7.g. GETAC Stroke Committee Update to Council

Chair: Robin Novakovic, MD

Vice-chair: Sean Savitz, MD

GETAC Stroke 2026 Priorities

Chair: Robin Novakovic, MD

Vice-chair: Sean Savitz, MD

Stroke Committee

GETAC 2024 Strategic Plan

2026 Committee Priorities

Strategic Plan Pillar & Objective	Strategy and Implementation Activity
1. **Coordinated Clinical Care:** Promote timely access to care for urgent conditions regardless of geographic location across the state. (Objective 6 of Coordinated Clinical Care) • Develop standardized processes to minimize the time from stroke onset to definitive acute stroke care at an appropriate designated stroke facility. Focusing on public education and early recognition through acute management.	**a. Strategy:** Develop standards to minimize the time from onset of illness or injury to definitive care. (Strategy 2 of Coordinated Clinical Care) **b. Activity:** ▪ Recommendation for prehospital Stroke Triage algorithms for adults and pediatric patients ▪ Rural stroke work group to identify barriers and opportunities to improve access to stroke care, Rural Stroke Survey ▪ Post acute stroke care work group implemented ▪ TX stroke awareness campaigns.
2. **Coordinated Clinical Care:** Utilize evidence-based and/or best practice metrics to evaluate the emergency healthcare system, deliver evidence-based care, and provide public transparency of such data. (Objective 8 of Coordinated Clinical) • Enhance stroke care performance by utilizing evidence-based and best practice metrics to evaluate the emergency healthcare system, ensure delivery of high-quality, evidence-based care, and promote public transparency of outcomes.	**a. Strategy:** Develop standards to minimize the time from onset of illness or injury to definitive care; and define data elements necessary to evaluate emergency healthcare system effectiveness. (Strategy 2+3 of Coordinated Clinical Care) **b. Activity:** ▪ DIDO performance measure recommendation ▪ Neuro IR coverage recommendation ▪ Establishing and maintain standards to minimize the time from last known well to definitive stroke care. ▪ Define, track, and regularly review performance measures necessary to assess and improve the effectiveness of both EMS systems and designated stroke facilities. Examples: ○ Rural stroke performance report from GWTG and EMSTR ○ GWTG performance reports ○ GETAC Stroke semiannual performance report (GWTG and EMSTR)

Stroke Committee

GETAC 2024 Strategic Plan

2026 Stroke Committee Priorities

Strategic Plan Pillar & Objective	Strategy and Implementation Activity
3. <u>Coordinated Clinical Care:</u> Deliver the highest quality care across the continuum of the emergency healthcare system-from prevention to rehabilitation. (Objective 7 of Coordinated Clinical Care) • Develop and maintain a coordinated stroke system of care spanning the entire continuum of the emergency healthcare system—from public recognition and prevention through acute management, post-acute recovery, and secondary prevention. Focusing on disseminating best practices and educational resources to address knowledge gaps and optimize outcomes across all phases of stroke care.	**a. Strategy:** Adopt the national goal of achieving zero preventable deaths related to injury and time-sensitive illness and minimizing trauma and disease-related disability. (Strategy 1 of Coordinated Clinical Care) **b. Activity:** ▪ Best practice recommendation for optimizing and reducing DIDO ▪ Pediatric Stroke Task Force working on tip sheet for thrombolysis in pediatric patients and minimum requirements for pediatric facilities specializing in stroke care. ▪ Endorsing and promoting statewide stroke educational opportunities ▪ Looking to start mentorship program for stroke managers and continue to identify resource documents ▪ TEAM Stroke ED study evaluating standardized stroke education ▪ Resource documents posted to GETAC Stroke Committee website ▪ Establish AHA, DNV and JC liaisons to the committee
4. <u>Public Education</u>: Explore innovations for providing interactive, collaborative, and targeted public education. (Objective 2 of System Support/Public Education) • Develop innovative and applicable knowledge content in stroke recognition and prevention strategies for public consumption across the State of Texas.	**a. Strategy:** Promote and provide information to local agencies related to layperson education and training to improve stroke recognition and utilization of 911 to provide timely and appropriate interventions (Strategy 4 of System Support/Public Education) **b. Activity:** ▪ Texas Stroke Awareness Campaign ▪ Texas Rural Stroke Awareness Campaign ▪ BEFAST education material in Spanish and English ▪ Education to target school age children and adult lay persons

GETAC Stroke Committee 2025 Outcomes

Chair: Robin Novakovic-White, MD

Vice-chair: Sean Savitz, MD

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: GETAC Prehospital Adult and Pediatric Routing and Resource recommendation	• Passed by GETAC committees and GETAC Council. • Working on education and dissemination. • Available on the GETAC Stroke Committee webpage.	
Coordinated Clinical Care: Pediatric Task Force working to outline tip sheet for pediatric stroke workup and management, and minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke	• Task Force Lead – Stuart Fraser, MD • Members consist of EMS providers, pediatric stroke neurologists, RNs and Stroke Committee members • Activities ongoing • Working with International Pediatric Stroke Organization Readiness Work Group – submitted a brief report of examples how pediatric SSOC and recommendations are made, including GETAC efforts.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Rural Stroke Work Group – working to improve access and quality of stroke care in rural areas across TX.	• Work Group Lead – Robin Novakovic-White, MD • Members consist of EMS providers and leadership, RAC leadership, stroke neurologists, RNs, AHA representative, and Stroke Committee members • Defined the rural scope of the WG, rural regions, resource challenged and rural hospitals. • Heat Maps for TX • Activities ongoing • Rural Stroke Needs Assessment Survey • Working to define rural stroke recommendations • Rural targeted layperson stroke education • Working on best practice recommendation for DIDO • Exploring ABT in rural areas.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Quality and patient safety issue	• Letter presented from providers citing patient safety issue regarding Neuro IR call coverage. • Multiple providers in state of Texas gave first-hand experience supporting statements in the letter. • Stroke Committee and Council approved the concerns are a quality and patient safety issue that need to be reviewed. • DSHS met with accrediting agencies to discuss • Stroke Committee recommended performance measures hospitals could use to monitor • SSOC to present proposal for recommendation on Neuro IR coverage best practice	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Post Acute Care Work Group	• Work Group Lead – Sean Savitz, MD • Members consist of stroke neurologists, PMR providers, RNs and Stroke Committee members • Activities ongoing, will meet monthly	
Coordinated Clinical Care: Work with DSHS to outline stroke facility level rules	• Task not completed • Stroke Committee endorsed AHA/ASA as resource guideline for DSHS (previously BAC).	
Coordinated Clinical Care: Interfacility Stroke Terminology	Approved by committees but not the GETAC Council. Next steps: EMS Time Sensitive Deconfliction Task Force	
Coordinated Clinical Care: Establish recommendation for stroke facility infrastructure based on ASA recommendations Optimal Care of the Injured Patient 2022 Standards	• The System of Care Work Group reviewed the ASA recommendation. • Reviewed the optimal care of the injured patient 2022 • Paused while waiting for the July 2025 revision.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Provide list of recommended stroke education and certification courses	• Education Work Group - compiling a list of courses and certifications pertaining to stroke education endorsed by GETAC Stroke Committee.	
Coordinated Clinical Care: Stroke education resources for stroke facilities	• Next steps: work with DSHS to create webpage resource for stroke education. • Provide lectures at the DSHS level meetings	
Coordinated Clinical Care: Stroke Coordinator Mentorship program and needs assessment survey.	• Education Work Group – working on follow up survey for stroke managers/coordinators • Resource documents for coordinators endorsed and available from GETAC Stroke Committee webpage.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Performance Improvement: Report and disseminate quarterly TX stroke quality performance report and semi-annual GETAC Stroke performance report	• Share report with committee, council and TCCVDS • Quality reports help guide recommendations • Quality reports assess performance of the Texas stroke system of care. • Stroke Committee PI WG and Rural Stroke WG use the quality report with benchmarks to identify barriers to stroke care and opportunities for improvement.	
Performance Improvement: GETAC Stroke Committee recommended performance measures	• GETAC Stroke Committee has made recommendations on performance measures to follow and registry participation. • Recommendation for participation in GWTG EMS and DIDO layers.	
Performance Improvement: DIDO performance recommendations goals	• Committees and GETAC Council approved. • Disseminated information and educate • Monitor performance	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
EMS Education: Disseminate current information on stroke best practices and educational opportunities to satisfy knowledge gaps.	• Working on TEAM Stroke Ed study - providing standardized stroke education to EMS providers, first responders, and dispatchers. • Endorsed by Committees and Council • Seeking funding for study	
EMS Education: Texas EMS Stroke Survey	• Survey completed • Data analyzed • 3 scientific abstracts accepted at two international meetings from the Texas EMS Stroke Survey Results • Next steps, write finding up for publication.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Public Education: Explore innovations for providing interactive, collaborative, and targeted public education.	• Texas Stroke Awareness Campaign, seek approval at the 11/2025 meeting.	
Public Education: Explore innovations for providing interactive, collaborative, and targeted public education.	• Texas Rural Stroke Awareness Campaign, seek approval at the 11/2025 meeting.	

