



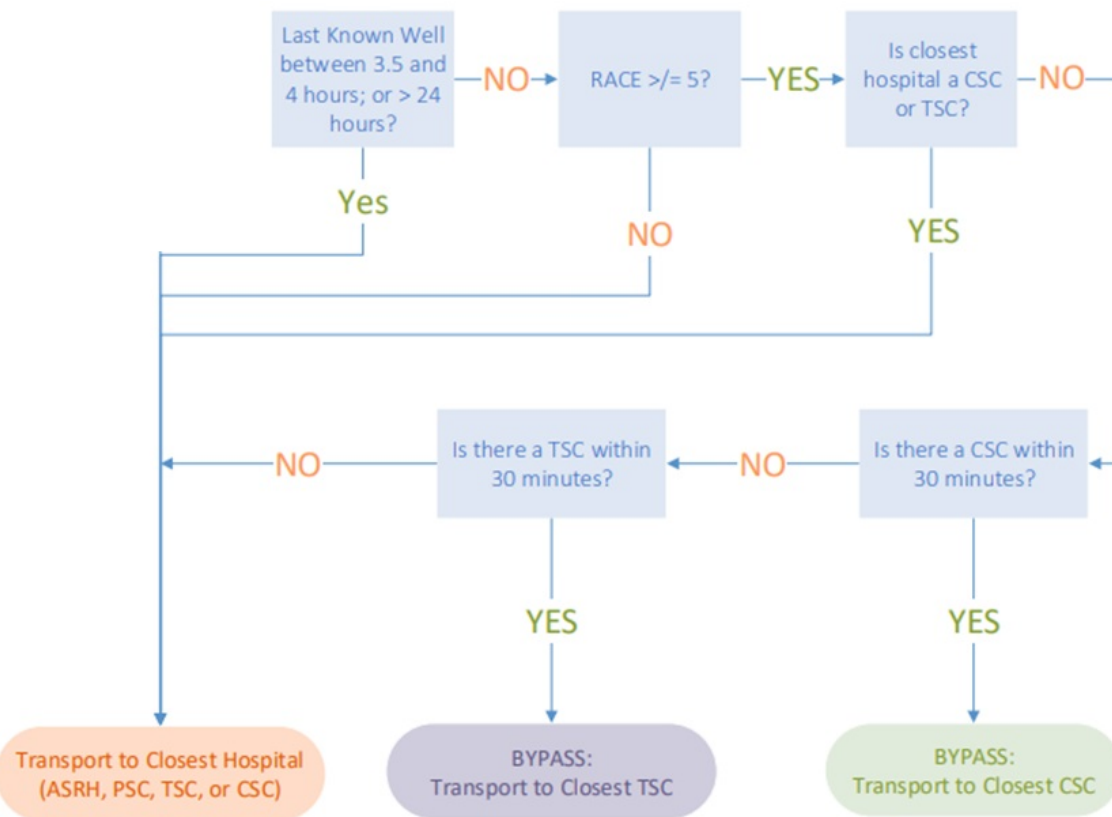
New Jersey Stroke Coordinator's Consortium 11/21/2024 Meeting Minutes

Date of conference/ Meeting:	11/21/2024	President:	Eileen Gornell
Location:	Hampton Inn Cranbury /In person meeting	Recorder:	Connie Mastrangelo
Time:	9:00 am-3:00 pm	Attending:	See attendance list November 21, 2024

