Draft Minutes of Meeting – Subject to Change Upon Approval by the Stroke Task Force at their next regularly scheduled meeting

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

STROKE TASK FORCE MEETING

September 4, 2019 – 9:00 A.M.

MINUTES

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Scott Wagner, EMSTS Field Representative
Christian Young, MD, EMSTS Medical Director
Gerry Julian, EMSTS Field Representative
Rae Pettie, Recording Secretary

PUBLIC ATTENDANCE

Jim Kindel
Kim Moore
Maya Holmes
Margaret Covelli
Ravishankar Konchada, MD
Jennifer St. John
Stacey Smith
Michael Holtz, MD
Steve Johnson
Derek Cox
Kim Dokken, RN
Jessica Rosy
Josephine Covel
Tony Greenway
Mark Calabrese
Shane Splinter
Neil Chio
Jessica LeDuc, DO
Brett Olbur
Kimberly Cerasoli, RN
August Corrales
Stacie Sasso
Sophia Student
Chelsea Monge
Karen Dalmaso-Hughey
Jason Driggars
Scott Selco, MD
Spencer Lewis
David Cercone
Krystal Coffman, DNP
Troy Tuke
Paul Stepaniuk
Dan Shinn

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Stroke Task Force convened in the Red Rock Trails Conference Room at the Southern Nevada Health District on Wednesday, September 4, 2019. John Hammond called the meeting to order at 9:03 a.m. Mr. Hammond stated the Affidavit of Posting, Mailing of Agenda, and Public Notice of the Meeting Agenda were executed in accordance with the Nevada Open Meeting Law.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Mr. Hammond asked if anyone wished to address the Board pertaining to items listed on the Agenda.

Maya Holmes, Culinary Health Fund, expressed concern that the composition of the Task Force includes payors and patient representatives.

II. CONSENT AGENDA

Mr. Hammond stated the Consent Agenda consisted of matters to be considered by the Stroke Task Force that can be enacted by one motion. Any motion may be discussed separately per member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes - Stroke Destination Steering Task Force Meeting August 6, 2008

A motion was made by Troy Tuke and seconded by Mark Calabrese to approve the minutes as written. The motion carried unanimously.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss the Election of Stroke Task Force Chair & Vice Chair

Mr. Hammond stated the focus of today's meeting will be to look at the clinical differences between comprehensive stroke centers, primary stroke centers, thrombectomy capable stroke centers, and acute stroke capable hospitals, and how we can get stroke patients to the appropriate facility to get the best care in the shortest amount of time. Mr. Hammond asked for nominations for Chair and Vice Chair.

A motion was made by Ms. Dokken and seconded by Chief Tuke to elect Dr. Scott Selco as Chairman of the Stroke Task Force. The motion passed unanimously.

A motion was made by Tony Greenway and seconded by Mr. Calabrese to elect Dr. Krystal Coffman as Vice Chair. The motion passed unanimously.

B. Review/Discuss Possible Stroke Receiving Facility Designation Criteria

Dr. Selco stated that in January 2010 prehospital providers were mandated to take stroke patients in the field to primary stroke centers. We were not yet in the era of LVO stroke treatment. The landscape has now shifted completely where they may need to decide, in a refined manner, to get the patient to the right place at the right time. One of the things they discussed at that time, but never committed to, was data sharing to analyze which subset of patients should be transported to which facility that can best care for those patients. The question today is, "How are the stroke centers performing?" and "How can we analyze that what we're doing is in the best interest of the patient?"

Dr. Coffman noted that Sunrise Hospital is currently the only comprehensive stroke center in Clark County. There are six hospitals that are thrombectomy-capable: Sunrise, Valley, Spring Valley, Centennial and UMC. She reported there are four levels of stroke ready hospitals through The Joint Commission (JC):

1) Acute stroke ready – Essentially drip and ship. A patient goes in with a stroke, gets TPA and is transferred to another facility.
2) PSC (primary stroke center) – A hospital that has a lot of different levels:
    - Treat with TPA and keep the patient
    - Treat thrombectomies and keep the patient
    - Keep ischemic stroke but transfer out hemorrhagic stroke
    - Keep ischemic and hemorrhagic strokes and transfer out thrombectomies
    - Treat LVO patient with a R.A.C.E. score of ≥5 with TPA, and if they're a candidate, do a thrombectomy and keep the patient

3) TSC (thrombectomy-capable stroke center) – Basically a rubber stamp from JC that you have a certified thrombectomy-capable program. Currently, nobody in Clark County has this certification. Six of the receiving facilities have the capability of doing thrombectomies, but none have pursued thrombectomy-capable certification. However, it doesn't mean they can't do thrombectomies.
4) CSC (comprehensive stroke center) – These are supposed to be your regional centers. A CSC facility is mandated to do IRB based research and have 24/7 in-house neuro ICU coverage.

