke to CMIP

- Sites can now elect GWTG-Stroke as a method for submitting TJC Quality Measures to TJC CMIP Tool
 - Available at no additional cost!
- Must enroll in associated layers before enrolling in submissions:

Level of TJC Submission	Required Layer
ASRH Measures	ASR Layer
PSC Measures	STK Layer
PSC with MT Measures	TSC Layer Or STK Layer with CSTK Layer
TSC Measures	TSC Layer Or STK Layer with CSTK Layer
CSC Measures	CSTK Layer

GWTG-Stroke to CMIP – Process

- Submit Permissions Form
 - Will need to have GWTG-Stroke contract on UPA
 - If your current contract is on the PHA, you will need to move to UPA
 - Contact Casey if you aren't sure

Complete GWTG-Stroke Questionnaire

- Sites will need to update their stroke questionnaire within the form management section of GWTG-Stroke tool.
- The questionnaire can be updated at any time to change submission selections

GWTG-Stroke to CMIP – Important Deadlines & FAQ

Q: Will GWTG-Stroke automatically submit any updates we make to the data after the 15th of the month?

A: Sites will have 15 days between the GWTG-Stroke to TJC CMIP Submission date and the actual TJC Submission deadline to make any manual updates to CMIP data

Eileen Gornell on
behalf of Casey Chu

Quarter	Deadline for Permission Form and Questionnaire Completion / Updates	Submission Date from GWTG-Stroke to TJC CMIP Tool	TJC Measure Submission Deadline
Q1	June 1 st	June 15 th	June 30 th
Q2	September 1 st	September 15 th	September 30 th
Q3	December 1 st	December 15 th	December 30 th
Q4	March 1 st	March 15 th	March 30 th



Upcoming Learning Opportunities

Get With The Guidelines®-Stroke Quality Forum
 Tuesday, May 28, 2024 | 12pm – 1pm ET

Join us for our quarterly Get With The Guidelines-Stroke Office Hours. We will be sharing tips, tricks, and updates. Even if you are unable to attend, we recommend registering as a recording will be sent to all registrants.

[Click To Register](#)

Certification Review Visits

Alyson Byrn Momouth Medical Center

- Surveyor: Bush
- RFI related to patient education not being personalized to the patient’s risk factors.
- Action plan is to streamline risk factor education in EPIC
- The surveyor was complementary to the community outreach and support group referral program they offer.

Amanda Community Hospital

- Surveyor: Melissa Richardson
- Surveyor was very collaborative and requested for them to bring forward their goal from the survey. What do they need to do to make the program better?
- RFI provider driven, related to not utilizing stroke order sets and copy paste on progress note. Bylaws for providers, CMO needs to address.

11:00-11:45
am

All consortium
members

- “time is brain,” it is paramount that appropriate transfer patients receive stroke intervention upon arrival as quickly as possible.
- AHA/ASA) and Get with the Guidelines recommendations, target time from patient arrival to revascularization (Door to First Pass) is established in less than 60 minutes.
- In 2021, the RWJUH Comprehensive Stroke Center initiated new guidelines to establish which patients could bypass repeated and unnecessary diagnostic imaging in order to improve these times.
 - This initiative would also decrease unnecessary diagnostic imaging in order to improve DTD times.
 - Decrease radiation exposure for patients
 - Decrease cost

Objective:

To increase the percent of transferred stroke patients who receive vessel revascularization from time of arrival (Door to First Pass) in less than 60 minutes to greater than 60%, in a two-year period (2021-2022), by eliminating unnecessary repeat diagnostic imaging without compromising patient safety

Methodology:

CT-BYPASS ELIGIBILITY CRITERIA CHECKLIST:

- ✓ Patient arrival within 6 hours of last known normal (LKN)
- ✓ Patient arrival within 3 hours of last cat-scan (CT) with Alberta Stroke Program Early CT Score (ASPECTS) > 6
- ✓ No significant change in National Institute of Health Stroke Scale (NIHSS) defined as greater than 2 points change

Results:

- In 2020, only 53% of transferred patients achieved Door to First Pass in less than 60 minutes.
- After initiating this new bypass strategy in 2021, percent of patients meeting a goal of less than 60 minutes improved to 60%, and in 2022, 72% hit the target.
- Furthermore, the volume of transfer patients has continued to grow during this period, from 57 patients in 2020 to 78 patients in 2022.
- Rates of symptomatic hemorrhage were also monitored during this time, and no significant increase was identified (2.3%, 2020; 3.5%, 2021; 2.1%, 2022). No clinical adverse events were reported during this period.