GETAC Stroke Committee Report November 2025

Chair: Robin Novakovic-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
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. • Stroke Committee endorses data elements that are highly recommended for completion in GWTG • **Presented quality report from GWTG, and rural stroke data from GWTG and EMSTR** • **Discussion – rural stroke survey may help identify barriers to stroke care and opportunities for improving DIDO**	
RDC report	• Update from RDC at Stroke Committee meeting. • Previously discussed more rural hospitals participating than higher levels I and II. • RDC will not be the ultimate source for the performance report. Need to continue with GWTG	
Stroke Committee 2026 Priorities	• **Stroke Committee 2026 Priorities approved by the stroke committee 11/2025** • **Stroke Committee identified liaisons to the GETAC Committees** • **Stroke Committee identified liaisons from AHA, DNV and JC**	

2026 Stroke Committee Returning & New Members

Stroke Committee Member	RAC/TSA	Affiliation
Sean Savitz, MD	**Q**	McGovern Medical School
Saud Khan, MD	**F (rural)**	Titas Regional Medical Center
Sarah Elizabeth Andrews, RN	**L**	Ascension
Farzan Ghodsianzade, DO	**O**	BSW
Joseph Dominguea, RN	**V (rural)**	KNAPP Medical Center
Avni Kapadia, MD	**Q**	Baylor College of Medicine and Texas Children's

Committee Liaisons

- **Committee Liaison Updates:**
  - Air-Medical – Chantel Molina, RN
  - EMS Education – Amanda Jagolino-Cole, MD
  - EMS – Chief Kevin Cunningham
  - Pediatric – Melanie Aluotto, RN
  - EMS Medical Director – Robin Novakovic, MD

New Liaison Roles

- Allison Capetillo – AHA Liaison
- Janine Mazebob – DNV Liaison
- Andrea Yates – Joint Commission

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Patient safety and quality concern – Neuro IR coverage	• Letter citing patient safety concern regarding Neuro IR call coverage discussed. • Multiple TX providers gave first-hand experience supporting statements in the letter 11/2024. • Stroke Committee and GETAC Council approved as a quality and patient safety concern. • Barriers to finding objective measures to demonstrate delays, patients inappropriately denied MT and misuse of resources. • DSHS is working with DNV and TJC to review transfers out from hospitals • Stroke Committee and SSOC WG recommendation for internal performance measures to follow. • **SSOC work group and Stroke Committee endorsed using the NCTTRAC Neuro IR coverage best practice recommendation as the GETAC recommendation.** • **NCTTRAC approved that it can be branded as the GETAC resource.**	

Neuro IR Proposed Recommendation

NCTTRAC
NORTH CENTRAL TEXAS TRAUMA REGIONAL ADVISORY COUNCIL

Regional Stroke System Plan
Stroke Recommendation for Neuro IR Coverage
Stroke Committee

I. Recommendation

This recommendation serves to provide acceptable neurointerventional coverage (primary and backup call coverage) at Level I-Comprehensive and Level II-Thrombectomy Capable Stroke Centers in the NCTTRAC region and has been endorsed by the NCTTRAC Stroke Committee, the Board of Directors, the Stroke Medical Directors, and the majority of the C-Suites of the Level I and II Stroke-designated facilities in TSA-E.

A. Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy should have adequate coverage to meet the emergent needs of multiple strokes.
B. Each facility should have a written call schedule readily available within the hospital system, identifying the on-call and backup on-call interventional provider privileged to perform mechanical thrombectomy (neurointerventionalist) 24 hours a day, seven days a week, 365 days a year.
C. The neurointerventionalist taking calls should be available by phone within 20 minutes and available on-site within 30 minutes from notification.

i. When concurrent facilities are covered by either the primary or backup on-call provider, the following should be in place:
   1. If one neurointerventionalist is primary on-call concurrently at two (2) facilities there should be one dedicated backup on-call provider for each facility (e.g., two hospitals with shared coverage, one primary and three tier backup on-call coverage).
   2. The dedicated primary neurointerventionalist on-call at one facility may serve as backup call for no more than one hospital at any given time (e.g. primary call at one facility and backup at one additional facility).
   3. The facilities with cross coverage should be in close proximity, allowing the neurointerventionalist either serving as primary or backup on-call to be available on site within 30 minutes.

ii. Comprehensive and Thrombectomy Capable Stroke Centers that utilize a system of care to deliver stroke care, treatment, and services may utilize the same interventionists provided the following requirements are met:
   1. Written call schedules are readily available within the hospital system to demonstrate how stroke care, treatment, and services are provided at all hospitals in the system 24 hours a day, 7 days a week, 365 days a year.
   2. If one physician is covering more than one facility or another service in the organization, there is a written plan for backup coverage.
   3. Protocols and processes are developed and implemented to detail the system and organizations' plans to meet the emergent needs of multiple complex stroke patients.
   4. Protocols and processes are developed in response to situations when organizations would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify Advisory-Capability with a comment in EMResource.

iii. Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy and utilize an independent contracted provider or group for neurointerventional coverage to deliver stroke care, treatment, and services should have the following requirements met by the contracted provider or group:
   1. Written call schedules are readily available outlining all of the hospitals that the primary and backup on-call providers are covering for the shift.
   2. A written plan to meet the emergent needs of multiple stroke patients for each of the facilities if one contracted physician is covering more than one facility.
   3. Protocols and processes are developed in response to situations when the primary and backup on-call providers would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify of Advisory-Capability with a comment in EMResource.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Adult Prehospital Stroke Resource	• Final routing algorithm approved through GETAC Council 03/2025 • Resource document for adult algorithm revisions approved by required committees and Council 06/2025. • **Resources available from the GETAC Stroke Committee webpage.**	
Pediatric Stroke Task Force	• **Pediatric Stroke Tip Sheet is still under review by the Pediatric Stroke Task Force. Goal something to review by 11/2025** • Next steps, minimum capability recommendations for pediatric hospitals to be destinations for pediatric stroke. • Algorithm approved by required committees, pediatric stroke task force and Council 06/2025. • Revisions approved by Pediatric, Stroke Committee and Council 08/2025 • **Resources available from the GETAC Stroke Committee webpage.**	