9:00- 9:15 am	  Gayle Walker-Cillo <i>Immediate Past President</i> Morristown Medical Center Atlantic Health System  Eileen Gornell <i>President</i> The Valley Hospital Valley Health System  Kimberly Hollender <i>President-Elect</i> Robert Wood Johnson University Hospital RWJ Barnabas Health  Shibani Gupta <i>Treasurer</i> Mountainside Medical Center Hackensack Meridian Health  Connie Mastrangelo <i>Recording Secretary</i> Morristown Medical Center Atlantic Health System  Joan Legaspi <i>Media & Corresponding Secretary</i> The Valley Hospital Valley Health System Opening Remarks by Eileen Gornell president for 2024-2025
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9:15-9:45am	Ice breaker interactive socialization	Gayle Walker-Cillo
9:45-10:00am	NJSCC Board Open positions and Candidates for 2025 Board President-elect: 2025 (Must have been a member for 2 years) <u>President-elect: 2025</u> Kerry Stroud, CentraState Medical Center, Atlantic Health System Media Secretary: 2025-2026 (Website updates and member list updates) Vandana Parikh, Saint Clare's Health Prime Healthcare <u>Media Secretary: 2025-2026</u> Vandana Parikh, Saint Clare's Health, Prime Healthcare Kelli Ward, Overlook Medical Center, Atlantic Health System Corresponding Secretary: 2025-2026 (Emails, discussion board, post events) <u>Corresponding Secretary: 2025-2026</u> Marianna Ingrao, Jersey Shore University Medical Center, Hackensack Meridian Health Annjill Singh, Overlook Medical Center, Atlantic Health System Recording Secretary: 2025-2026 (Minutes & attendance for board and all member meetings) <u>Recording Secretary: 2025-2026</u> Amanda Leibowitz, Community Medical Center, RWJ Barnabas health. o Please use the link below to vote by Tuesday November 12,2024 Each hospital center gets only one vote. https://forms.gle/xJqXkjDbe3oudm6X8 o Any questions please contact Joan at JLEGASP@Valleyhealth.com	Eileen Gornell
10:00-10:35am	Report and updates NJ Stroke Care Advisory Panel (SCAP) Update NJ Department of Health Update • 11/19/2024 meeting report: - The committee previewed Q1 and Q2 of the STK & CSTK aggregate data collected by the DOH for the dashboard. Based on the review they conquer the data is being successfully collected. - Measure request to split CSTK-09- for CSC and TSC stroke centers to be reported as A and B, the goal is to standardize the measure being reported as either the median or mean. No live date chosen. - EMS office has completed their survey the results are being compiled. - This data is meant to be publicly reported data. Currently the descriptors of the measures are too high level for the public, they are using the descriptors/definitions from GWTG/JC. Need to create	Gayle Walker-Cillo Eileen Gornell

	a glossary that would allow the public to find the definitions for each measure at the 6-8 grade level. • Dr Halperin is the chair of the NJSCAP and reported they will create a summary of the SCAP activities for 2024 and submit it to the state, within this summary is a proposal to bypass all stroke centers for large strokes defined as RACE Score ≥ 5, to a CSC, <u>if</u> CSC is within 30 minutes. • This recommendation would bypass all the designated thrombectomy capable centers by the JC or DNV. • To address the Bypass proposal, on behalf of the NJSCC Eileen presented the NJSCC recommendation of NOT bypassing TSC centers for LVO strokes. • The NISCC recommends EMS uses the RACE scale and BE FAST assessment to prescreen LVO patients and take them to the center closest to the patient that can perform thrombectomies/MER. (what center is closer to the patient, if closest to CSC go there but if closest to TSC go there). • The NJSCC explained that it will not be possible for TSC certified centers to meet their mandatory designation volumes if all LVO volume will bypass them for a CSC. • Currently there are 5 TSC centers in NJ. • NJSCC proposed algorithm:	
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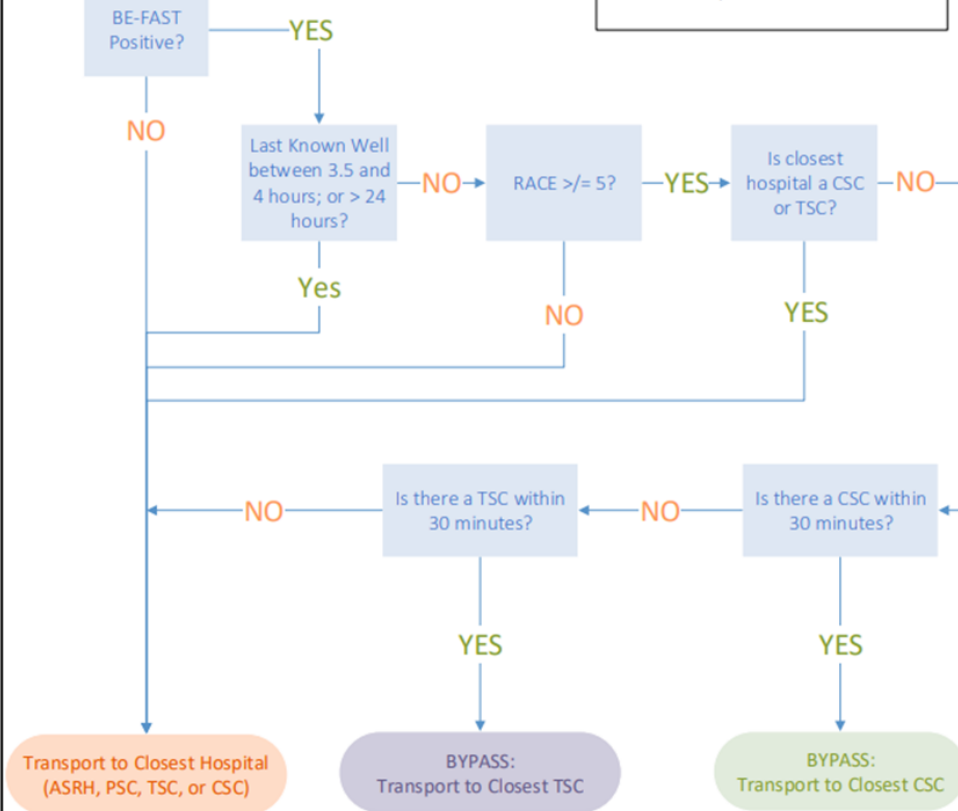


