

Supplementary figures for one-way deterministic sensitivity analyses over the lifetime of the cohort.

Figure e-1. Probabilities of mRS 0 to 2 after mechanical thrombectomy (A) or after IV tPA (B). The ICER is $[(\$_{\text{Multi-modal CT}} - \$_{\text{NCCT}}) / (\text{QALY}_{\text{Multi-modal CT}} - \text{QALY}_{\text{NCCT}})]$. A) For probabilities <61%, multi-modal CT has reduced costs with greater QALYs compared to NCCT. For probabilities $\geq 61\%$, multi-modal CT has reduced costs and fewer QALYs than NCCT. B) For probabilities >38%, multi-modal CT has reduced costs with greater QALYs compared to NCCT. For probabilities $\leq 38\%$, multi-modal CT has reduced costs and fewer QALYs than NCCT.

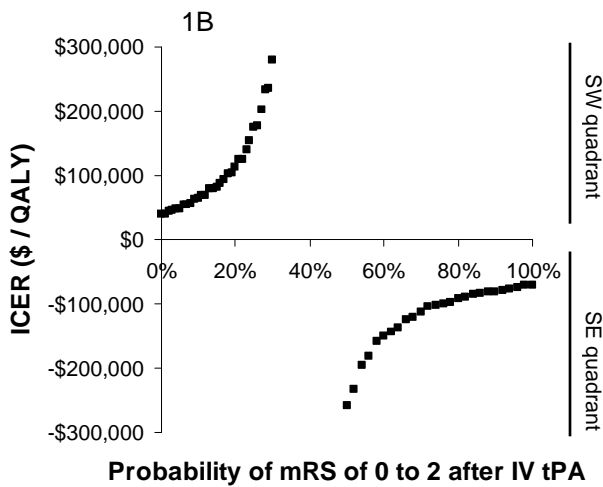
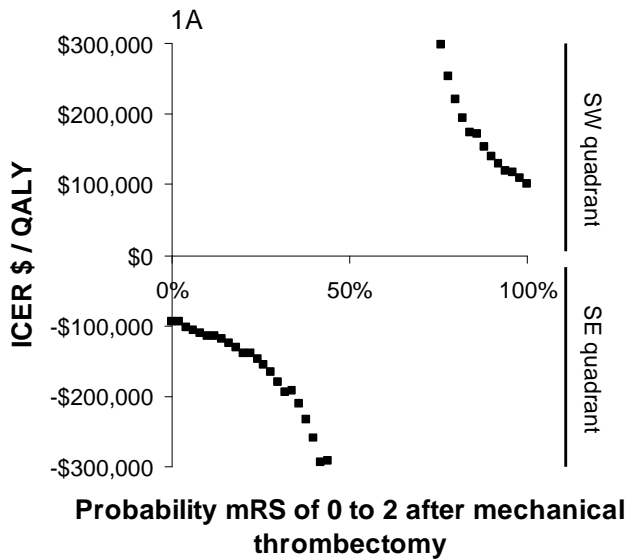


Figure e-2: Probability of symptom improvement at 1 hour after IV tPA. The ICER is $[(\$_{\text{Multi-modal CT}} - \$_{\text{NCCT}}) / (QALY_{\text{Multi-modal CT}} - QALY_{\text{NCCT}})]$. For probabilities $\geq 91\%$, there is an ICER (willingness-to-pay) for multi-modal CT compared to NCCT, where multi-modal CT has greater costs but also more QALYs.