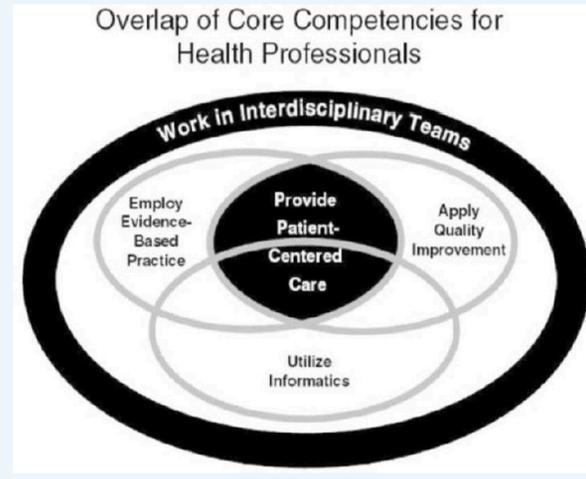
1:15-1:45pm

Professional Competency

Quality Chasm Report

Core Competencies

- Patient centered care
- Interdisciplinary teams
- Evidence based practice
- Quality Improvement
- Informatics



Health Care Professionals Core Competencies:

- Provide Patient-centered care
- Employ evidence-based practice
- Work in interdisciplinary teams
- Apply quality improvement
- Utilize informatics

Domains within Core Competencies

Clinical/Technical	Critical Thinking	Interpersonal
• Cognitive skills	• Problem solving	• Communication
• Knowledge	• Time management	• Customer service
• Psychomotor skills	• Priority setting/Planning	• Conflict management
• Technical understanding	• Ethical implications	• Collaboration

Pat Hogan

Competency Models

- Traditional competency model:
 - Competencies determined by leadership
 - Verification checklist or post test
 - Process focused approach

Competency Models

Wright's Competency Model

Competencies determined through collaboration between staff and leadership

Competency verification usually performed by a variety of methods

- Guided, reflective practice approaches
- Outcome measurements of daily work
- Verification methods that can develop critical thinking skills

Outcome-Focused/ Accountability Approach

Pillars Of Wright's Competency Model

1. Select Relevant Competencies
2. Determine Appropriate Verification Methods
3. Clarify Roles and Accountability
4. Foster Engagement and Commitment through Employee-Centered Verification

Competency Assessment Verification Methods

❖ 3 Primary competency assessment/verification methods:

1. Self-assessments, in which the employee evaluates their own level of competency
2. Manager/Mentor assessments, in which the manager/mentor evaluates the employee's competency
3. 360-degree assessments, in which the employee is evaluated by managers, peers, and other inter disciplinary team members

Competency Verification Methods

- Standardized test
- Return demonstration
- Evidence of daily work

- Case studies
- Exemplars
- Peer review/ feedback
- Self assessment
- Discussion/ reflection groups
- Presentations
- Mock surveys/events
- Chart audits/ quality monitoring

Adult Learning Theory:

- Adults are internally motivated and self directed
- Adults bring life experiences and knowledge to learning experiences
- Adults are goal oriented
- Adults are relevancy oriented
- Adults are practical
- Adults need to be respected



Networking Opportunities

Annual Conferences

Specialty Certification

Specialty Organization Membership



Jefferson Health | University City Campus | 1015 Locust St. | Philadelphia, PA 19104

“RACE” to the Comprehensive Stroke Center (CSC)

1:45-2:30 pm

- Utilization of ELVO tools such RACE to identify potential Large Vessel Occlusion and determine need to direct bypass to a CSC
- Pre-registering by EMS while in transit to CSC expedites patient care and shaves off minutes
- Data tracked/collected:
 - Outcomes, mRS tracking post thrombolytic and thrombectomy/MER

Michael Ramage

<p>2:30-2:45 pm</p> <p>2:45-3:00 pm</p>	<ul style="list-style-type: none"> o Diagnosis to BP control goal 30 min o Evaluation of Neurointensivist while patient is in the ED o Diagnosis to ICU admission goal 90 minutes <p>Opentable</p> <ul style="list-style-type: none"> • The 2024 education standard does not include a specific hour requirement. It needs to be defined by your program • Must be able to report your internal goal times • Ensure providers/tele vascular neurologists have read to treat privileges. • ED providers are covered to order thrombolytics based on their training and competency. • Ensure documentation of justifiable delays for initiation of MER to appropriately exclude cases from the DTP measure. • Establish your internal time as to when the neurosurgeon's 30 minute clock starts. Most sites using Code thrombectomy activation to NSX arrival in EV/OR suite <p>Closing</p> <ul style="list-style-type: none"> • If anyone is interested in presenting to the group, please email Eileen or any of the board members with the fact that you would like to present and what topic. • Next meeting will be in person September 26 at the Hampton Inn in Cranbury, NJ, 9-3pm • Reminder <p>Discussion Board: For the discussion board know that there is an app available, QR code below. If you have not yet registered, please email Joan for an invite.</p> <div style="text-align: center;"> <p>QR Code for GitHub website:</p>  <p>Download GitHub on your smart phone through its app:</p>  </div> <ul style="list-style-type: none"> • Questions or comments please contact Joan at jlegasp@valleyhealth.com 	<p>All consortium members</p> <p>Eileen Gornell</p>
<p>3 pm</p>	<p>Meeting Ended</p>	<p>Eileen Gornell</p>