Suspected Stroke: EMS Destination Plan

Stroke Suspected?

- Perform BE-FAST Stroke Screening
- Determine Last Known Well
- Perform RACE Stroke Severity Assessment

Stroke Certification Levels
 ASRH= Acute Stroke Ready Hospital
 PSC= Primary Stroke Center
 TSC= Thrombectomy Capable Stroke Center
 CSC= Comprehensive Stroke Center



Summary

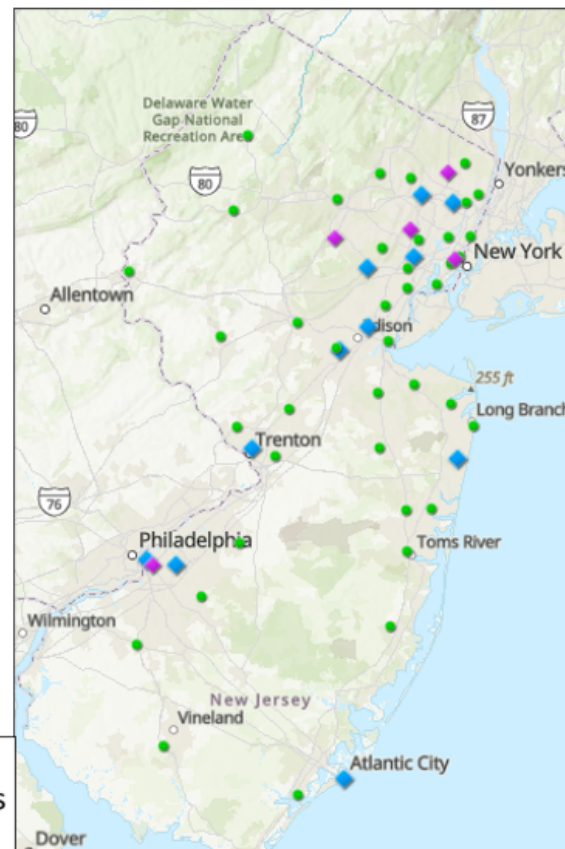
- For suspected large vessel occlusion stroke (RACE ≥ 5) and last known well < 24 hours, follow algorithm to transport to closest hospital with thrombectomy services (CSC or TSC).