Dr. Coffman pointed out that according to the AHA there is literature that some patients should be transferred from a PSC to a CSC. However, there is currently no literature that recommends you transfer a patient from a PSC to a CSC if you are a thrombectomy-capable facility. Ms. Dokken stated that one distinctive difference between a TSC and a CSC, is a TSC is just thrombectomy-capable. A TSC doesn't have to do coilings for bleeds, where a CSC does, and those measures are applied to a CSC and not to a TSC. She noted that most facilities that are thrombectomy-capable also do bleeds. But that is also a distinction. So, some TSCs may transfer to a CSC for bleeds. Ms. Rosy noted that another distinction is a CSC needs to provide staff education and other services that are provided to stroke patients in addition to just the procedure.

There was some discussion that the monthly ED/EMS Leadership Committee has been collecting STEMI data, and is now starting on stroke data. They hope to have their first aggregated data city-wide stroke data from all the hospitals at their next meeting. Ms. Dokken suggested that all data submitted be shared for review by the Stroke Task Force. Ms. Cerasoli noted the UMC coordinators don't sit on the committee. Chief Tuke stated that everyone is invited; there have been several coordinators from almost every facility that have been attending on a monthly basis for the last year and a half. Mr. Hammond stated the ED/EMS Leadership Committee is not a publicly noticed meeting. The Health District provides a venue for the meeting for their community partners and stakeholders. He suggested they determine the metrics they would like to analyze related to stroke data and performance measures, much like they do in the Trauma Medical Audit Committee (TMAC) and Regional Trauma Advisory Board (RTAB). Chief Tuke expressed concern that their motive should be to get the patient the best care possible, not which hospital gets a bigger piece of the pie.

Ms. Cerasoli and Ms. Dokken stressed the importance of gathering the appropriate data to get the most accurate picture from the perspective of both EMS and ED. The right people are needed to be able to discuss how it affects each of them. It's not just improving EMS, it's also about how the receiving facilities can collaborate with EMS to get the best outcome for the patient. Ms. Dokken noted she had not been attending ED/EMS Leadership Committee meetings either, so she is unclear as to what data is being submitted. She does not want a duplication of services and is concerned that the data she submits will end up in a black hole. Chief Tuke responded that the committee has been very productive from both sides. They have developed actionable items to improve the system. He invited them to review past minutes and the STEMI and stroke data they have compiled.

Dr. Young noted the ED/EMS Leadership Committee was historically held in a small meeting room because they only had eight people in attendance at that time. Discussions began with issues related to L2K patients and internal disaster. When AHA came to town with the Mission: Lifeline grant they had meetings at different sites and facilities. Everyone was invited. They discussed STEMIs and how to improve the system and garner more attendance. Sometimes there would be three coordinators and no physicians, or two cardiologists and no coordinators. It was very intermittent, and they were voting on issues on how to improve the system. It was difficult to get everyone represented. That was when they came up with the regional STEMI plan. Since it was a sensitive topic at that time, AHA blinded all the data for us. Labeled as Hospitals A, B, C, D, E, no one knew which hospital's data was being evaluated. Soon after, the grant ran out, but it was such a productive meeting it was decided to continue holding further discussions in the ED/EMS Leadership Committee. It has really grown into a meeting that has been very productive, well attended, and free from the official motions, seconds, and consent agendas. They are currently looking at sepsis care. The Committee provides a think tank to bring items of interest forward to the MAB and the DDP. Dr. Young explained that's how issues come to the table. They have