Stroke Committee GETAC Approved Recommendations

Committee Resources

GETAC EMS Acute Pediatric Stroke Routing Resource Document
GETAC Prehospital Pediatric Stroke Triage and Management Resource Document
GETAC Door-in/Door-out (DIDO) Performance Goals
GETAC Prehospital Adult Stroke Triage and Management Resource Document
GETAC EMS Acute Stroke Routing Resource Document - Urban
GETAC EMS Acute Stroke Routing Resource Document - Suburban
GETAC EMS Acute Stroke Routing Resource Document - Rural
Southwest Texas Regional Advisory Council (STRAC) Stroke Program Manager Manual

GETAC Stroke Committee Page:

(Scroll to bottom of the page)

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

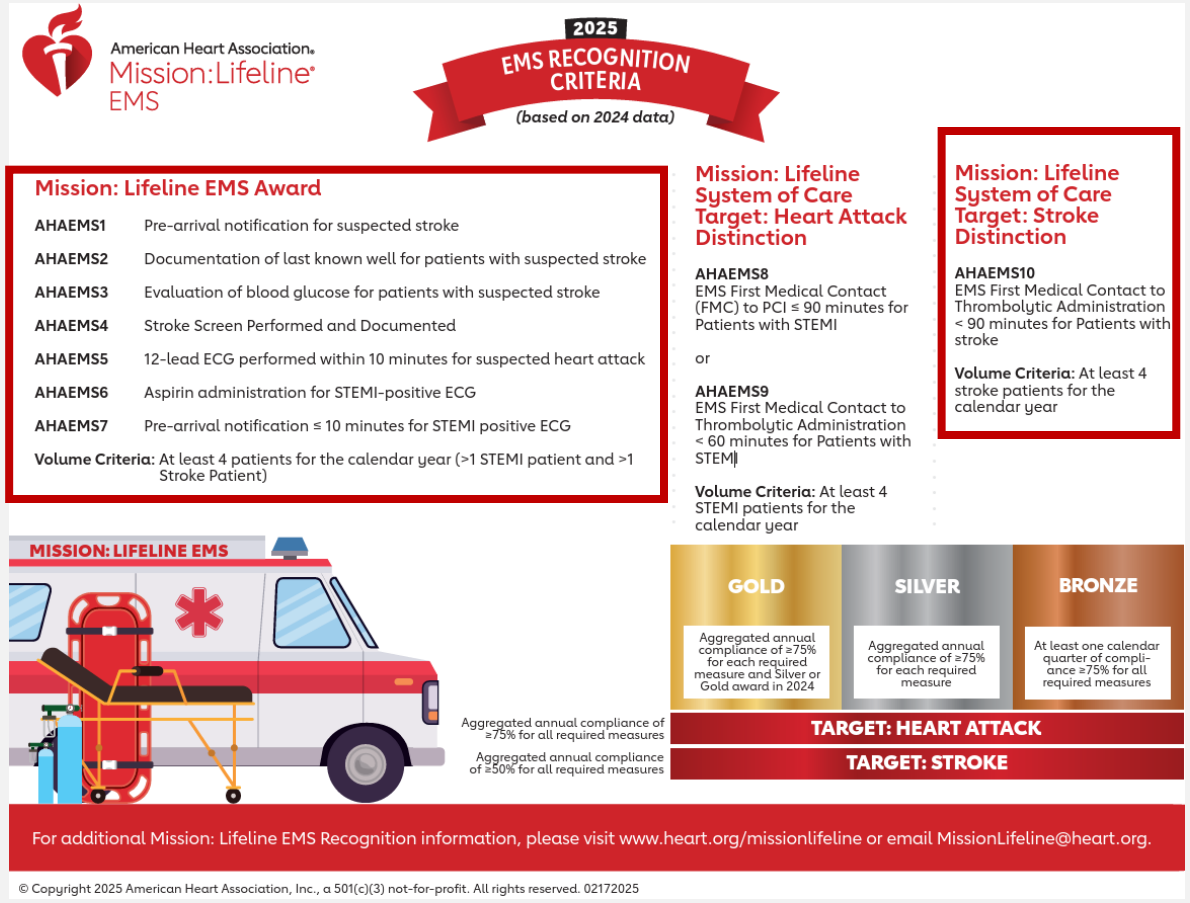
Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• Drs. Fagan and Winckler provided input on terminology, approved by the Stroke, EMS, Air Medical, and EMS Medical Director Committees in 11/2024. • Presented to the GETAC Council but not approved 11/2024. • **Participating with the EMS Time Sensitive Deconfliction Task Force.**	
DIDO performance recommendations	• Approved by Committees and the GETAC Council 11/2024. • Email recommendations to participate in GWTG DIDO layer and performance goals to RAC chairs and continue to share with stroke programs. • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO • **Recommendation for best practice to improve DIDO – present 03/2026**	
TEAM EMS-Ed Study	• Study endorsed by Stroke, EMS and EMS Medical Directors Committees and council 06/2025. • Informed EMS Education Committee and seeking members for writing group 08/2025. • **Seeking funding.** • **Working on the standardized education**	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Post Acute Stroke Care Work Group	• Approved by Stroke Committee 11/2024 • Dr. Sean Savitz leads the work group • Had their first meeting 11/2025 • **Request made at 11/2025 that the work group look into financial barriers to post acute care.**	
Stroke Managers Mentorship Program and Texas Stroke Coordinators Collaborative Survey	• Education Work Group discussing the platform and feasibility of the mentorship program. • Working on the stroke managers' survey. • Will incorporate some questions from the prior survey.	
STRAC Stroke Program Manager Manual	• Collect and share resources related to stroke program management, stroke coordinator & manager roles, and process improvement. • Presented 11/2024, approved by stroke committee as a good resource. • Available resource from the GETAC Stroke Committee Webpage.	
Mission: Lifeline EMS Recognitions	• **To bridge the gap between data EMS collects to what the hospitals collect for GWTG metrics an EMS recognition was created.** • **Stroke Committee approved endorsement to promote 08/2025** • **APPROVAL ITEM: Approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs and at DSHS stroke meetings**	

Education Workgroup - Mission: Lifeline EMS Recognition



https://www.heart.org/en/professional/quality-improvement/mission-lifeline

Measure Narratives: https://www.heart.org/en/-/media/Files/Professional/Quality-Improvement/Mission-Lifeline/2025-EMS-ML-Measure-Narratives-Final.pdf?sc_lang=en

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Rural Stroke Work Group	• Met twice after the 08/2025 session, plan to meet monthly. • Approved rural and resource-challenged regions and hospitals to be included in the scope of work group. • Reviewed heat maps 08/2025. • Needs assessment survey approved by work group, Stroke Committee and Council 08/2025 • EMSTR data request approved 08/2025 • Working on DIDO recommendation. • **11/2025 review performance from EMSTR and GWTG.** • **Rural Stroke Needs Assessment Survey live.**	

Rural Stroke
Resource and Needs Assessment Survey

Survey QR Code:

Public Survey URL:
https://ais.swmed.edu/redcap/surveys/?s=NT4X9HJYRNPP8ACM

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	• Results shared • **Two abstracts accepted to ISC 2026 (one accepted as oral presentation), one abstract presented at SVIN 2025** • **Plan for paper**	
The Stroke Committee endorsed stroke education and certification courses.	• Ongoing effort identifying stroke educational opportunities for providers	
Stroke Education Resources for stroke facilities	• Council approved stroke resources to be posted to GETAC Stroke Committee webpage 08/2025. • GETAC Approved Stroke Resources available on Committee webpage. • EMS Education Liaison – Dr. Jagolino-Cole • Met with RAC chairs 08/2025 to seek guidance, recommended email RAC chairs via Deidra with updates.	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Pending further direction	

Confidence Drives Utilization: EMS Provider Perspectives on Stroke and LVO Screening Tools in Texas

UT Southwestern Peter O'Donnell Jr. Brain Institute

S. Hegde[1], S. Novakovic[1], J. Schmider[2], C. Winckler[3], E. Fagan[4], J. Benno[5], E. Stevenson[5], J. Klein[5], H. Pervez[1], S. Savitz[6], K.Cunningham[7], L. Hutchinson[8], C. McAlpine[4], C. Escobar[9], A. Capetillo[10], J. Mazabob[11], A. L. Jagolino-Cole[6], V. Cairns[12], M. Aluotto13, S. Khan[14], M.Steiner[15], J. Burwell[16], A. Webb[17], C. Molina[18], A. Kapadia[19], R. Novakovic[1];[1]UT Southwestern Medical Center, Dallas, TX, [2]Texas Department of State Health Services, Dallas, TX, [3]UT Health, San Antonio, TX, [4]Baylor Scott &White, Dallas, TX, [5]Texas Department of State Health Services, Austin, TX, [6]UT Health, Houston, TX, [7]Midlothian Fire Department, Midlothian, TX, [8]UTHealth Tyler, Tyler, TX, [9]University Medical Center of El Paso, El Paso, TX, [10]American Heart Association, Dallas, TX, [11]DNV GL Healthcare, Sugar Land, TX, [12]Ascension Texas, Austin, TX, [13]SouthEast Texas Regional Advisory Council, Houston, TX, [14]Titus Regional Medical Center Mount Pleasant, Mount Pleasant, TX, [15]Parkland Health, Dallas, TX, [16]CHRISTUS Trinity Mother Frances Tyler, Tyler, TX, [17]DNV, Corpus Christi, TX, [18]Laredo Medical Center, Laredo, TX, [19]Baylor College of Medicine, Houston, TX.

Background

Stroke screening and large vessel occlusion (LVO) tools are critical for prehospital triage, guiding recognition and transport destination. Provider confidence in applying these instruments may directly affect their frequency of use and reliability. Few studies have compared EMS provider confidence across different stroke screening tools or examined whether similar patterns exist for LVO-specific assessments.

Methods

We analyzed 189 responses from a Texas statewide EMS survey conducted in 2024. Providers reported their confidence in performing stroke screening tools (very confident, confident, somewhat confident, not confident) and LVO tools, along with which instrument they used most often. Associations between tool selection, confidence, training frequency, and utilization were assessed using chi-square tests and Cramér's V effect sizes.

Results

- Confidence significantly influenced stroke screening tool use but varied significantly by stroke screening tool used.
- Cincinnati was most frequently associated with higher confidence and greater utilization (χ^2=15.7, p=0.0035, Cramér's V = 0.32), whereas FAST and LAMS demonstrated lower independent associations with confidence.
- LAPSS and Boston were rarely used.
- Importantly, providers who reported higher confidence in any stroke screening tool were also significantly more likely to report using the tool >75% of the time ($\chi^2 = 44.0$, $p < 0.001$, Cramér's V=0.31).
- For LVO tools, overall confidence was lower compared with general stroke screening. Only 54% of VAN users reported being "very confident," while fewer than half of FAST-ED, C-STAT, RACE, and LAMS users expressed high confidence.
- Utilization followed a similar pattern: >50% of users for RACE, C-STAT, VAN, and FAST-ED reported they used their tool >75% of the time, whereas rates were lower for LAMS (43%). Training frequency varied, but providers receiving annual or more frequent training were more likely to express higher confidence across all LVO tools (trend consistent but not statistically significant).
- Importantly, confidence gaps in LVO tools were consistent across provider levels (EMT vs paramedic), though paramedics tended to report slightly higher confidence.

Results

Table 1. Confidence, Utilization, and Training by LVO Tool

Tool	N	Very Confident %	>75% Utilization %	Annual/More Training %
VAN	52	53.8	50.0	76.9
C-STAT	20	40.0	55.0	70.0
FAST-ED	8	37.5	50.0	50.0
LAMS	7	42.9	42.9	42.9
RACE	7	28.6	57.1	57.1

Table 2. Confidence, Utilization, and Training by Stroke Screening Tool

Tool	N	Very Confident %	>75% Utilization %	Annual/More Training %
Cincinnati	130	59.2	70.8	68.5
FAST	65	52.3	69.2	69.2
LAMS	10	70.0	80.0	60.0
NIHSS	10	50.0	70.0	60.0
LAPSS	5	60.0	60.0	60.0

Figure 1. LVO Tool Comparison

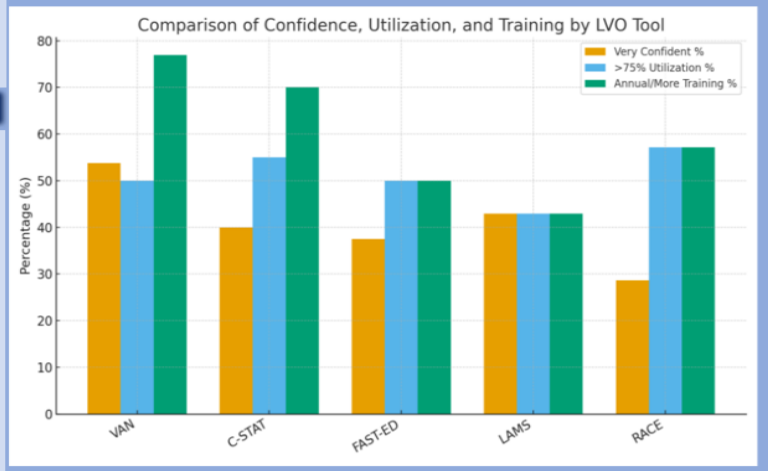


Figure 1. Comparison of EMS provide confidence, utilization frequency (>75%), and annual/more frequent training across five major LVO tools (VAN, C-STAT, FAST-ED, LAMS, RACE).

Figure 2. Stroke Screening Tool Comparison

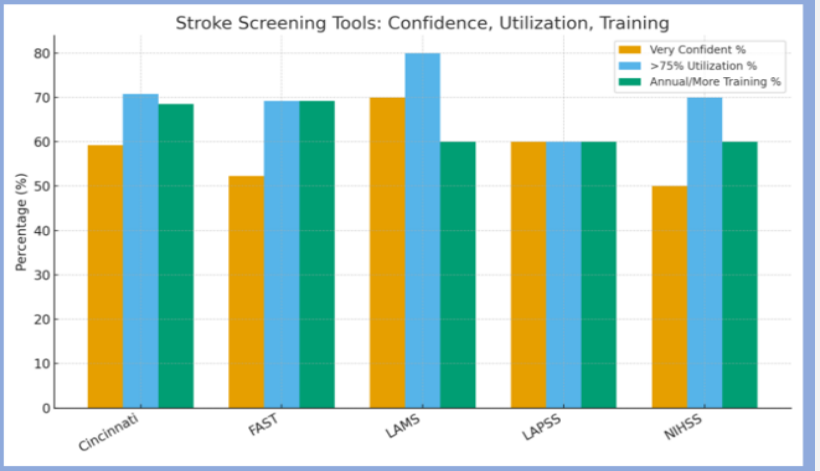


Figure 2. Comparison of EMS provider confidence, utilization frequency (>75%), and annual/more frequent training across general stroke screening tools (Cincinnati, FAST, LAMS, LAPSS, Boston).