1035-1050

NJ Stroke Certified Hospitals

Certification Level	Number of NJ Hospitals
Comprehensive	11
Thrombectomy Capable	5
Primary	40
Acute Stroke Ready	1

- ◆ Comprehensive Stroke Centers
- ◆ Thrombectomy-Capable Stroke Centers
- Primary Stroke Centers



[NJ Stroke Coordinator Consortium](#)

- EMS 2022 interim clinical practice guidelines EMS protocols. Volume 52, Issue 5 May 2021, Pages e133-e152. These guidelines state Ems should be using BE FAST and RACE, however it does not provide a clear directive as to where to take the patients to.
- EMS standardized education: recommended to include LKW, BE FAST, RACE and Destination plan yearly, and include competency assessment.
- Currently there is no law determining what education is required and mandatory. The NJSCC recommended NJSCAP should provide mandatory guidelines to EMS
- Extensions to update your state designation to mirror the JC certification goes away as of January of 2025
- The NJSCC also sent the Recommendations for Advancing the Stroke System of Care in New Jersey to the Hospital association, DOH
- How is the state going to measure where the patients are going?

Casey Chu

- Recommendation to all NJSCC members to reach out to their CNO, CEO and Hospital director to send a letter to the hospital association and Dr Halperin due to the impact this is going to make for all the TSC center which potentially will not be able to keep the volume to maintain accreditation.
- Letters should have a unified statement not describing CSC and TSC interchangeable. But to not bypass patients from a TSC if it is closer than a CSC
- All this information is now posted on the NJSCC website with the document and algorithm presented to NJSCAP. Please review that the EMS certification for your institution is accurate.
- Is there a certificate of need to apply for the TSC certification. Which forces investigation of the need specific for the area.

DOH website

https://www.nj.gov/health/healthcarequality/documents/Designated_Stroke_Centers_2024.pdf

<https://www.nj.gov/health/healthcarequality/health-care-professionals/cardiac-stroke-services/stroke-services/index.shtml>

Casey Chu

AHA updates November 2024

Upcoming CMIP submission dates shown on the graph below.

- Sites will have 15 days between GWTG-Stroke Submission and TJC Submission deadline to make any manual updates to CMIP data.
- GWTG will NOT automatically send updates after the GWTG-Stroke Submission date (column 2)

