Organizational Updates

American Stroke Association Stroke Council Update

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This new feature in the journal Stroke is intended to update readers at least yearly about activities within the AHA/ASA. Although clinical and laboratory science are the focus of ASA’s flagship journal, Stroke, there are many other critical issues related to stroke and the mission of the ASA/AHA, such as improving cardiovascular and brain health, public education, delivery and access to stroke care in the United States and worldwide, advocacy and funding for research, and political and societal engagement, which are all critical to accomplishing our goals.

AHA/ASA and the Stroke Council
The American Heart Association/American Stroke Association (AHA/ASA) is a nonprofit organization dedicated to reducing the burden of death and disability from heart disease and stroke. It advocates, funds research, and provides professional and community education to accomplish these goals. There are 2 distinct arms of the AHA/ASA: local and national. Both have ample opportunities for physician volunteerism and require that involvement to be successful. The local chapters are engaged in community education, fundraising for research, policy implementation (eg, stroke systems of care), and local implementation of quality programs such as Get With the Guidelines. The National organization provides peer review for research grants, hosts the International Stroke Conference and other national conferences, and sets the policy and advocacy agenda. All of these functions require physician and allied health engagement, which is provided through the Scientific Councils. The Stroke Council is 1 of 16 Councils in the AHA/ASA. It is unique among the councils owing to its enormous scope ranging from basic and clinical research to clinical efforts for stroke prevention, treatment, and recovery. In addition, the pathogenesis of stroke is diverse. As a consequence, it is probably the most diverse council in terms of different medical specialties and allied health professionals. It is one of the largest councils with >4700 members.

The Stroke Council is charged with providing scientific direction and input to help guide the AHA/ASA accomplish its goals, which are defined with input by council members serving on various National committees. Within the Council there are several committees charged with important functions. The Stroke Council Scientific Statement Oversight Committee fosters the timely generation of the 6 core AHA/ASA Stroke Guidelines (Primary Prevention, Secondary Prevention, Subarachnoid Hemorrhage, Intracerebral Hemorrhage, Rehabilitation and Recovery, and Acute Ischemic Stroke) and other Scientific statements related to stroke. Other important Council subcommittees include the Emergency Neurovascular Care Committee, the Early Career Committee, the Stroke Rehabilitation and Recovery Committee, the Professional Education Committee, the Quality of Outcomes Committee, the Minority Affairs Committee, the Stroke Nursing Rehabilitation and Professions Committee, the Stroke Performance Measures Oversight Committee, and the Telestroke Committee. These committees help to identify key areas for research or advocacy and encourage the engagement of important but underrepresented medical professionals that are critical to the AHA/ASA mission.

Major AHA/ASA Initiatives

1. 20/20 Goals: In 2010, the AHA/ASA described the 10-year goals for the organization shared by the Center for Disease Control: “By 2020, to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%.”

2. Million Hearts initiative in partnership with the Center for Disease Control: The goal of the Million Hearts initiative is to prevent 1 million heart attacks and strokes for the next 5 years.

3. Educational Activities:
   a. AHA/ASAs My Life Check–Life’s Simple 7: Improvement in cardiovascular and cerebrovascular health and mortality is dependent on primary and secondary prevention through model health behaviors. The message behind Life’s Simple 7 is to create awareness of the community about those factors that are considered ideal health behaviors that can be modified for ideal health. These behaviors include nonsmoking, body mass index <25 kg/m², physical activity at goal levels, diet that is consistent with guideline recommendations, total untreated cholesterol <200 mg/dL, untreated blood pressure <120/80 mmHg, and fasting blood glucose <100 mg/dL. The community is encouraged to use these metrics to understand where they are in attaining ideal health. Healthcare professionals are encouraged to tell their patients to get involved with Life’s Simple 7 to measure their health status and to try to help them move to higher levels toward ideal health. The AHA has a website for the community to log on and take the Life’s Simple 7 assessment. Participants can assess and monitor their health using this tool. See link: http://mylifecheck.heart.org/Multitab.aspx?NavID=3&CulturCode=en-US.
b. Communication about stroke warning signs to public: This year ASA launched Together to End Stroke initiative, with the goal of teaching Americans that stroke is largely preventable, treatable, and beatable. This initiative focuses on warning signs education, including the Spot a Stroke FAST Ad Council public service announcement Campaign (Face Drooping, Arm Weakness, Speech Difficulty, and Time to Call 911) and Healthcare professional-community activation through the new Web Resource Center (StrokeAssociation.org/resources). The Spot a Stroke FAST campaign was launched with the Ad Council in the November 2012. This campaign is designed to educate the public on the most common signs and symptoms of stroke, and to tell them what to do if stroke is suspected. The FAST acronym is used for media/public education (public service announcements) venues, whereas the SUDDENS is still used for Web/print explanations to detail the other signs and symptoms stroke. In addition, we are integrating FAST messaging in Hispanic and Multicultural Initiatives. Other key priorities of the Together to End Stroke Platform are (1) prevention: the heart and brain connection, and integration of Stroke in AHA events/organizational messaging; (2) stroke is beatable: the ASA is developing a poststroke support program for stroke survivors.