Conclusions

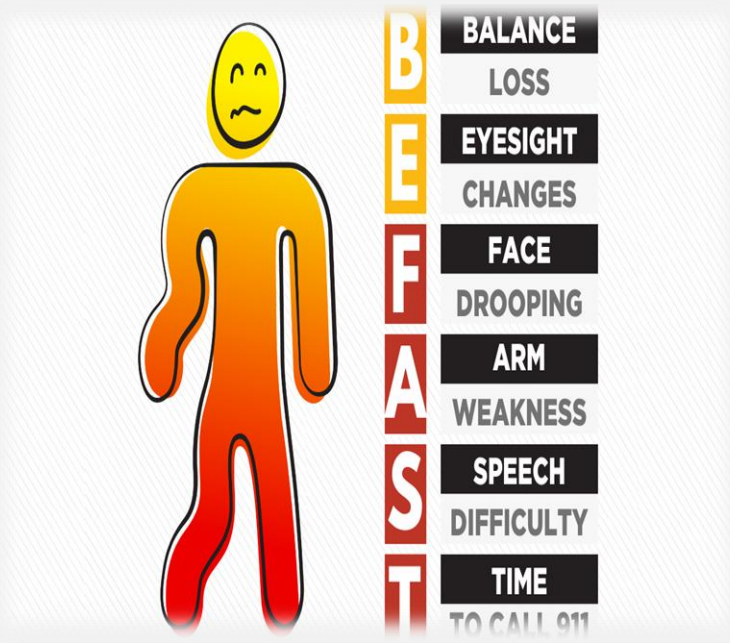
Confidence remains the strongest determinant of utilization for both stroke and LVO tools. Cincinnati was associated with the highest confidence and use among stroke screening tools, while VAN and C-STAT were most common among LVO instruments, albeit with lower confidence overall. These findings highlight an urgent need for standardized, recurring education on LVO tools to strengthen provider confidence and consistency. Improving training may enhance the reliability of prehospital stroke triage and ultimately improve patient outcomes.

GETAC Stroke Committee

- **Committee items presented for Council approval 08/2025:**
  1. Data request EMSTR for rural stroke approved by the stroke committee - APPROVED
  2. Pediatric resource document with recommendation to add edit for end tidal CO2- APPROVED
  3. Rural stroke survey- APPROVED
  4. Council approval for endorsed stroke resources to be on GETAC Stroke Committee website - APPROVED
  5. Approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs and at DSHS stroke meetings. - Differed
- **Committee items needing council approal:**
  1. Neuro IR coverage recommendation best practice
  2. Approval to promote - Mission: Lifeline EMS Recognition. Mission Lifeline EMS Stroke Recognition
  3. Texas Stroke Awareness Campaign and Rural Stroke Awareness Campaign
  4. 2026 GETAC Stroke Committee Priorities

Stroke Care Starts Before the Door

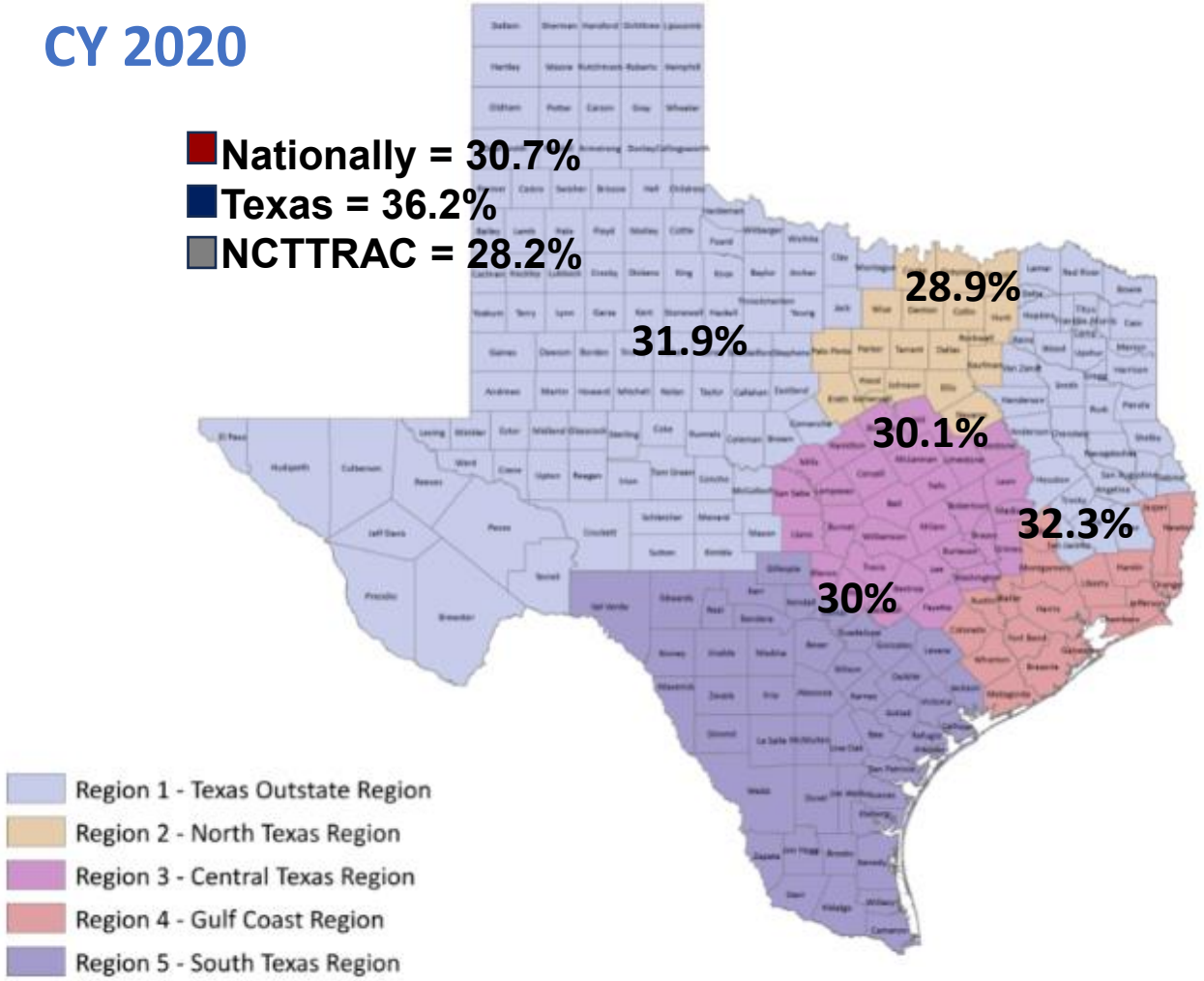
- **Recognition** of stroke symptoms is a critical first step in the access to treatment pathway.
- Early symptom recognition along with EMS **activation** contribute to reduced prehospital delays and faster higher-quality care.