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

GWTG stroke submission and TJC

AHA can fill out the CMIP based on the data they have on their data base

TJC 2025 Updates

10:50-1130

1130-1150	Frequently Asked Questions: • Are there any updates to TJC measures in GWTG for 2025? • So far there have been no changes made by TJC to their stroke measure algorithms to date for 2025, which means that it will also remain the same in GWTG-Stroke. For TJC standard specific questions, please reach out to your TJC representative. • How does GWTG-Stroke stay up-to-date with TJC stroke standards? • GWTG-Stroke is a data vendor for TJC. The Health IT team from GWTG holds monthly meetings with TJC to discuss any necessary measure updates as needed based on TJC changes. The measure algorithm in GWTG-Stroke reflects that of what is displayed in the TJC measure manual. Any updates to these are summarized in the GWTG-Stroke release notes.  How to access the GWTG stroke release notes: IQVIA support sends emails to all GWTG stroke users to notify of any upcoming releases. Release notes can also be found in the library section of GWTG stroke Link to be access online other TJC measure resources <i>“Chart Abstracted Measure Specifications Manuals”</i> TJC measure specifications manual Learning Opportunities • Get With The Guidelines-Stroke Quality Forum. Tuesday, November 26, 2024, 1-2pm Register Here • Webinar Hemorrhagic ICH stroke updates in GWTG Thursday December 5, 2024, 1-2pm. ICH layer is voluntary and free of charge, email Casey if your institution is interested. Register Here • Florida’s First Mobile Stroke Unit: Mobilizing Optimal Stroke Care and Quality, Wednesday, December 11, 2024, 12-1pm. Register Here • Please utilize the GWTG touch base booking calendar to set up an appointment with Casey. GWTG Touch Base Booking Calendar ○ Choose Meeting Type ○ Select Date/Time ○ Look for confirmation email with meeting link • casey.chu@heart.org Lunch	All consortium members
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	Certification Review Visits CentraState Primary Stroke center Kerry Strout • Focusing on how institutions are determining competency with providers? not just education • They will look at things outside of the core measures, how many of the VTE fall outs end up being a DVT, swallow screen not done what is your rate of aspiration pneumonia. • TNK comparison how many coded out as strokes and presentation if not documented as stroke. • Implementing the 2024 guidelines, to specific population, transgender, Obgyn • How are the pharmacy staff being educated. They want to see stroke education specific to that group. • Make sure the neuro checks are not only GCS and pupils. Follow presenting deficits • How do you educate about EVD management. • Social work what tool are they using to assess family's readiness to take patient home. They are looking for a specific scale or verified tool. Caregiver readiness assessment to take patient home Anthony recommends also including PT, OT, SLP to the stroke education. Pharmacists start conversations on stroke and medication reversals. ED providers having a post-test after the education to show competency, or attestation, most places do it through med affairs Primary Stroke Center Virtual Mary Rogers Dr Susan Law • Social worker assessment of family readiness • They chose the newest nurse to assess their stroke specific knowledge TSC Stroke Center Shibani Gupta Eileen Hawkins Thrombectomy capable designation expert • BP monitoring and timely documentation • Mock code strokes, how they are done and what you learned from it. • ED tracer, spoke to security officer and data entry to demonstrate what would happen if someone came in with a stroke symptom, their education know =BE FAST • Follow the path of the stroke patient and asked everyone met what stroke education they received, CT etc. • ICU intensivist interview of stroke process • Interested on the acute and post stroke care	All committee members
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1150-12:15pm	• One post TNK patient missing one BP at 30 minutes while patient is being transported to the Cath for thrombectomy • Thrombectomy patient pre and post pedal pulses not documented • Patient being dc stroke no intervention the medical dc provider used a template and under their notes it said you have not been dc on any medications and not deleted even though there were medications ordered further on the note. • Hem patient presentation they did not suspect stroke on arrival with c/o of headache and there was a delay on symptom recognition • Patient education must be personalized should not be pre-checked • Patient satisfaction process. Need to link education opportunity to drive patient satisfaction • Community outreach and relationship with EMS. Mock codes once a quarter. Hackensack CSC Tina Kriccheer Mary Kelly • New SPM and new Stroke coordinator • Once he mentioned they were new she focused on turn over and orientation manual. Who is orienting her, what does that look like. Show me the map • Clear need to have a dedicated SPM as per the standards • Diagnostic Angio, updated neuro assessment documentation missing post test • Charity care patient not recommended PT no documentation of offering services even though the patient declines • EVD management want better documentation on levels. • With tina is calm second day will create chaos. Asking for things that are not typical. • Flow diverters, coiling, clipping, etc. • The goal was quality assurance not • Be careful with smart phrases. Patient TCAR was labeled as carotid education. TSC Stroke Center Morristown Medical Center Gayle Walker-Cillo & Connie Mastrangelo ICH management: • Timely BP management • Timely Anticoagulant reversal • DIDO for ICH patients out of the ED • BP parameters Leadership involvement with the stroke program • Leadership presence and involvement to help support the program • Need to be able to show their involvement and support holding people accountable to achieve and maintain stroke metrics, care, and program development. • Stroke Education requirements	Michelle San Fillipo
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12:15-1300pm	• Education requirements should be tailored to be meaningful to address the site's stroke program needs and goals. • As MMC stroke program continues to grow there must be very specific plan to help meet the increased demand. • Liked the fact that MMC has all RN including cardiac complete 4 CE including the NIHSS, since cardiac patients not always go to the neuro unit. GENENTECH YouTube readymade education modules • EMS • Determining disability and NIHSS • Best practices on assessing patients with low NIH • Virtual evaluation of acute stroke patients Stroke awareness website and access all the Genentech resources, can ordered from there. Stroke Information and Resources Stroke Awareness • We can use this education modules for education and grant CEU, it can be made available in HealthStream for free and made them available. Search the word stroke (three chapters) • Resources, you can download the tools and add your hospital logo. • Videos with patient stories https://youtube.com/@acutestrokeresourcesforhcps?si=w3rUxqmFOnlpdZ0  Stroke Resource Center: Disease education to support your patients  Acute Stroke Resources YouTube Channel Break Stroke coordinator's role Panel Discussion Pannel Kerry Stroud	Eileen Gornell
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13:00-1345pm 13:45-14:45	Marianna Ingrao Ryan Wilkinson Eileen Gornell What is your actual job title: • Stroke program manager: program development, parallel to ortho • Stroke quality coordinator, clinical coordinator parallel • APN Stroke program coordinator no one is parallel because they are not APN • Stroke coordinator and CNS for medical surge unit. managers are all grouped What are the expectations of your role? • Stroke program management but also have a stroke APN at clinical side. Conquering monitoring, infrastructure to implement updates. Data quantitative and qualitative, where are the processes working and where are the opportunities. Systematic processes to obtain better outcomes. Community education, EMS appreciation dinner, including community EMS, staff education and huddles. Hospital goal alignment, dc to home, readmission related to stroke. CITI trained to collaborate with the current studies. Creating councils specific to the thing you want to improve program development. • Quality coordinator, abstractor, data analysis. PI work for survey readiness, coordinating education. Reporting data to all different areas, case review, code stroke review, communication with stake holders • Stroke program management and clinical, list of neuro patients weed through them read charts and order all the pending measures, need to do patient specific education and document it on EPIC in the AVS. No abstraction. Community education is a challenge not able to leave the site. • APN Goes to all code strokes and writes a note on those patients. Not a neuro consults but a program perspective. <u>To whom do you report?</u> • Reports to a nursing director • Report to nursing a close neuroscience and dotted line to medical director. service line • AVP neuroscience, nursing, and dotted line to medical director neuro service line • Director of specialty services, through nursing, to CNO. Resources available <u>Who else is involve with the stroke program?</u> • Vendor to abstract charts, but they look at the charts for opportunities, stroke data nurse, collaborative with units but not specific to stroke • No one reports to him, lead APP does the provider and nursing education portion. System stroke collaborative, abstract own charts. • Quality department does abstractions, Program manager needs to only review outliers. Education department are part of the stroke committee. Community education is using nursing for PACT	Kim Hollender
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- Stroke data nurse, (does abstraction, community, and support education) provider and nursing education done by SPM, reviews, and feedback too.

