Maine Stroke Alliance Meeting

April 24, 2018, 9:30-11:30 AM-Maine EMS Location

MINUTES

Present: Tina Love (MCDPH), Rick Petrie (APEMS), Pete Tilney (CMMC/LFOM), Diane Campbell (MCDPH/MCHC), Jane Morris (MMC), Dottie Carroll (MGMC), Merica Tripp (RH&PCP), Deborah Gregoire (MMC), Tho Ngo (MMC), Angela Wheelden (EMMC), Gillian Gordon-Perue (EMMC), Don Sheets (MEMS), Kate Zimmerman (MEMS), Shaun St. Germain (MEMS), Corey Fravert (MMC)

On Phone: Nicki Van Loan (Bridgton), Becky Smith (AHA), Kelly Collins (MCMH), Jennifer Green (MGMC), Dave McDermott (Mayo Hospital), Lisa Bemben (AHA), Kalyn Horst (AHA)

Agenda Item	Discussion	Follow-up/Recommendations
Welcome/Introductions		
Approval of Minutes	A motion was made and seconded to accept to February 5th minutes as written.	
Follow-up from Minutes	<u>AHA Tristate Med Dir Mtg</u> Matt was unable to join us today but Kate shared that there was a brief phone call of this group during Grand Rounds at MaineGeneral – will talk more about this when Matt is able to attend. <u>AHA Tristate Stroke Coordinator Mtg</u> Dottie reports there was a call last week. Discussion centered around challenges of new standards and how to implement them esp. around VTE prophylaxis. Not using pharmacological but all mechanical- hard sell. Jane states they have not changed practices at this point – will want to look at the data more. Gillian reports they changed their order sets and the default is now the sequestian compression devices (SCD), TEDs were removed. Gillian pointed out there was a correction to the new guidelines printed April 18th (edition of ***Stroke)*** showed where whole sections were removed. Some changes included the dysphagia screen and the BP screening. Gillian needs to review more. One section for EMS Systems that has been changed (no evidence for time for bypass), everyone needs to look at. Gillian and Jane advise the group to be cautious before changing practice as these guidelines are still evolving. There are lots of questions from the stroke community.	Homework – check out the new Stroke guidelines.

	<u>Transfer protocol Mtg</u> Matt, Kate, Pete, and Norm planned to meet to discuss the transfer protocols but have not had an opportunity to meet yet. A short discussion did take place around tPA. They acknowledge there are needed protocol revisions to be done.	
Alteplase vs Tenecteplase	A discussion was held regarding Alteplase vs Tenecteplase. Tenecteplase is half the cost of Alteplase, even the labor is cheaper as it is not an infusion but a bolus. Note the dosing is also different however it gives people options. However, we need to standardize for the state. Jane reminded all that Tenecteplase is not FDA approved for stroke – it is an off-label use – but patients can get a thrombectomy an hour sooner using it. Pete shared that Lifeflight has a set of protocols to be used post-thrombolytics (transfer order set). Discussed potential delays in transferring patients depending on staffing. Local hospitals will have to make a decision on whether they would use Tenecteplase in stroke, we couldn't mandate it. Although it is commonly used for STEMIs. Recommendation could be that we will all use the FDA approved method first, but that Tenectoplase may be an option with extenuating circumstances to prevent patient transfer. EMS has to wait for infusion to end before transporting unless staff from the sending hospital is available to go with the transport. No delay with Lifeflight transport due to medication administration but can be a delay with all other EMS services. LVOs – need to get to the hospital fast. Possibly use a small hospital as a pilot site. Don't want to have to wait an hour for the infusion to be administered, maybe use Tenecteplase instead. We will discuss this at our next meeting in July.	Discussed exploring more to see if a smaller hospital might consider this discussion. Next step – Jane suggested a small workgroup to see if someone can pilot, a smaller remote hospital such as Pen Bay. Jane will bring up at next tele-stroke steering committee meeting.
MeCDC Update	Merica Tripp (in attendance for Nicole Breton from the Office of Rural & Primary Health) indicated that within the last two weeks the Federal Office announced $2 million available to states for the Flex EMS sustainability project. Considering the amount of states that would be interested in this, Maine submitted a letter of intent to support. Hopefully this will increase the participation in the project and the coordination – There is a quick turnaround time to submit applications – applications are due May 18. Merica may be reaching out to some of you for info. We have a good feeling about this but no guarantees. This could provide up to $48,000 for the stroke group for at least one year. There is the possibility of consecutive years of funding. Should know by June if the Letter of intent was accepted. August 1 is the approval date with funds starting in September for 1 year. The funds could support a statewide stroke coordinator, network and share resources, data collection, implementation of surveys & assessments (state-wide stroke survey done already). Feds like to see the coordination and the surveys we have already done as a group. It could also support certification and CT tech training on equipment (but	Email any comments or priorities to merica.a.tripp@maine.gov