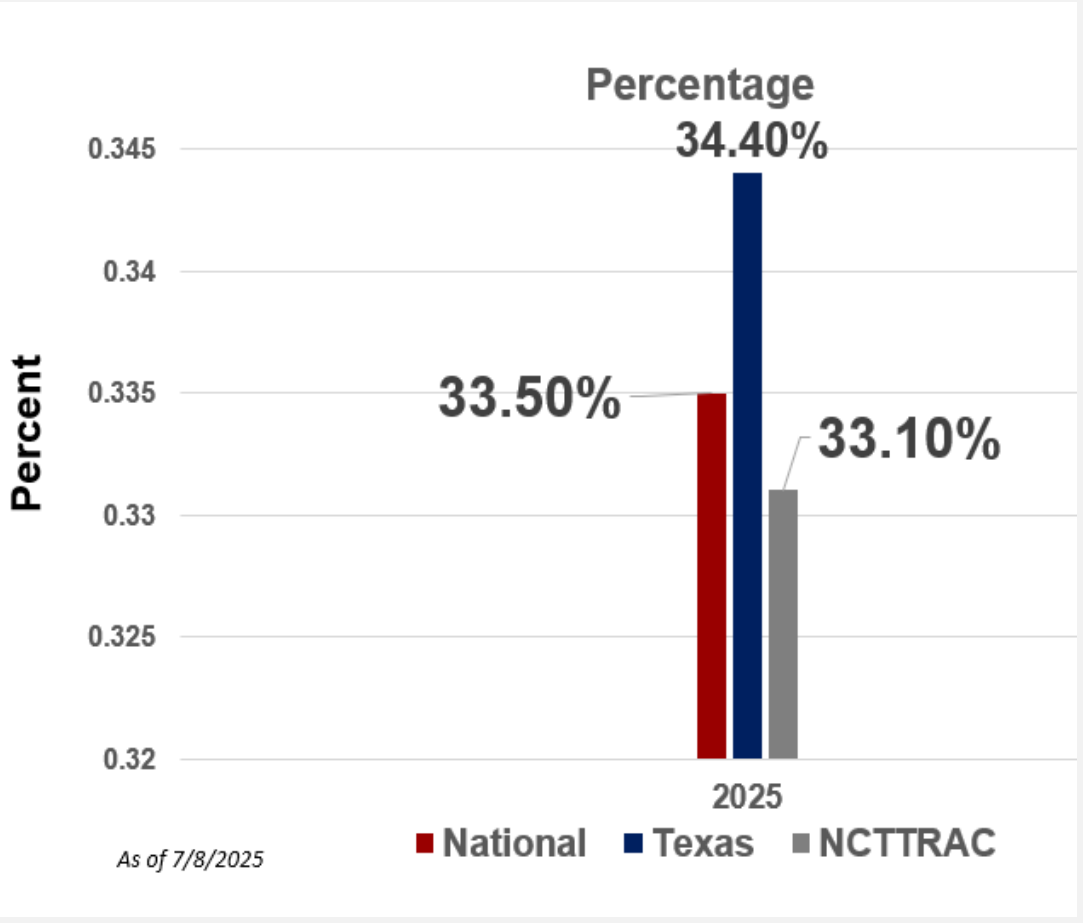
- Patel MD, et al. Prehospital notification by emergency medical services reduces delays in stroke evaluation: findings from the North Carolina stroke care collaborative (Stroke 2011).
- Ekundayo OJ, et al. Patterns of emergency medical services use and its association with timely stroke treatment findings from Get with the Guidelines-Stroke (Circ Cardiovasc Qual Outcomes 2013).
- Nielsen VM, et al. The Association between presentation by EMS and EMS prenotification with receipt of intravenous tissue-type plasminogen activator in a state implementing stroke systems of care (Prehosp Emerg Care 2020).