Hospital system support available:

- Neuroscience
- System stroke and neuroscience collaborative
- AHS service line collaboration with all SPM
- Standalone institution no system support

How has your role evolved over time, how do you see it move forward,

- The role has been split to program driver and clinical structure, evolution to strengthen each focusing on outcomes.
- Future unknown large turn over. Hoping for dedicated abstractor splitting the responsibilities to be more coordinator based. APP coverage, who help with order sets, also a stretched group.
- Kerry has autonomy to determine her role. If she does not respond the code stroke still runs smoothly but the staff prefers when she is there
- Role is constantly adding new responsibilities to either monitor or accomplish, such as US news and world report and OE data.
- If you are reporting to nursing, you are more pull to contribute to medical nursing piece
- If you have a service line expected to be more quality driven

Lunch

Hemorrhagic stroke standards

Clinical Performance Measures for Adults Hospitalized With Intracerebral Hemorrhage: Performance Measures for Healthcare Professionals From the American Heart

Association/American Stroke Association <https://doi.org/10.1161/STR.000000000000171>

Stroke Volume 49, Number 7

ICU layer in GWTG is based on this article

- 2023 free ICH layer, voluntarily adapted
- 24 extra data points (performance measures and descriptive measures)
- ICH elements not consistently seeing ICH volume or etiology documented
- ICH volume, stroke neurologist, Teleneurologist, nsx, neurocritical care, emergency medicine, or radiology. Not on board to figure the math required. A, b, c data abd tgeb ABC/2 . Ai rapid has the capability to do the volume calculation but it is at extra cost. 35,000 annual cost
- ICH etiology:

ICH & JC:

2024 AHA/ASA Performance and Quality Measures for Spontaneous Intracerebral Hemorrhage: A Report From the American Heart Association/American Stroke Association. *Stroke*. 2024;55:

e199–e230. <https://doi.org/10.1161/STR.0000000000000464>

- PM6 & PM7 Diagnostic Vascular imaging for lobar and nonlobar ICH
- PM8 DSA for acute bleed
- **PM3 Anticoagulant reversal**

