Maine Stroke Alliance Meeting

July 24, 2018 ~ 9:30 – 11:30 am ~ Maine EMS

MINUTES

Present: Kate Zimmerman (MEMS), Shaun St. Germain (MEMS), Don Sheets (MEMS), Rick Petrie (APEMS), Diane Campbell (MCDPH/MCHC), Dottie Carroll (MGMC), Deborah Gregoire (MMC), Gillian Gordon-Perue (EMMC), Corey Flavert (MMC), Norm Dinerman (EMMC/LOM), Shaila Delea (MMC EM Residency)

On Phone: Pete Tilney (CMMC/LFOM), Dave McDermott (Mayo Hospital), Lisa Bemben (AHA), Mary Philbrick (CMMC)

Agenda Item	Discussion	Follow-up/ Recommendations
Welcome/Introductions		
Approval of Minutes	A motion was made and seconded to accept the April 24, 2018 minutes as written.	
Meeting Updates	AHA Tristate Stroke Coordinator Meeting This group met last Thursday. Talked about the CT issues at various hospitals, the CT process, and when the process fails ways to improve. The question was asked if any organizations were bypassing facilities to get to a primary or comprehensive stroke center and found that it typically doesn't happen. There was some idea sharing of what this group does and who they are. Some are DMV(?) certified and some are joint commission but the focus is on the same thing. Talked about patient specific care plans. NIH Stroke Scale documentation was brought up. It's sporadic if the ED Docs fill in the numbers. A July news release from the Joint Commission said that for August there were going to be new rules and by January 2019, the NIH Stroke Scale has to be documented within 12 hours. Gillian indicated that she had been documenting on the first note - whoever did that first note whether it be a neurologist or ED note – now we are going to have to be looking at what time it was documented. NIH Stroke Scale Scoring tool – (see attached) – has tips on it. Might be good to laminate it and have available. AHA Tristate Medical Directors Meeting – no information to share on this. Transfer Protocol Meeting – no information to share.	 NIHSS Scoring.pdf
Web Site Update	A new graphic was placed on the website to replace what was there serving as a placeholder. The group viewed the new graphic and agreed it was better. The site is still a development site so is not accessible to the public. There is still a lot of information to fill in.	http://dev.mcd.org/msc/

Discussion of New Stroke Guidelines/ Corrections	This was talked about at the last meeting. Full sections of the 2018 Stroke guidelines were removed. The guidelines had officially been published but said it was due to feedback from the clinical committee. They took out the section on secondary stroke prevention as well as other sections – dysphasia, blood pressure. You can review the corrections. This doesn't change a lot of what we do day to day – it does pull the status quo for the previous guidelines and the previous guidelines looked at the type of acute stroke management – tried not to go too far into the in-hospital-stay management. The writing group is going to rework it and then come back with new recommendations but are going to do that process diligently and carefully. AHA does not usually put out their guidelines for public comment, however the American Academy of Neurology does. They were suggesting in the article that it could get put out for public comment before being published the second time but haven't heard anything more. It won't change the foundation of what we do - tPA is still tPA. Those foundations still remain in place.	
Discuss/agree upon a screening tool for prehospital providers for LVO	We have the RACE score, but there is something out there new called FAST-ED which currently is not validated in the pre-hospital setting. Vermont is interested in using it in the pre-hospital setting and trying to gather data to validate. New Hampshire is on board as well as Massachusetts. Essentially, what FAST-ED does is looks at (and there is an app you can put on your phone) face – arm - speech - time and eye deviation. You can plug in what the score is and if all the hospitals key in what their capabilities are into this system you can look at where you should go. The group who made it is from Emory – they used a lot of traffic data for the mobile app and used what the known capabilities were – comprehensive or not. Didn't know if it would work directly for us, per se, because it was based primarily on Atlanta/Emory data. Liked the idea because it was dynamic and interactive and it has an app for your phone. We would probably have to do some work around stability or geography. It is a great idea for urban areas but hard pressed to see how it would work in our environment because not only the geography and the weather but also the availability to travel long distances presumably by Maine EMS. If this occurs in Bar Harbor are you going to go an hour and 15 minutes to Eastern Maine? There might be other utilities for it, like just having the score or just using it for large vessels. You could simultaneously launch LifeFlight so you could build in a parallel processing universe that might work in rural America. It might be set up similar to our Trauma protocols that we have and those are set up regionally around hospitals and the availability of resources, transport time. Our trauma triage guidelines actually deviate from the National Guidelines as we have a pretty good handle on what's available to us in the state and between the Medical Directors and regional offices and services over a long period of time have teased out -- whatever screening tool we pick we are going to have to have conversations based upon where you are what is the right destination. We won't be able to do a one size fits all in Maine. But it would be good if we could be standardized using one thing. (Gillian) when I looked at the prehospital protocols screening tools – there were others – I liked the FAST-ED one – more because I thought it was easy enough to use. FAST is a really easy algorhythm to use – Face, Arm, Speech, Time and eye deviation is pretty obvious – it's a yes or no – which is nice – either your face droops or it doesn't. I would recommend – FAST-ED. But I'm more vested in all of us using the same thing rather than one score versus another. (Kate) That's what we would like to do statewide. The goals section of our protocols is coming up next month and we are starting to talk about this stuff – and I think it is important to hash this out here – what would be the recommendation for the screening protocol and since we are heading towards identifying LVO – what are we going to do with that information. The FAST-ED app has a map of the area that has been	