	not equipment purchase). Open to all states, 41 states trying for it, but no guarantees.	
Data metrics/Stroke Data Base	Any time you look for funds you need data metrics. Jane created a Data Request Proposal and picked what she thought were good data metrics. She also talked to Matt Scholl about what he is already collecting and what is not being collected. The proposal was reviewed and is attached and includes comments from Matt. EMS is already collecting the top data but could add transfer information. Data collection needs to be a part of the future focus of this group. RACE score – will be training on it but not using yet. Once we do, we will need to collect the scores. Tim from Maine EMS runs the database. It was asked if we can add anything. There is a stroke module that could be added to the EMS data being collected. May be some cost to add additional info/modules to the database. Need to collect this info on all stroke runs. Need education and then collecting of information on RACE scores, Routing, TPA, timeframes (importance of getting last known well vs time found), importance of contact info. Mandate this is all the info required for a stroke run. Reviewed the metrics- Jane outlined the 3 tPA questions to add, clarifying that EMS is not analyzing the data- just collecting and reporting to ER who will then decide what to do with info. The tPA questions are: • Has the patient had any trauma or surgical procedures in the last 3 months? (document what it was and when) • Has the patient had any bleeding problems in the past? If yes, what was it and when did it occur? • Is the patient taking any anti-coagulants including orals and injectables? If YES, what are they and when was it last taken? Kate shared there is a Maine EMS (MEMS) stroke protocol she will share. Don said it is new and not sure all sites have it fully implemented yet but all have been trained. Not currently documented like this in their current run report. Some hospitals don't have a "code stroke" protocol. These words make a difference – everything moves faster. Important for all hospitals to recognize the "code stroke" protocol and have one if they do not. Have them start tracking door in/door out or door in/needle time. Want to resemble STEMI care. We need to build resources for them. Many hospitals don't even have a neurologist so shared protocols and order sets would be beneficial. EMHS will be doing quarterly calls with sending hospitals. Helping them identify code stroke team, provider/nurse. EMHS built own "Code stroke" database for data to be inclusive of all coming in with stroke using Access database. Still using Get with	 Updated- Data Metrics info for Stroke MEMS to look at pricing to add metrics and a stroke module to their current database. Kate will send us a copy of the current MEMS stroke protocol. Don to clarify terminology used in database

	the Guidelines but is more a retrospective view and does not include those where stroke was ruled out. Discussed how staffing changes also a challenge with protocol implementation. Interfacility transfers: Discussed time of notification - the difference between time dispatch is notified vs when the ambulance is notified by dispatch. Need to decide what metric we would want or both? Door in and door out information has been noted to be a big challenge. Gillian and Angela have been meeting with EMHS hospitals to discuss transfers. tPA transport: Not currently collected but to capture data listing if they received tPA at sending hospital or was given during transport. Jane shared they have new Telestroke packets that have been distributed to all MaineHealth hospitals. It was asked if EMS runs any specific reports for stroke. They replied that they have the availability to do so, but don't collect it by diagnosis as a routine. Discussed the UTAH tool kit and the project which was led by the Dept. of Health in Utah that collected the data from a variety of sources (EMS-Hospitals) to have full reports. Discussed options and looking at using ImageTrend (MEMS database) as the foundation for the database. Unfortunately MEMS indicated that they have not had a lot of success so far in pulling in data from other sources for cardiac arrest info. ImageTrend is set up for individual data entry not large data transfers. Discussed it would be costly to get hospitals systems to connect information with ImageTrend. Discussed having the grant include data collection from critical access hospitals in Maine who have limited resources/support (no stroke coordinators). Rick shared they have been trying to get data from smaller hospitals for trauma for about 20 years but the push back has been that they do not have the staff to enter in the data. Suggested we should talk with the hospitals first to find out if we give a database to them, will they be able to enter the data. Don't want to waste resources. Discussed having a position where someone could go into the hospital to collect the data. Discussed current systems in hospitals for EMRs: MMC-Epic and CMHC & EMHS- Cerner. Another challenge in the EMR is terminology different (ie "numbness/tingling vs paresthesia"). Information in narrative	Suggested MEMS start to pull report on "suspected stroke" to then use that data to look back to see if in fact it was a stroke.