90 minutes from arrival to reversal administration

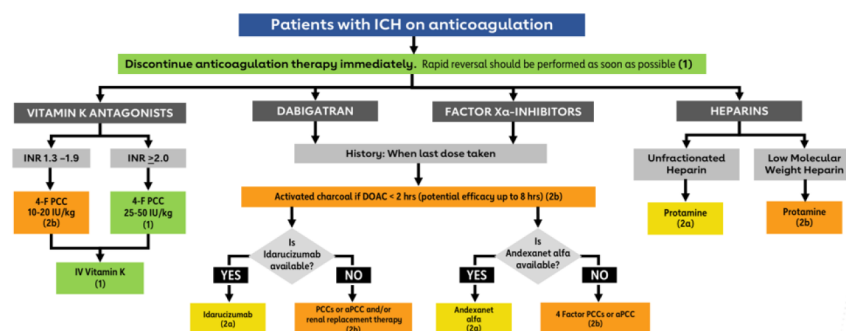
Need to choose the agent that your center uses the most. (JC does not script which agent to use)

5.2.1. Anticoagulant-Related Hemorrhage

Recommendations for Anticoagulant-Related Hemorrhage
Referenced studies that support recommendations are summarized in Data Supplements 18 and 19.

COR	LOE	Recommendations
1	C-LD	1. In patients with anticoagulant-associated spontaneous ICH, anticoagulation should be discontinued immediately and rapid reversal of anticoagulation should be performed as soon as possible after diagnosis of spontaneous ICH to improve survival. ¹⁶²

2022 ICH Guideline Management of Anticoagulation Reversal



Abbreviations: 4-F PCC indicates four-factor prothrombin complex concentrate; aPCC, activated prothrombin complex concentrate; DOAC, direct oral anticoagulant; ICH, intracerebral hemorrhage; and INR, international normalized ratio.

Greenberg, S. M. 2022 AHA/ASA. Guideline for the Management of Patients with Spontaneous Intracerebral Hemorrhage. Circulation.

- PM9 patients with hydrocephalus transferred
- % of patients that transfer and how long does it take

- PM11 surgery for deterioration cerebellar ICH
- neuro behavioral tx, rapid treatment to EVD

in addition to screening for mood disorders are they being screen for cognitive function
time to BP target med to given within one hour and hit target within range on 2 hours.
Rapid transfer to EVD

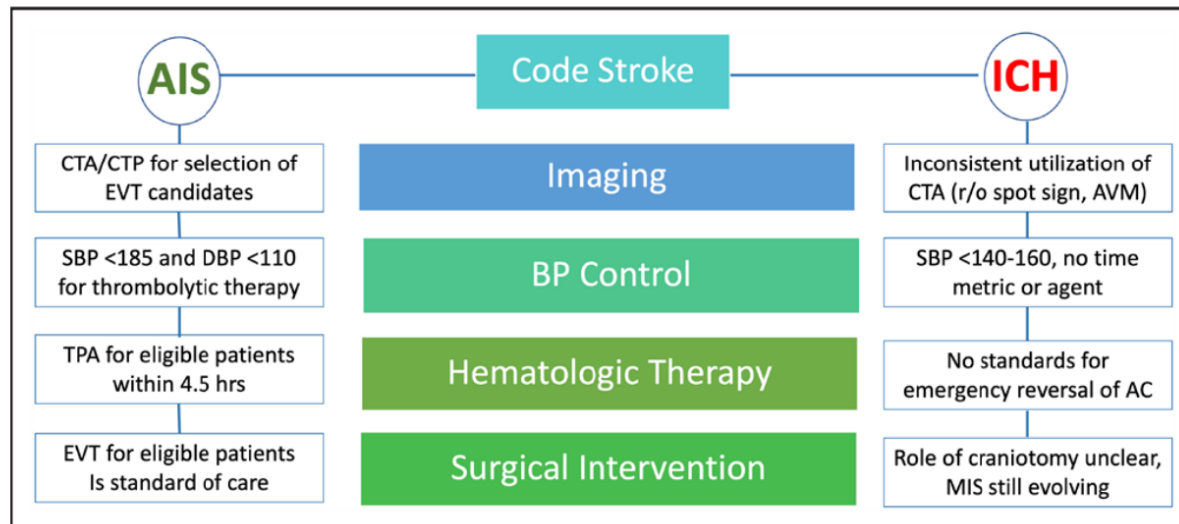
Brainstorming:

Should code stroke continue after IV thrombolytic decision?