	downloaded in their database which helps to direct you and they are using traffic too. There is also the RACE score which has been validated by pre-hospital providers – although the patient population may have been preselected a bit so there would be some bias to that. RACE is the only one that has been validated – how strict do we want to be – like if these other states are using it, we should be too. (Gillian) I'm concerned about the EMS providers in the Portland area that are already learning RACE. How easy would it be to change from RACE to FAST-ED? From an EMS standpoint, most thought it would be OK. (Rick) The assessment points are the same, it's where you put the info and what number you're assigning. (Dottie) For those who use the Get with the Guidelines database to abstract stroke data – there is a new tab in there so it is collecting dispatch time, on-scene time, depart-time, etc. It asked what stroke scale was used. As far as EMS providers go, they don't mind changing but they do want consistency. Big emphasis on not changing what they use every year or so. And this would also affect our credibility. VT has adopted FAST-ED already and in April 2018 Massachusetts went live with the FAST scale in the EMS Protocols. Maine couldn't do it until December 2019 – these protocols are being worked on now. We should start collecting some data just to see how we are doing in our state. The piece that we forget is that all the hospitals need to be trained as well as the EMS providers. We need to get the hospitals online. How much lead time do we need to get on the agenda for the MDPB. They actually will begin talking about this at their August 15th meeting. The MSA only meets quarterly, so we would need to do something soon. The MDPB has to finish up their recommendations somewhere around March. You could give a soft recommendation now. Lisa B. from AHA has some resources she can share. Under "Stroke Treatment Resources," it is #8 - http://www.strokeassociation.org/STROKEORG/Professionals/www.strokeassociation.org/STROKEORG/Professionals/Stroke-Treatment-Resources_UCM_481426_SubHomePage.jsp Should we vote on this today or online vote recognizing that if we online vote it will delay things and that might be a challenge for the specific timeline. Don is sensitive to the list that the MDBP's still has to go through between now and March and because this is a large component of what they plan to discuss at their August meeting, this could delay them. It was pointed out that Matt and Jane were not able to attend this meeting and Jane has worked really hard to implement RACE at MMC. The components are very similar between RACE and FAST-ED – the only real difference is that RACE documents the Leg Motor Function. Could we say that the consensus of this meeting is to follow this path but the formal vote would be at the October meeting. It would at least point the MDPB in a direction that they are already leaning towards already. With them knowing that this group would still weigh in in October.	Gillian will talk with Jane – if she has strong objections, it will need to come back to this group. Gillian will try to reach her by email and get an answer by August 6.

