SEQIP General Meeting agenda

July 28, 2020

1. October meeting- Kari

    A. Keynote speaker ideas:

        i. Rapid versus Viz AI from actual hospitals using the software; What differences and similarities there are between the two and how this effects the stroke coordinator role. Medtronic hosted a Cryptogenic event prior to SEQIP meeting last fall; The stroke coordinator from FL stated her hospital used both;

        Ambra stated that Baptist Health Louisville has also used both. Consensus from their hospitals is Rapid is more accurate, Viz's app is more user friendly.

        Norton is a demo site for Rapid to build the app. Easy to add chats and a dashboard being built. Concerns about the AI part because docs to call in and complain about CTA false positives. Rapid ICH software almost ready to go out to hospitals. ASPECT scoring was just FDA approved.

        Chauncey stated with her telemedicine experience with 34 hospitals that each software system has equivalent features at this time. Rapid will also have a desktop app for people who don't want to have this on their phones.

        Perfusion capabilities of software? A lot of facilities don't have the capabilities of the software for perfusion but rapid offers the software. Hospitals might be able to get a cheaper package deal. Unsure if other companies are doing this?

        Cassy stated there was a third company Bernomics that also offers a rapid ICH determination program built in. Bill stated there is a value in this information when looking at deciding if a patient needs to be transferred, in his case it would be Vanderbilt.

        ii. Stroke in the time of Covid-19- evaluation, treatment and management; NIH website has a webinar offering of these patients but it is geared more towards tele patients; if patients also have Covid and stroke they are managed in the COVID unit; There have been about 10-12 across the state of Covid + Stroke patients. Some patients have been labeled as a code stroke but final diagnosis was Covid only in younger populations.

        Lacy- JAMA study out of NYC; 31 patients that were Covid + Stroke. The patients that were admitted, they looked at when the patients presented, admitted to the ICU and when they had a stroke in the study. Those patients that when they presented to the hospital and when they had their stroke, Covid had to manifest itself in these patients for a longer period of time before they showed positive for stroke. This data was compared to Wuhan and France data, and looked at those patients who were Covid + and also had stroke. There is a caveat that some of these patients were to critical to take to MRI. They were thinking there were more stroke positive patients in the Covid

population but couldn't prove it because of patient instability and being transported to MRI.

The EMS providers appreciated this information because they had not received this information from anyone to know it could be Covid or Stroke or both.

How are we managing patients that are Covid + and have an inpatient stroke; ? Thrombolytic eligibility: if an LVO- are we going to transfer? There are several unanswered questions.

Look for a talk on how to manage for possible or confirmed Covid patients with Stroke. The logistics, increased risks, management of these patient for testing and if testing can't be done how to manage and support for these patients.

Covid is also a higher reimbursement; stroke may be listed as a secondary diagnosis; If you are just depending on your HIM department to provide your stroke patient list, you may not be fully capturing your patient population if it is secondary or lower diagnosis for Stroke.

2. Overreact campaign- Kari

The Overreact campaign as is refers to Genentech, 4 cities including Louisville with looking at print, radio and media ads to try to raise awareness for people to respond to stroke symptoms immediately and "overreact". We have been working on this for 1 year with marketing from Genentech trying to use SEQIP data by zip code along with the zip codes that were targeted in Louisville. Genentech and AHA nationally looked at time of onset to arrival, arrival mode and utilization of Alteplase and patient outcomes. Due to legal agreements, we cannot share date with Genentech and vice versa. We do have the zip codes for the areas in Louisville that were targeted and our SEQIP data.

We are now moving forward with this and analyzing the SEQIP data from the Overreact campaign during the timeframes that it was run to see if it made a difference in when patient are presenting to the hospital and/or arriving faster.

3. Louisville Stroke Systems of Care pilot- Lacy

Kari, Lacy and Amy, Greater Louisville hospitals with input from Chapman Offutt (Baptist Health Paducah), Scott Helle (KY Office of Rural Health- EMS) and Kyle Williams (Paul B Hall/AirMethods).