- Time to BP target
- Time to anticoagulation

Should there be set criteria to trigger potential ICH transfer?

- ICH volume (>20ml supratentorial, >15ml infratentorial?)
- Who will calculate the ICH volume? Leverage AI platforms
- Intraventricular hemorrhage?
- Hydrocephalus?
- GCS score



1 Q, Yakhkind A, Alexandrov AW, Alexandrov AV, Anderson CS, Dowlatshahi D, Frontera JA, Hemphill JC, Ganti L, Kellner C, May C, Morotti A, Parry-Jones A, Sheth KN, Steiner T, Ziai W, Goldstein JN, Mayer SA. Code ICH: A Call to Action. Stroke. 2024;55:00-00. doi:10.1161/STROKEAHA.123.043033



Currently there is no time goal from EVD to transfer.

Measure Door to ICU ICH patients required one on one monitoring, data shows better outcomes and decrease mortality on patients that rapidly transferred to neuro ICU.

Discussion:

Anthony Rocco

Connie Mastrangelo

- Any primary center uses the GWTG ICH layer
- PSC vs CSC ICH metrics
- How have you built in ICH into your code stroke workflow?
- Do you have any standardized criteria for when to transfer ICH patients.

Certification for Advanced Stroke Coordinator (ASC-BC) ANVC Certification:

The ASC Certification is the only certification that recognizes the unique and essential contributions of a stroke coordinator.

Attainment of ASC-BC status demonstrates expertise in stroke competencies including understanding and mastery of skills used to diagnose stroke, evidence-based management of principles for both ischemic and hemorrhagic stroke, knowledge of role history and role evolution, stroke data collection, data analysis methods, data presentation, quality management, and principles and strategies supporting effective adult education, change mastery, and time management.

Review courses supporting attainment of the ASC-BC credential are available throughout the year.

Certification examinations are offered through the Neurovascular Clinicians Certification Corporation (NVC-3). <https://www.anvc.org/>

Code stroke logs

For what do we use code stroke logs?

Logs are a structural component of any stroke program

- Acute Treatment/Response
- Telestroke Protocol
- ED Patient/Stroke Code Activation
- Stroke Patient Performance Measures
- Case Review Form
- Performance Metric Reports
- Quality/Performance Improvement Project Form/Worksheet

Code Stroke Activation Report

- Captures all code strokes or code stroke neurointervention
- List patients by arrival
- Captures time first documented NIHSS helps with Inpatient cases

Microsoft Power BI Medications Given For Stroke

- Patient identifiers
- Date of arrival
- Thrombolytic dose given
- Provider name
- Discharge disposition location
- Department (pt location) inpatient cases heads up
- ECG, XR, CTH WO (start, prelim, final),

	• Arrival to test and Thrombolytic TNK Manual data abstraction Post TNK Excel workbook • BP monitoring/agent used/BP 4 h post • Treatment rate by provider • Treatment Delay documentation • CT discussion capture from notes • TNK dual sign off • EMS/ALS records and staff • NIH on arrival and DC • Hemorrhage post tx Manual data abstraction Post MER Excel workbook • Treatment rate by provider • Treatment Delay documentation • RAPID preliminary result • Complications (hem, death, pseudoaneurysm...) • Post TNK y/n • Staff arrival NSX, IR RN 1, RN 2 • Type of anesthesia (general, MAC) • NIH prior to tx and at DC Summary: • Logs are tools • Limited by computer program features, documentation field consistency • Unable to capture information within notes • Can be used to drive interventions and PI • Needs to be specific to your program needs	
14:45-3pm	Meeting Ended	Eileen Gornell