What Distance to Endovascular Center vs time to tPA center	What is the right time to head to an Endovascular Center? So for right now, Maine Med is the only endovascular center in the state. EMMC is looking for candidates as their endovascular physician officially resigned. It's hard to do with one person. If you know of anyone, send them their way. They actually need more than one. If that one person is not supported then what happened might happen again in a year. MMC just hired a third endovascular provider who will start in a month or so. But they are not a neurosurgeon – she is a neuroradiologist so it gives us versatility that you don't necessarily have if you are just in endovascular. The state could actually support two centers. Last time we had these conversations was surrounding stemi and we had a heart committee and the lead cardiologists from the three major centers sitting in the room having a conversation on what the appropriate time frame was that was supported by the literature and transport time and there was also a discussion on resources. It started with a recommendation on what the literature was showing on how to help the EMS Provider make that decision. Unless you were transporting into Bangor, Lewiston, or Portland there should be no diversion whatsoever from the local facility. That's been a while ago and we have loosened up those circles but that is how it started. What does the literature show on endovascular access. One of the sections of the new Guidelines that was removed was on bypassing facilities – that tells you what the current state of the literature is. One piece of literature did reference bypassing within 15 minutes and that makes sense - if you are within 15 minutes of a comprehensive center you can bypass the other hospital. That would only work for EMMC and St. Joe's and Maine Med and Mercy. The rest of the hospitals are farther apart. There are others that say 30 minutes or 45 minutes – but they are all having their own challenges on the data. The one that referenced 15 is based on Get with the Guidelines so it's kind of a national registry. Need to look at the survey that we did. What are our hospitals capable of doing before we say 45 minutes is the structural – we have to take into consideration the tPA window. We might not be able to get it down to a one size fits all – this might have to get down to regionalized protocols – but we could provide some level of guidance. Should we create small workgroups to do each region and what that would look like and then come back to the group. If you look at the survey, you can probably get our regional medical directors and regional offices to help with these conversations at the regional hospitals. This group could create some general guidelines of circumstance – if these resources are available then do such and such. Need to look at the papers that have been referenced and look at what is a safe place to divert – that will give us a circle and also what the individual hospitals are capable of. We'll have to figure out how to integrate all the pieces – LifeFlight and everything else that will be a piece of it – can LifeFlight fly – are they available, what is the weather like? Create different scenarios.	

	We could recommend to our regional directors along with the survey results to start a conversation with the MDBP in terms of - MDBP is in the best position to talk with the State. Lisa B. would be happy to help with looking at resources at each of the hospitals and provided the following resource links: http://www.heart.org/idc/groups/ahaecc-public/@wcm/@gwtg/documents/downloadable/ucm_498615.pdf http://www.heart.org/HEARTORG/Professional/MissionLifelineHomePage/MissionLifeline-Stroke_UCM_491623_SubHomePage.jsp Looked at chart Jane created last year – severity and time based – stroke triage algorithm for Maine EMS. Jane had 30 minutes. Some is knowable some not - it depends on weather, traffic, season. Gillian would go with AHA and use the 15 minutes. But there are debates where the numbers come from - 15 seems pretty tight but did not adversely affect outcomes. Just remember we are really early in this process. Looking for patients with LVO that are beyond six hours. Need to be careful that the smaller hospitals don't get bypassed or feel like they are getting bypassed. State of CT – each year each of the hospitals have to send to the Dept of Public Health their level of stroke certification and category, date of certification, and contact person. At least it is an annual update. We could come up with something like that and host it on the MSA website. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/ems/pdf/Home/StrokeFacilityAttestationList20180220.pdf?la=en. See if we can get a chart made.	
Other	Should we break into smaller sub groups that meet more often so we get more done between our quarterly meetings? • EMS – ED • In-hospital • Rehab • Legislation • Finance – and how to keep this group going Need to make sure that one group doesn't affect the others by what they decide. Maybe regionalize to get more rounded conversations and do we regionalize around the bigger hospitals? Next question is who's	

	going to lead these groups and get them together? Update - MaineHealth Stroke Hospital Standards with the MASH group – started working with a project manager who is helping to organize this effort and the goal would be we want to partner with the STEMI group. Right now we are establishing leadership among all the MaineHealth organizations. Most have Telestroke so we are already connected – only four do not so we are starting at the ground level with those organizations. Physician leaders, nurses, stroke champions – we are asking them to establish an acute stroke team, have acute stroke pathways in place, have a form of evaluating their stroke care with specific data requirements and reporting to the larger group and education for providers and nursing around stroke care on an annual basis. Inpatient stroke alert processes we're seeing if they have these as well as data and quality assurance processes. Many of the hospitals already have some of these in place but we are working with others that don't with the idea that it will be similar to this group but within MaineHealth. This could be preliminary work for the entire state.	
Action Steps	• Gillian to email Jane by August 6 about FAST-ED vs RACE • Connect with MDPB after the above conversation as we start to work on the stroke protocols • Ask regional medical directors to connect with their hospitals and try to gather some info and start working on these systems of care • Look at survey and come up with a table similar to Connecticut's – think about doing something like that down the road and check it annually – maybe create some outreach programs • October is next meeting • Think about how we want to break groups up – think about the ideas we proposed – EMS regions – continuum of care or other thoughts • Look at a charge or charter to lay the foundation for the regionalization concept	
Next Meeting	Next meeting will be October 23rd, 2018, from 9:30 to 11:30 am at Maine EMS.	