	not in specific fields so again difficult to collect. Suggested having staff person to collect data not just for stroke but also trauma and STEMI, for quality data. You need to be a partner organization in order to receive this program at no cost. Discussed database built by Vanderbilt- called Red Cap –generates reports, customizable. Dept of Health in Mass. (Coverdale grant) listed a position for statewide stroke quality improvement specialist who will work with hospitals to ensure entering stroke data and providing technical assistance. Something to think about funding for this type of role. Lack of consistent data from rural hospitals is an issue. We need to get resources at the front end. The problem is staff turnover and grants end. So no consistency. Need to look at resources we already have.	
Action Items	Shaun & Don can investigate whether we could add the data we are looking for to ImageTrend – starting with transfer data– see what the challenges are - can we do something internally, can they customize for us, can it be streamlined so there isn't as much work – people would have to be trained on the system. We need to see whether we can accomplish our goals with existing resources. Subset of reporting like inter-facility transfer patients - Maine Med already doing this as a subset. Questions on whether hospitals could enter data into EMS database? Identified challenges with using Imagetrend would be how customizable, making it more automated data vs manual data entry along with education to EMS on the importance of the data collection with outcomes for increased adherence. EMS changed their system last year where they went from collecting 170 elements to 450 with the new system. Has been a challenging transition for EMS staff. They need to get outcome data to see the value.	Suggested starting with EMS data for patient transfer data. Getting sending facility data as part 1. Part 2 may be outcome data. Shaun sent an email to Tim, their data person, to identify opportunities/challenges.
Stroke Survey	Now questioning some of the answers we received. Since not everyone has a stroke coordinator, the person who ended up filling out the survey may not have been the best person to do so and that may also be why some of the data was missing – because they simply didn't know. Use just as a base line – in a year or so do another survey and see if there are improvements.	
Next Steps	The priority should be the grant. Data is also a big component. Maybe if we had a stroke coordinator level person, they could help gather this data. On the public health side, we should be doing education on stroke. The Maine CDC's priorities are not on acute stroke but more on the prevention of stroke.	

	Their new contract goes into effect July 1. Jessica from the Maine CDC will be part of our group after July. We should set a goal to create a Maine Stroke Tool Kit. We could put it on our website. It could include the basics – Protocols, Pathways, and Metrics. It could have downloadable forms that hospitals could put their logo on and adjust to their liking. Have forms that are appropriate for a smaller hospital and one for a larger hospital. If possible, get every hospital to identify two stroke champions – an ED physician and nurse, minimum – if they admit patients, they should also have an inpatient physician and nurse and maybe more than that. Try to get names of people that the Maine Stroke Alliance could contact so if we want to do stroke education, they would know who to contact. We at least have some names from the survey. How do we accomplish this? We have the website we can use. Right now it is still a development site but we could make it live. The mission and members list has been updated to only include the organization. We have included the meeting minutes. Protocols could go on the resources page (are resources same at EMMC as MMC?). The website should be a public site with the Alliance having their own private pages to log into. The resources should be unbranded so anyone can use them. Also discussed in the future all hospitals doing CTA for stroke for possible LVO. Also looked at patient education materials and including this as resources for prevention and post stroke. Including s/s stroke- importance of calling EMS with s/s.	Maine Stroke Tool Kit - available to all hospitals to download and put their logo on etc. Enc. Hospitals to identify a stroke champion for a contact. http://dev.mcd.org/msc/ Jane to share ED Stroke protocol in addition to Telestroke protocol for all to identify what we might want to adopt as a protocol to be used by other orgs.
Other	In the future AHA may do some legislation in Maine around collecting stroke data, but it will depend on who the next Governor is and how well the legislature is geared towards public health. Possible dedicated funding via state. AHA around the country is working on state registries around stroke, stemi, etc. In Louisiana they are pushed by legislation to do the data. Have a coordinator to provide assistance - benefit of no upfront cost for orgs to participate. Angela at EMHS– starting a Stroke support group this week if anyone is interested or wants more information. Might be an idea for the website – do a virtual support group for those who can't travel.	
Next Meeting	Next meeting will be July 24th, 2018, from 9:30 to 11:30 am at Maine EMS.	