This report represents the Spring 2014 update of the Stroke Council. Much has happened in the past 6 months, and we want to particularly focus on the new strategic plan for the American Heart Association (AHA)/American Stroke Association (ASA) and new research opportunities within the AHA/ASA.

Goals and Strategic Plans to Get There
Each Stroke Council Update starts with restating our 2020 Goals: By 2020 to improve the cardiovascular health of all Americans by 20% while reducing deaths from cardiovascular diseases and stroke by 20%. To reach this goal, the AHA/ASA has worked hard, with input from throughout the organization, to craft the next detailed strategic plan for the AHA/ASA, including the strategic plan for the ASA that will be distributed throughout the organization in the upcoming months. One issue became apparent while reviewing the strategic plan for AHA/ASA: stroke rehabilitation and recovery are not emphasized currently in the Strategic Plan for the AHA as they deserve. In part, this reflects more limited research data and metrics available for assessing the effect of various approaches to stroke recovery compared with extensive research and public data about cardiac rehabilitation. Our stroke strategic plan must prioritize increasing engagement and advocacy for stroke recovery and rehabilitation. For example, in March, Congress passed another temporary fix to the Medicare therapy caps. They extended the exceptions process for 1 additional year (through March 31, 2015). This process allows stroke survivors on Medicare to get more outpatient therapy than the $1920 caps allow but only if their healthcare provider jumps through additional hoops to get those services covered. Although this short-term fix is good and is a direct result of advocacy from many stroke-related organizations, a long-term fix to Medicare therapy caps is paramount, and advocacy by all of us will be needed to ensure a long-term solution.

Another strategic focus is to increase research on the best methods to enhance recovery and rehabilitation after stroke, as well as the best methods for transitions of care from the acute hospital to various subacute and long-term settings. Although this research is ongoing, we must continue to advocate at the regional and national level to protect our patients’ ability to receive physical, occupational, and speech therapy after stroke. For those who are interested in working in this area, please contact Stephanie Blackmon, Project Coordinator at the ASA.

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Engagement, Accomplishments, and Pressing Issues
The AHA Stroke Council is a large international organization with 3177 domestic members across 50 states and 719 international members from 62 countries. We are working to grow both our US and international membership. The success of the AHA/ASA is driven by our members and community supporters. This includes donations of time, talent, and financial resources. We want to personally thank all of the members of the Stroke Leadership Council for 100% participation in terms of financial support of the AHA/ASA this year. This is in addition to their larger contributions in terms of time in participation in the various committees.

One of the major goals of the ASA is education of our members and the stroke community in general. In 2013, we published the update to the Guidelines for the Early Management of Patients With Acute Ischemic Stroke and 2 other scientific statements (Factors influencing the Decline in Stroke Mortality and An Updated Definition of Stroke for the 21st Century). To date in 2014, the Stroke Council has published 2 guidelines (the updated Guideline for the Prevention of Stroke with Transient Ischemic Attack and the new Guideline for the Prevention of Stroke in Women), as well as 3 scientific statements (Recommendations for the Management of Cerebral and Cerebellar Infarction With Swelling, Stroke Outcomes Measures Must Be Appropriately Risk Adjusted To Ensure Quality Care of Patients, and Palliative and End of Life Care in Stroke). In addition, there are 9 guidelines or scientific statements and 2 stroke performance measures manuscripts currently in progress for 2014.