gone from a very blinded data set to a lot of individuals bringing good data to the table. And for the first time they're getting aggregate quarterly data. It's not 100% perfect, but they thankfully have the resources at the Health District to clean the data and look for outliers to improve the fidelity of that data. We rely on people bringing that data to the table. What are we doing with that data? Are we identifying STEMIs? How are we doing? Are we getting the right person to the right place at the right time? Are we giving feedback to our EMS crews when a STEMI EKG has been activated? Those are the kinds of issues that have come out of that. He feels the initial momentum of that meeting was such that they wanted to continue into the stroke venue. The idea was, do we need to add "STEMI Center" to the designation list at the back of the protocol manual? The current stroke destination is for the primary stroke centers because that's all we had back in 2008 when everybody came on line. Now obviously the depths of resources are getting greater. Hospitals are putting more resources into increasing those capabilities. There are going to be different areas geographically, and now they need to decide where to redirect patients, perhaps analogous to the trauma system. That's where they need to rely on AHA, American Stroke Association, and JCAHO to help them direct traffic in the right way. The resurrection of this Task Force in its official capacity is the appropriate route to make changes.

Dr. Selco agreed that the last round of meetings about stroke destination seemed to be amiss in their follow through. The protocols should evolve in the context of LVO treatment, management, and transport. The data collection and blinded data evaluation is a key part of it, but the data evaluation piece should outlive the work of the committee. They should continue to look at the data even if the committee's work slows down so the data is always current. Dr. Young commented that the data can be difficult to obtain.

Dr, Selco related that he used to sit on the Western States Affiliate of the American Stroke Association. It included California, Nevada, Arizona, Utah, New Mexico and Colorado. There is a regional consortium of stroke directors that generally meets twice a year. One of the issues discussed was combining data across the Western states, i.e. from stroke centers. But since all of us use "Get with the Guidelines® Stroke" it requires all hospitals signing off on the use of de-identified data. The data's there. It's sitting in the data guidelines repository. If each hospital committed to signing off on the de-identified use of the data, we would at least have access to the data. That leaves out the prehospital portion of the data because that's not contained in "Get with the Guidelines® Stroke" so there's going to be very limited prehospital data. But the holy grail is to obviously do both of those together. If the hospitals in Clark County agree to sign a data-use agreement that would be a great start. Ms. Cerasoli noted there would be a delay in obtaining the data. Dr. Selco noted that any data at this point would be better than no data.

Ms. Cerasoli suggested they move towards a TMAC type of meeting where there are representatives from hospitals and EMS who basically review the data and outcomes. They can then feed the unprotected data to the people who are immersed in data. She advised they form a group, like TMAC, who meets prior to the ED/EMS Leadership Committee, to arrive at discussion points and provide guidance. She related that the TMAC reviews mortalities and morbidity; they discuss their findings if there was a fall out or peer review issue. It's a closed meeting so it tends to more candid. She was unsure if they belong consistently in a group of EMS providers who are really working on the EMS issues. This is a two-part transaction for which they both need to work to get the desired outcome. Chief Tuke disagreed and stated that you can't look at the data differently by keeping the hospital issues separate from the prehospital issues. Ms. Cerasoli replied that the report will be from a group who filters through the data. Chief Tuke stressed that the strength of the ED/EMS Leadership Committee is that everybody can have an open discussion. If they segregate the two entities again, they're not going to make any progress, and they may remain another nine years in the same spot.

Dr. Young related that there was a time when the EMS crews' job stopped when they got to the ER door. The ED's job stopped when the patient got to the catheter lab, and then it was the cardiologist team. They saw the most improvement when EMS' job was finished when the patient was in the catheter lab. So now they see patients with early activation from the field going right to the CT scan. There is a gray area where there is an overlap. And that's where we really saw the best improvement. He agreed it's a multi-disciplinary approach when discussing the data because everyone has a way of looking at it differently.

Dr. Young noted that they have had everyone at the table except the cardiologists. He gave kudos to Dr. Selco for representing neurology. He noted that it really does take a village. Dr. Young stated he likes the idea of a closed-door meeting as he feels it would improve the fidelity of the data. The one tactical disadvantage in the STEMI data is there isn't a STEMI registry in Nevada. As for duplicating resources for submission of data, he realizes there is an administrative burden and hopefully the ESO data exchange will come online soon as another option. Mr. Hammond suggested the Task Force remain focused on the questions that need to be asked and answered in this meeting and going forward. He agreed with the idea of creating a TMAC-type meeting to review the data.