LKW to Arrival - % arrive within Thrombolysis window

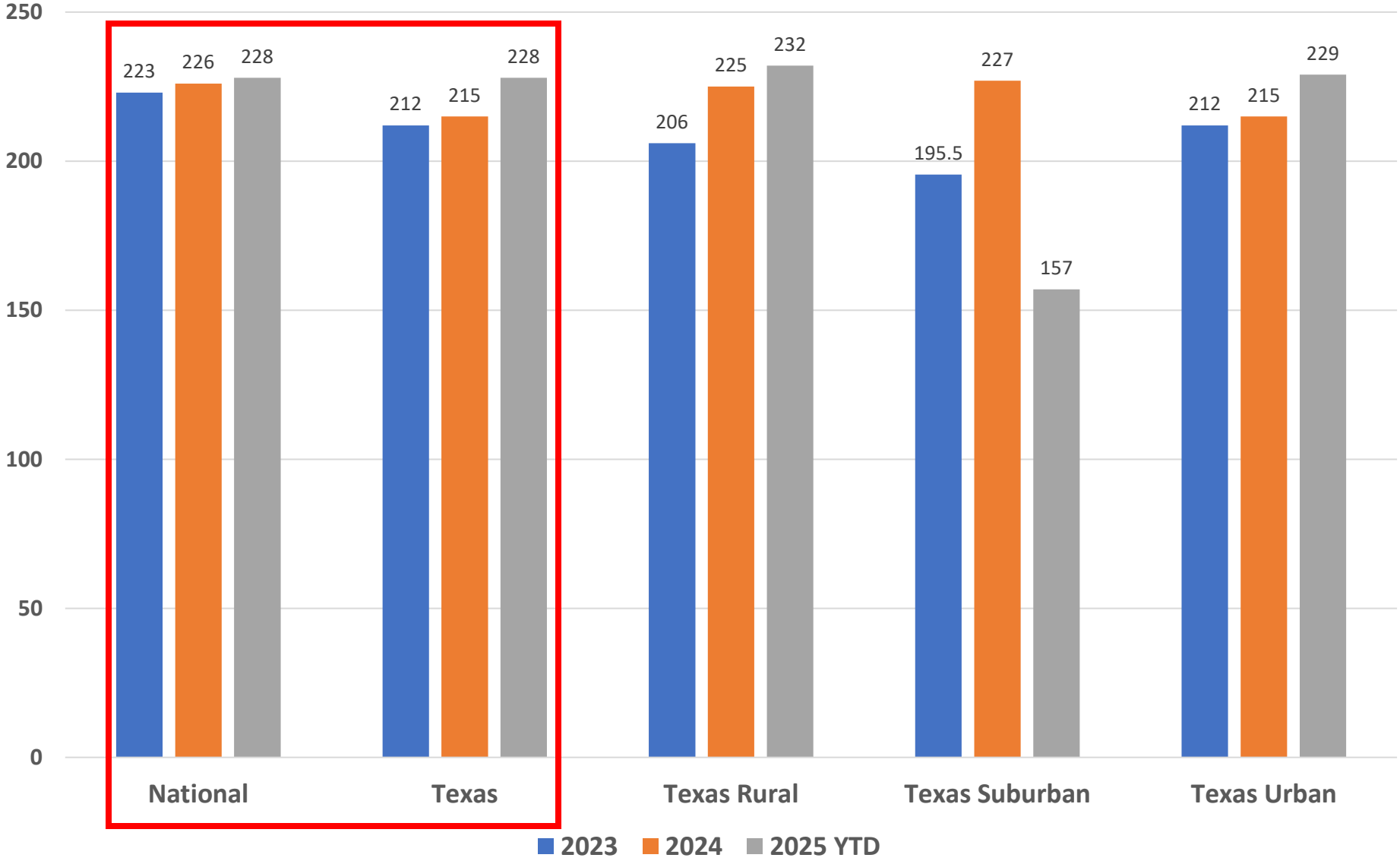
CY 2020



YTD 2025

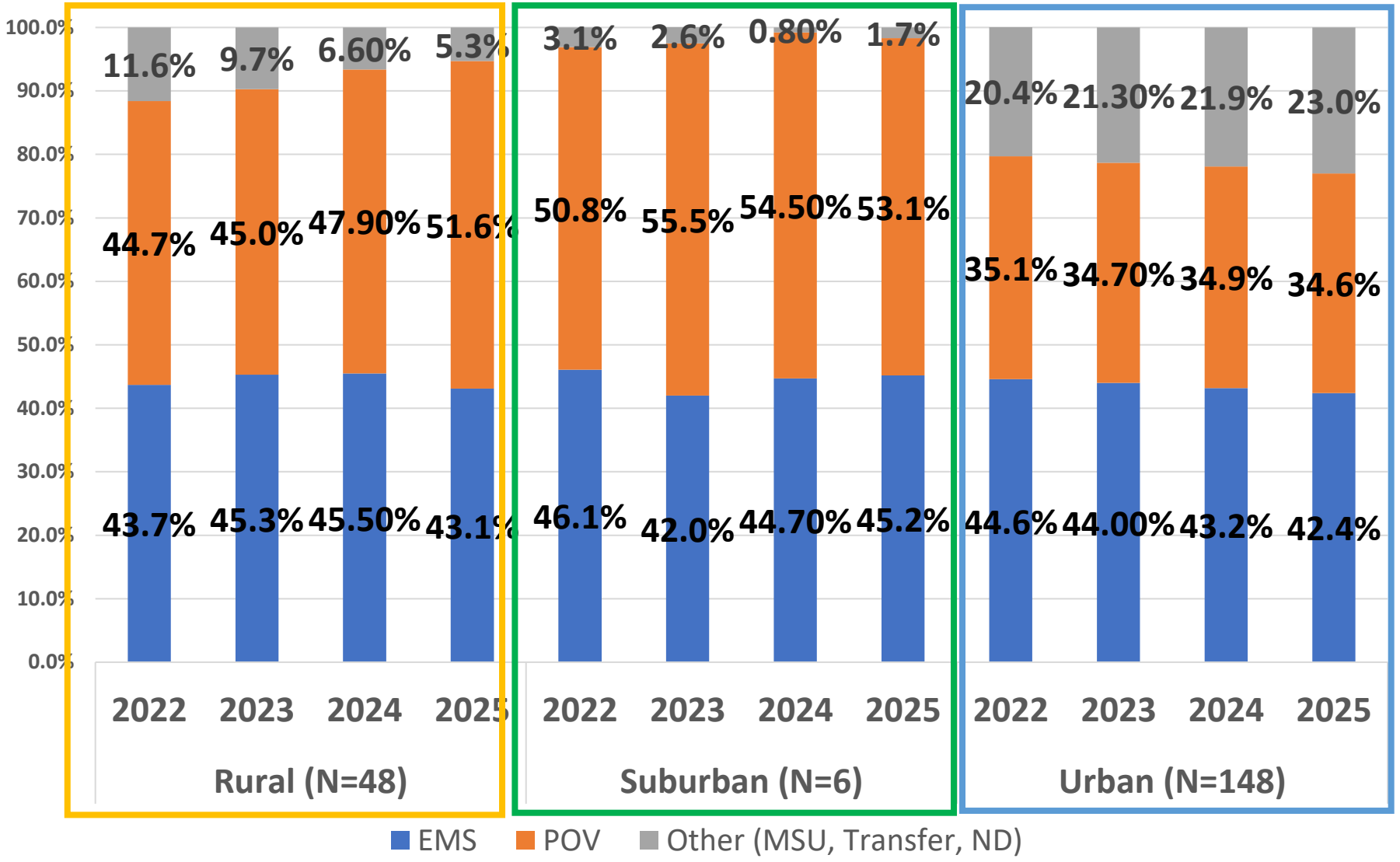


Median Time LKW to Arrival by Geographic Size



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 11/4/25.

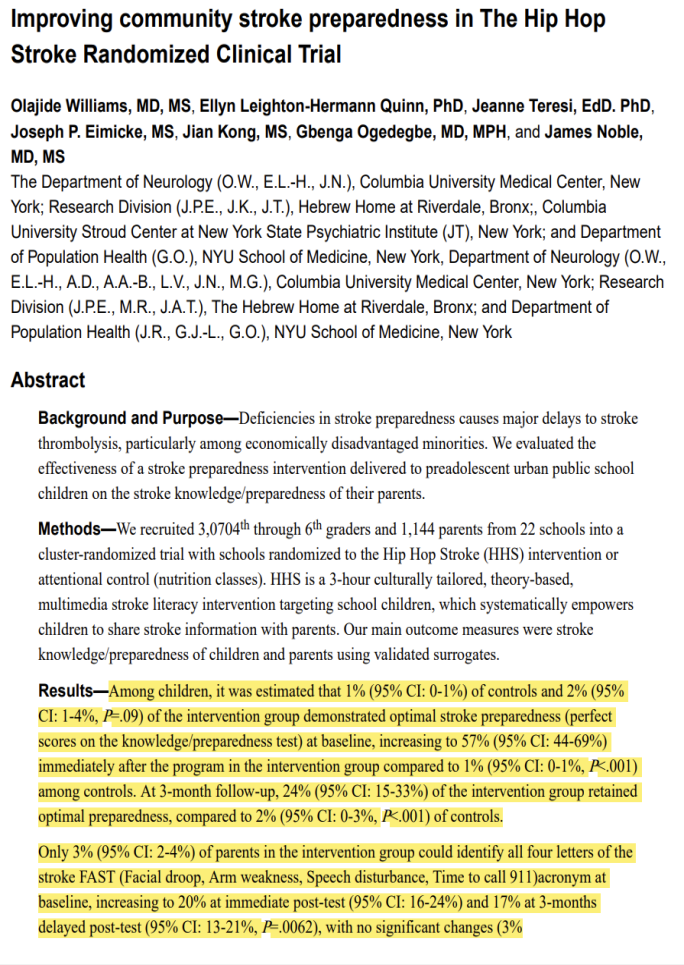
Texas Modes of Arrival to ED by Geographic Classification



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 11/4/25

Innovative Approaches

- **Stroke awareness campaigns** need to improve symptom recognition while emphasizing **rapid EMS response** targeting **multilingual** equity-oriented approach.
  - Massachusetts Department of Public Health
- Other innovative strategies include school-based programs such as Hip-Hop Stroke.



Improving community stroke preparedness in The Hip Hop Stroke Randomized Clinical Trial

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Abstract

Background and Purpose—Deficiencies in stroke preparedness causes major delays to stroke thrombolysis, particularly among economically disadvantaged minorities. We evaluated the effectiveness of a stroke preparedness intervention delivered to preadolescent urban public school children on the stroke knowledge/preparedness of their parents.