These guidelines and scientific statements address important and sometimes controversial topics that affect our daily practice as healthcare professionals and impact public health. The stroke in women statement generated a great deal of media interest and was extremely successful in promoting the message of risk factor reduction. The scientific statement in the January issue of Stroke about mortality and readmission measures for stroke has particular relevance for all stroke physicians and hospitals who admit patients with stroke.1 A Presidential Commission paper from the ASA on same topic was published in February 2014.2 As mentioned in the last Stroke Council Update, there has been a strong push by the government and society as a whole for high-quality healthcare
and stroke is no exception. Center for Medicare and Medicaid Services (CMS) was tasked to develop quality measures for stroke care at US hospitals. The measurements chosen by CMS were 30-day mortality after ischemic stroke and 30-day readmission rates, and models were developed to assess hospital performance. These models did not include baseline stroke severity that is not currently present in the CMS administrative database and which is by far the most important determinant of stroke mortality and outcome.\(^3,4\) However, CMS measurement of hospital performance by these measures has begun, and these data will be publicly reported. It is expected that primary and comprehensive stroke centers, particularly those in urban centers with disadvantaged populations, would be most likely to have the most severe strokes and have higher stroke mortality rates compared with smaller hospitals that keep more straightforward and less severe patients. CMS has agreed to work with the AHA/ASA to improve the measurement and model. However, this is an extremely important political issue for all physicians, caregivers, and hospitals in the United States that care for patients with stroke. ASA members should be vocal and active on this issue with their governmental representatives.

The International Stroke Conference Scientific Sessions and preconference meetings in San Diego were a huge success with the second largest number of attendees on record (4860). The Emergency Stroke Care symposium had a record 524 attendees, and a new preconference symposium for students/trainees/early career laboratory scientists had 100 attendees.

**New Research Opportunities**

**The National Institutes of Health StrokeNet**

The National Institutes of Health (NIH) has created the NIH StrokeNet to conduct small and large multicenter clinical trials and research studies to advance acute stroke treatment, stroke prevention, and recovery and rehabilitation after a stroke. This network of 25 regional centers across the United States, which involves >200 hospitals thus far, is designed to serve as the infrastructure and pipeline for exciting new potential treatments for patients with stroke and those at risk for stroke. In addition, NIH StrokeNet will provide an educational platform for stroke physicians and clinical trial coordinators. The National Coordinating Center for the network is at the University of Cincinnati, and the Data Management Center is at the Medical University of South Carolina. A large proportion of NIH Regional Centers are already part of the Get With the Guidelines Stroke Network and the ASA, and the NIH StrokeNet leadership will be working on ways to leverage Get With the Guidelines Stroke with the new NIH StrokeNet research network.

**Stroke Focused Research: Bugher Foundation Funding for Bugher IV**

The Henrietta B. and Frederick H. Bugher Foundation is the most generous research donor in AHA/ASA history, working with us for ≈30 years to further stroke research. The latest initiative is the American Stroke Association-Bugher Centers of Excellence in Stroke supported by a grant of >$9 million.

The next 3 research centers have been named: the University of California at Los Angeles, the University of Colorado at Denver, and the University of Miami. The 4-year awards will be activated in April 2014, providing for the 3 centers and training for 12 two-year research fellows. The centers will work collaboratively to accelerate scientific progress and stroke knowledge. Their new projects cover a wide aspect of stroke research, including stroke rehabilitation and recovery, secondary prevention, neuropsychology, neuroimaging, pediatric stroke, cognition after stroke, and basic science.

**Cardiovascular Genome-Phenome Study**

In November, the AHA announced an unprecedented research partnership with the University of Mississippi and Boston University, which is now formally named the Cardiovascular Genome-Phenome Study (CV-GPS). This new collaborative has the potential to transform current approaches to identify and assess risk and ultimately enable more effective and individualized treatments for cardiovascular disease and patients with stroke. During the next 5 years, the AHA will provide $30 million in funding to support CV-GPS, a portion of which will be dedicated to competitive grants. Stroke and cardiovascular investigators will be encouraged to submit grant applications.

**Summary**

The AHA/ASA success in reaching our stated goal depends on all of us. 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. For those who are interested in becoming more involved, please contact Veronica Zamora at 214-706-1487 or veronica.zamora@heart.org. You may also complete a volunteer involvement form via our Web site, www.my.americanheart.org/strokecouncil.

**Disclosures**

None.

**References**


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