The idea is to promote use of a large vessel occlusion scale (CSTAT) with EMS partners because we are not seeing that used frequently in prehospital care. The thought is by ground EMS having Air EMS dispatched for a stroke patient, they are bringing the patient to a CSC based on assessment. Chuck O'Neal, Deputy Director of KBEMS, will provide a recorded message during the webinars of them endorsing this pilot.

We have decided to start the pilot with Air agencies (PHI, AirMethods and Air Evac) in Louisville are that are scene flights. We will be educating them via Zoom around CSTAT use with their EMS

protocols. We will also be educating the ED staff of the Louisville hospitals on what the CSTAT scale is.

When Air crews prenotifiy with an ETA, patient presentation, we are asking them to include a CSTAT score. The ED staff will then recognize the patient may be an LVO. ED staff will not be repeating a CSTAT but the will be educated on what the scale means in the patient's possible stroke acuity. UL residents will be doing the CSTAT on arrival to the hospital.

The webinars will be held in September (see attached invite) and the go live date for the pilot is October 1st for all stroke transports. Data elements will be tracked and we plan to have an initial look at data in December.

Ground crews will be incorporated soon to the pilot.

CSTAT is being used because this follows the KBEMS protocol. Several EMS agencies in Bowling Green and a few in Louisville are using RACE for LVO because it is built into their EMS documentation software. We are not asking EMS agencies to change their protocols, they can use any LVO scale.

4. SEQIP website

Meetings page is up to date.

Britan is working on the main SEQIP page with all of the logos and links to all of the hospital websites. Goal is to have this complete by the October meeting.

For the chairs of committees, if you do not see your information listed, please send that to Britan as soon as possible.

5. Subcommittee updates

EMS Outreach and Education-

See Louisville Stroke Systems of Care Pilot

DSC

No surveys during Covid. We have had discussions of how the data is going to be looked at during those times. From other states, it has been reported that JC is not focusing to heavily on the data during the first months of Covid. JC wants to know more about the processes that are in place and if they are being followed.

The Specification manuals were updated as of July 1st to version 2020B.

DNV ASR standards were just updated- make sure you are doing a detailed review. Updates are consistent to what we are use to with Joint Commission.

Community education- DNV has a blanket statement to waive the requirement this year.

Both organizations (DNV and JC) are stating community education needs to be discussed and documented in the meeting minutes. If you have an alternative plan, it needs to be formally approved through the committee such as social media.

DIDO

New meeting scheduled in August for bringing group together to possibly to update.

Data Analysis and Performance Improvement- Sasha

STK OP1 a-f between months Feb- June would not run data; UL and state report; numerators and denominators are low because of furloughs and data not entered. Review your data- some multiple days that are entered for their transfers because of the buckets they fall into. This is skewing the data with large outliers.

In the admin tab, there is a place in the medical history if they have had Covid to be selected. In the Hospitalization tab, there is a place to select if the patient has an active bacterial or viral infection at admission or during hospitalization.

Lytics (TNK or Alteplase) can be tracked in GWTG

CSTK 10 for TJC did not breakdown the comparison as much as it could be with the Thrombolytics and interventions.

Navigating the Stroke Continuum of Care- Carrie

The committee is finishing up the nursing handoff report to share with hospitals. Will include transfer handoff report, shift to shift bedside report. Will be finalized in August.

Amy sent out an email for the committee's need for information on Stroke support groups and Covid and how family support is being impacted by Covid. They maybe looking at creating sheets on how to run a support group during Covid virtually or how to monitor patient satisfaction during a pandemic.

Community and Public Health Education and Outreach

Team will be getting together in August and reviewing the current messaging and the call for additional materials has been sent out. Recommendations will be sent out to the larger group for feedback late August.

Joe Akin is now the KY, WV and Louisville. He covers from Bowling Green to the Eastern Ky state boarder. Paducah and Madisonville may be covered by southern Illinois- Joe will follow up. He can provide Overreact materials and virtual education over Zoom or Google hangouts.