Methods—We recruited 3,0704th through 6th graders and 1,144 parents from 22 schools into a cluster-randomized trial with schools randomized to the Hip Hop Stroke (HHS) intervention or attentional control (nutrition classes). HHS is a 3-hour culturally tailored, theory-based, multimedia stroke literacy intervention targeting school children, which systematically empowers children to share stroke information with parents. Our main outcome measures were stroke knowledge/preparedness of children and parents using validated surrogates.

Results—Among children, it was estimated that 1% (95% CI: 0-1%) of controls and 2% (95% CI: 1-4%, *P*=.09) of the intervention group demonstrated optimal stroke preparedness (perfect scores on the knowledge/preparedness test) at baseline, increasing to 57% (95% CI: 44-69%) immediately after the program in the intervention group compared to 1% (95% CI: 0-1%, *P*<.001) among controls. At 3-month follow-up, 24% (95% CI: 15-33%) of the intervention group retained optimal preparedness, compared to 2% (95% CI: 0-3%, *P*<.001) of controls.

Only 3% (95% CI: 2-4%) of parents in the intervention group could identify all four letters of the stroke FAST (Facial droop, Arm weakness, Speech disturbance, Time to call 911)acronym at baseline, increasing to 20% at immediate post-test (95% CI: 16-24%) and 17% at 3-months delayed post-test (95% CI: 13-21%, *P*=.0062), with no significant changes (3%

- Williams O, et al. Improving community stroke preparedness in the hhs (hip-hop stroke) randomized clinical trial (Stroke 2018)

Emergency Medical Dispatcher Recognition

- **Dispatcher** recognition is a chokepoint.
- Sensitivity to accurate recognition is **~50%** without structured protocols.
- Caller language and the compressed call time hinder recognition, delaying downstream care.
- **Train call-takers with structured stroke prompts**; **target <60-sec dispatch.**

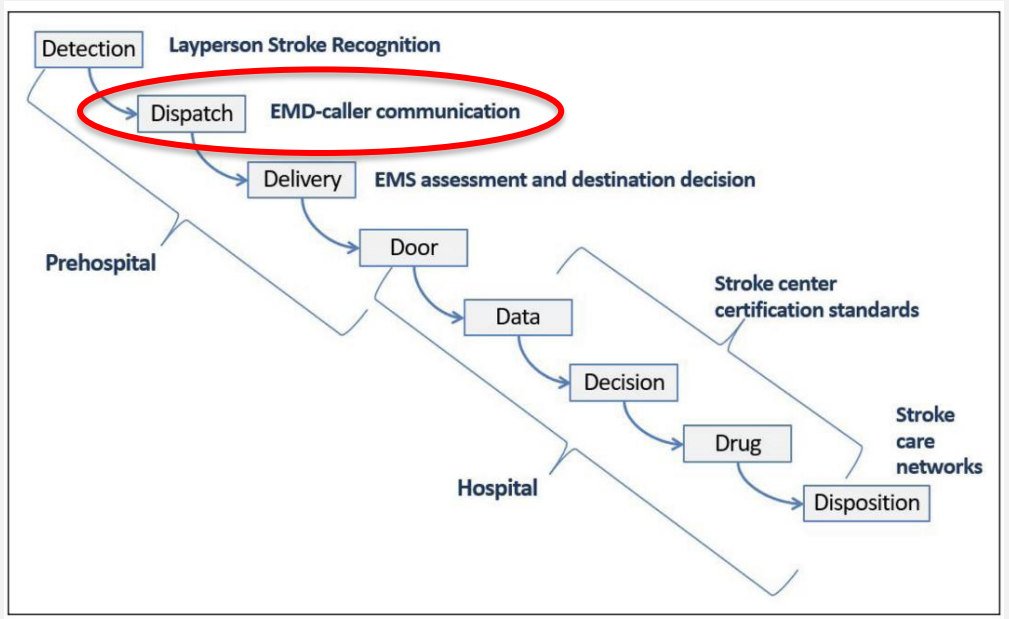

Figure. Stroke chain of survival within a systems of care framework.
EMD indicates emergency medical dispatcher; and EMS, emergency medical services.

- Zachrison KS et al. Prehospital stroke care part 1: emergency medical services and the stroke systems of care (*Stroke* 2023).

Emergency Medical Dispatcher Recognition

- Accurate dispatcher recognition has been associated with:
  - **Faster On-scene times** by responding paramedics
  - Higher rate transport to **stroke center**
  - **Faster Door-to-physician/CT**
  - Higher rate and **faster DTN**
- MSU may be particularly positively impacted accurate stroke dispatch.

TABLE 2. Prehospital and In-hospital Times by Dispatcher and EMS Provider Diagnosis

	Dispatcher Diagnosis			EMS Provider Diagnosis		
	Stroke/TIA $n = 232$	Other $n = 167$	P-value	Stroke/TIA $n = 230$	Other $n = 169$	P-value
Prehospital Time Intervals						
Call to scene arrival	7(5 – 10)	7(5 – 10)	0.553	7(5 – 10)	7(6 – 11)	0.195
On-scene time	17(12 – 22)	16(13 – 23)	0.890	17(14 – 22)	15(10 – 22)	0.011
Transport time	13(8 – 19)	13(8 – 19)	0.653	12(7 – 18)	15(10 – 21)	0.001
In-hospital Time Intervals						
Door-to-physician time, min	6(2 – 19)	6(2 – 20)	0.784	4(1 – 12)	11(3 – 27)	< 0.001
Door-to-CT time, min	27.5(17 – 51)	35(20 – 62)	0.010	23(16 – 37)	48(26 – 73)	< 0.001

Note: Data presented are medians with interquartile range in parenthesis. Wilcoxon Rank Sum used to test for differences between groups.

Abboud ME, et al. (Prehosp Emerg Care 2016)

TABLE 2 Dispatch practices according to suspicion of stroke by emergency dispatchers

	Suspected stroke/TIA N (%)	No suspected stroke/TIA N (%)	Unadjusted OR (95% CI)
Overall	2383 (56%)	1872 (44%)	
Ambulance dispatch priority[a]			
Lights and sirens (within 15 minutes)	2305 (97)	1111 (61)	Reference
Urgent (within 30 minutes)	46 (2)	507 (28)	**0.04 (0.03–0.06)**
Non-urgent (within 60 minutes)	32 (1)	205 (11)	**0.08 (0.05–0.11)**
Transport priority[b]			
Highest priority (time sensitive)	1289 (55)	800 (45)	Reference
Medium priority (non-time sensitive)	1057 (45)	980 (55)	**0.67 (0.59–0.76)**

Eliakundu AL, et al. (J Am Coll Emerg Physicians Open 2022)

Approval Item

- Texas Stroke Awareness Campaign
- Rural stroke Awareness Campaign
- Target dispatcher, first responders, layperson in Spanish and English

GETAC Stroke Committee

- **Committee items needing council approval:**
  1. Neuro IR coverage recommendation best practice
  2. Approval to promote - Mission: Lifeline EMS Recognition. Mission Lifeline EMS Stroke Recognition
  3. Texas Stroke Awareness Campaign and Rural Stroke Awareness Campaign
  4. 2026 GETAC Stroke Committee Priorities
- **Action items for the next session:**
  1. Pediatric stroke tip sheet and supplement – 03/2026
  2. DIDO Best Practice Recommendation – 03/2026
  3. Rural Stroke Work Group recommendation on best practice 2026

Stroke Committee

- **Committee items needing council guidance**
  1. None at this time

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

- **Items referred to GETAC for future action**
  1. None at this time