Dr. Ravi Konchada introduced himself as a radiologist at St. Rose Dominican Hospital. He noted that stroke care has changed in the last 4-5 years. It has been especially different in the past year. Thrombectomy became the standard of care in 2015. In January 2018 it was expanded to a 24-hour availability. He reported that in the last eight months to a year the stroke volume has doubled, if not tripled. He stated that what happened prior to 2015 is irrelevant. He went from doing 15-20 strokes a year to the same volume in the past six months.

Dr. Slattery referred the Task Force to the minutes of the last meeting and stated that it outlines a comprehensive approach to their initial venture into stroke destination, primary stroke destination, and changing care. He noted that a lot of the work had not been completed. He suggested they take time to review the last meeting minutes and the vision they had eleven years ago, then come back to the next meeting to define what they want to accomplish and move forward with a plan. Dr. Slattery stated that stroke is an important disease that is rapidly changing, and this is an opportunity to really leverage the minds around this table, as well as the members on the ED/EMS Leadership Committee, the MAB and the DDP. He suggested they think about what they want and need to accomplish, and are very inclusive in their decisions, including having payors and stroke survivors at the table. He recommended they take some time to look at the minutes and the structure that was put in place 11 years ago, see what's relevant today and come back with some good discussion. Dr. Selco agreed there is value in and evaluating whether the process then will be useful now. The question is, "What do we do now? Just simply for LVO." He added that we are building on top of the existing infrastructure that was implemented ten years ago. He doesn't believe it will be super complicated. They need to drill down the issues the Task Force should be addressing and come up with specific agenda items to tackle. Dr. Selco suggested they accomplish some tasks via email so they can work more rapidly than reporting back to a monthly meeting. Mr. Hammond explained that they need to comply with the Nevada Open Meeting Law. Those types of behind-the-scenes conversations are not allowable, especially if decisions are being made. He stated he will consult with the legal department and report back.

Ms. Dokken related that when they piloted the R.A.C.E. project with Henderson Fire Department the data showed very clearly that a R.A.C.E. score of $\geq$5 identifies a LVO. It also identified that those patients that didn't have a LVO ended up to be bleeds. Going forward, a R.A.C.E. score <5 can go to a PSC and a R.A.C.E. score $\geq$5 needs to go to a thrombectomy-capable center or higher. Dr. Selco clarified that they could go to a PSC or an acute-ready hospital. Ms. Dokken noted that they would then need to add acute-ready hospitals to the protocol manual. Dr. Coffman stated that in the stroke world there is no way to differentiate between an ischemic and a hemorrhagic stroke. There is no scale, no assessment, nothing other than a CT scan that can tell you the difference. If you've got a patient with a R.A.C.E. score of 3 and you take them to Summerlin, they are a primary stroke center, which is appropriate for a R.A.C.E. score of 3. However, they don't have neurosurgery so they are not appropriate for a hemorrhage. So, it doesn't matter what they do. We're always going to have a subset of patients who will be transferred after they go to a hospital. And that's not wrong. They are following appropriate protocol. There's nothing we can do about that. There is no way to tell a patient who is weak and dizzy has a subdural because he fell three weeks ago until you do a head CT. Those kinds of issues will never change.

Ms. Cerasoli stated there is a certain amount trust and understanding that, at least from a trauma perspective, when a patient gets mis-delivered it's not viewed as a fault. You're working with the best information you have at the time, and everybody's going to do the thing that's right for the patient going forward. As much as they all want to deeply impact that patient's outcome, they all have a point of care

where they're doing the best they can, and it might require reaching out for another set of resources, regardless of the diagnosis. The important part is recognizing what you can with what you have at that moment.

Mr. Hammond reiterated that he will meet with the legal department to discuss the Nevada Open Meeting Law prior to working with Drs. Selco, Coffman, and Young to determine the scope and breadth of the Stroke Task Force prior to creating the next agenda.

IV. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

V. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None

VI. ADJOURNMENT

As there was no further business, Dr. Selco called for a motion to adjourn. The motion was made, seconded and passed unanimously to adjourn at 10:05 a.m.