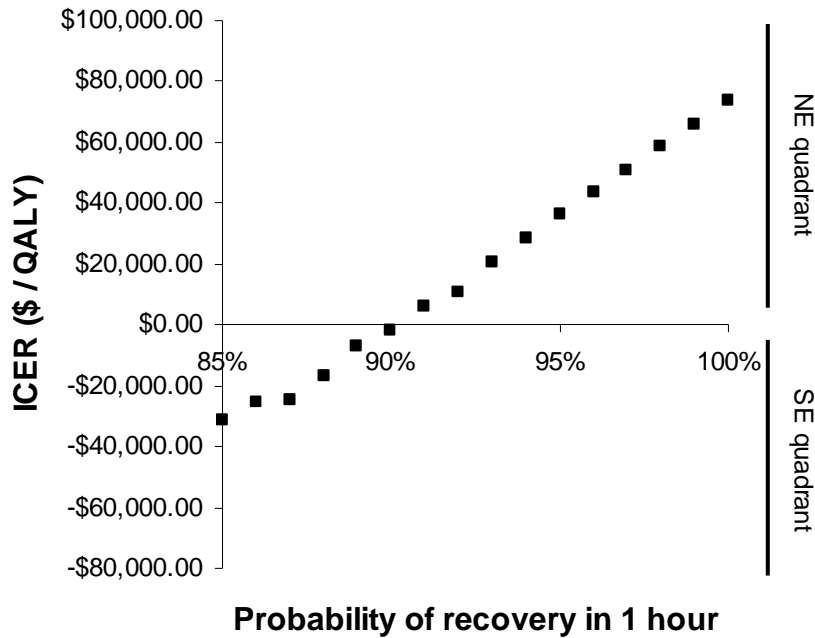
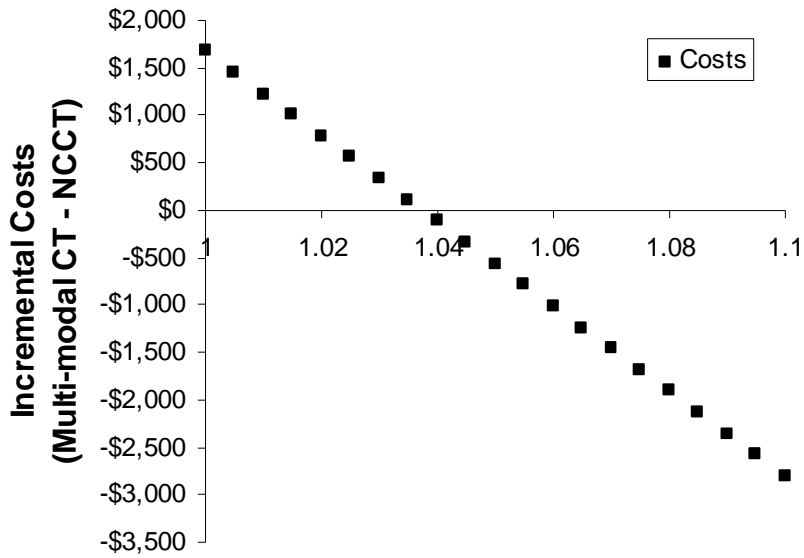
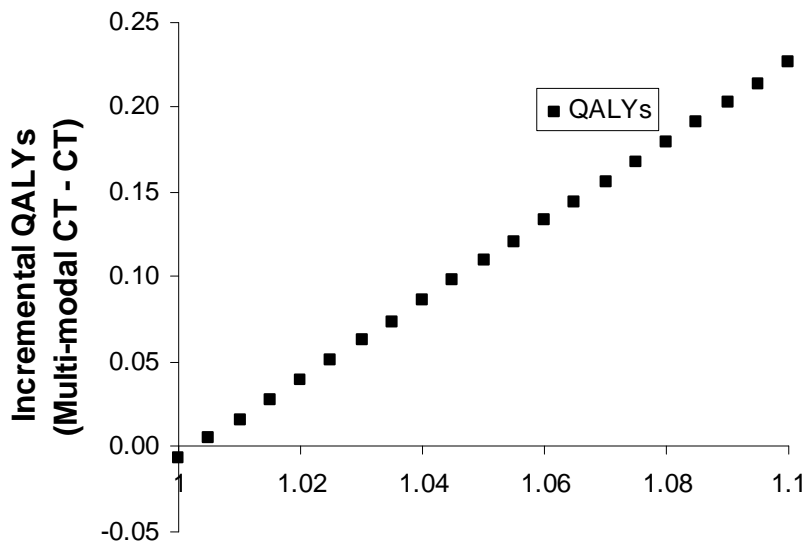


Figure e-3: Relative risk of a mRS of 0 to 2 to test improvements in outcomes with CTP data. All graphs are over the lifetime of the cohort. This cohort has a prevalence of clot of 78%.



Relative risk of mRS of 0 to 2 after CTP guided procedures (prevalence of clot=78%)



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