4. Strategic Planning and Collaborations

a. Update to AHA/ASA strategic plan is ongoing and the Stroke Council is playing an active role: The leadership of the Stroke Council is actively participating within the larger AHA organization to craft a new strategic plan. This process is nearing completion and will be the focus of a future update.

b. The National Institute of Neurological Diseases and Stroke (NINDS) Stroke Trials Network: In 9/2013, the NINDS funded a new stroke trial network consisting of a national coordinating center, a data management and statistical center, and 25 regional stroke centers throughout the United States. As part of this process, the AHA/ASA has committed to assist the network in recruitment efforts and in the use of the Get with Guideline Registry at participating regional sites to help assess the feasibility of proposed trials for the network. In addition, the AHA/ASA continues to advocate politically for increasing stroke and heart research funding through the National Institutes of Health (NIH).

c. The World Stroke Organization (WSO): The AHA/ASA has partnered with the WSO in offering Stroke Council Members an opportunity to join the WSO and the WSO is offering its membership the opportunity to join the AHA/ASA Stroke Council.

d. Center for Medicare and Medicaid Services (CMS): There has been a strong push by the government and society for high-quality healthcare and stroke is no exception. CMS was tasked to develop quality measures for stroke care at US hospitals. The measurements chosen were 30-day mortality after ischemic stroke and 30-day readmission rates, and models were developed to assess hospital performance. Unfortunately, these models did not include the severity of stroke at baseline, by far the most important determinant of stroke mortality and outcome. Currently, stroke severity is not captured in the CMS administrative database. Data from several sources, including from Get with the Guidelines, clearly show that failure to include stroke severity in a model leads to substantial misclassification of hospitals when comparing stroke mortality. For example, it is expected that primary and comprehensive stroke centers would be most likely to have the most severe strokes and have higher stroke mortality rates, as compared with smaller hospitals who keep more straightforward and less severe patients. An advisory group of stroke experts to the CMS, the AHA/ASA, and other physician-led organizations, such as the American Academy of Neurology, strongly discouraged the Center for Disease Control to implement a measure with substantial limitations. Despite lack of approval by the National Quality Forum and because of strong political pressure to have some stroke measure, the CMS is implementing the measure of stroke mortality without stroke severity. They have agreed to work with the AHA/ASA to improve the measurement and model. However, this is an extremely important political issue for all stroke physicians and hospitals that care for large numbers of patients with stroke and ASA members should be vocal and active on this issue with their governmental representatives.

e. Comprehensive Stroke Center Certification: In collaboration with the Joint Commission, the AHA/ASA has implemented comprehensive Stroke Center Certification as a next step after the major success and growth of primary stroke centers throughout the United States. As of September 2013, 56 centers have been certified as comprehensive stroke centers.

5. Research Focus:

a. Bugher Centers: The Bugher Foundation generously gave >9 million dollars to fund the next round of Bugher Centers for several years. This is the fourth round of funding the Bugher Foundation has given to the AHA/ASA for Stroke research. Currently, applications are in the review process. The intent is to have the 3 Bugher Stroke Centers up and running by the summer 2014. This initiative is intended to cover basic, clinical, and population stroke science and to address recovery after stroke including repair, regeneration, neuromodulation, and rehabilitation in addition to prevention.

b. New structure for research funding within AHA overall: The AHA/ASA has re-examined their approach to research funding overall and we will be starting to see this implemented within the upcoming years. More information can be found at: http://my.americanheart.org/professional/Research/Research_UCM_316889_SubHomePage.jsp.

This recurring contribution to Stroke will provide the reader with important ongoing activities in the Stroke Council and the AHA/ASA at large. The AHA/ASA is highly engaged to accomplish our mission and goals. We encourage all of our members to be active, not just in scientific and clinical activities, but in community, societal, and political efforts within the AHA/ASA and beyond to decrease the burden of stroke and heart disease. We welcome your feedback and engagement.
Disclosures

Dr Broderick is Principal Investigator of UC SPOTRIAS Center (includes NINDS-funded CLEARER and STOP-IT Clinical Trials), NINDS-funded Familial Intracranial Aneurysm (FIA) Study, and NINDS-funded T-32 Cerebrovascular Fellowship Training Program for Cerebrovascular Disease. Coinvestigator of NINDS-funded Genetic and Environmental Risk Factors for Hemorrhagic Stroke, NINDS-funded “Comparison of Hemorrhagic and Ischemic Strokes Among Blacks and Whites,” NIH Point of Care–Care Center for Emerging Neurotechnologies, and NINDS-funded IRIS Trial, CREST, ALIAS, and SWISS studies and has been Principal Investigator of NINDS-funded IMS III Trial. He received support from Genentech, Inc, alteplase for NINDS-funded CLEARER, IMS III trials; educational grant to the American Academy of Neurology for 2012 annual meeting program 2 AC.007 “What’s in a Stroke Center: Members, Services, Organization and Roles,” which he directed and is a member of the Executive Committee for the PRISMS study research grant. He received drug for NINDS-funded STOP-IT trial from Novo Nordisk, catheter devices for IMS III clinical trial from EKOS Corporation, drug for NINDS-funded CLEARER Trial from Schering Plough, a honorarium for participation in Data Safety and Monitoring Board from PhotoThera, in consulting fees from Pfizer, Inc, as a scientific advisor, and in consulting fees from The George Institute for Global Health as a scientific advisor. Dr Jauch’s disclosures include NIH Research support NINDS, Data Safety and Monitoring Board for FASTMAG Study, Novo Nordisk Research support Novo with drug in kind for STOP-IT, Genentech Executive committee for PRISMS Study, Toshiba/Covidien/Stryker/Penumbra, Executive committee for POSITIVE Study, Dr Derdeyn’s disclosures include W.L. Gore and Associates (Scientific Advisory Board and Consultant), Microvention, Inc (Angiographic Core Laboratory for clinical trial), Penumbra, Inc (Data Safety and Monitoring Board member for clinical trial), Silk Road, Inc (Data Safety and Monitoring Board Chair for clinical trial), and Pulse Therapeutics (Chair, Scientific Advisory Board).

References


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