CATRAC ML CCW Mtg Min Sept 9, 2009

QI Subgroup Update: Louis Gonzales

- Need representation from non-PCI hospitals & EMS further away from I-35 corridor

BASELINE ASSESSMENT TOOLS

- Cover letter included
- Focus on baseline assessment
- No actual performance data collected
- May stimulate question & thoughts (definitions of terms, methods for calculating measures, etc)

EMS

- Agencies that routinely respond to 911
- 1 assessment per agency
- Interfacility transfer aspects not yet addressed
- Sent to EMS Agency Director
- (only those that respond & transport included; not 1st responders)

Non-PCI

- No primary PCI performed
- 1 assessment per hospital
- Sent to ED Director

PCI

- Routinely perform PCI
- 1 assessment per hospital
- Sent to QI Director or STEMI Coordinator

NEXT STEPS

Distribution Plan:

- compile list of EMS/Hospitals
- divide among QI group
- fax/email/hand deliver assessments
- follow-up
- complete within 4 wks
- compile & summarize

Frank Zidar (FZ): What's defined as success? 80%?......group expects 100%.

- Develop & Distribute Interfacility Transfer Assessment Tool
- Define Data Points & Performace Measures
- Define Regional Data Collection Methods
- Identify other Action Items
- Develop Action Plan Timeline

NCDR Action Registry – highest goal to get info to there.
Robert Wozniak (RW): Is there software to crunch the data? People want to benchmark & thus improve.

Loni Denne (LD): The collection tool combines all info (including EMS) & is offered by ACC for free. ACC also offered availability to return regional data, but group needs to decide what data points to include (regional, national, etc.) – i.e., hypothermia; false negative/false positive; STEMI protocol. The regional reports ACC promised to get back will have a fee, but as yet the amount is unknown. Additionally, although not mentioned in the cover letter, specific hospital data will not be revealed in the aggregate data.

- ❖ Additional input by Friday
- ❖ Distribute next week (suggested standard distribution in PDF/word to prevent lost data)
- ❖ 4 wks from then, assessments due

FZ: Recap
- Insure we have a completed list
- Distribute/Completion of data
- Proposed changes
- **Next Leadership Meeting: Nov 11th**

Protocol Subgroup Update: Pat Ramming

- ❖ Still need volunteers & EMS from outlying areas for the group

- Plan to review & compare to N. Carolina's RACE
- Start with EMS & review
- Compiled packet distributed by Friday
- **Next Protocol Subgroup Meeting: Sept 16th, 7:30am-9:30am**

FZ: EMS will still maintain own identity, but most productive to get input from EMS at both group meetings

Education Subgroup Update: Helen Raab

Meet last week & mainly focused on public education.

- ❖ Looking for someone passionate about 12 lead portion

- Most of what the group is interested in is already out there. If done right, can be low cost & a public service. AHA website had helpful information & the group based their focus on that.
- Would like to address the lag time patients face getting to EMS
- Assess readiness of learned; signs, symptoms, recognition, calling 911, CPR
- Goal to have project completed by December
- Mission statement: simple & quick
- **Next Education Subgroup Meeting: Oct 21st, 1:15pm-2:15pm**

FZ: Should education be broken into 2 parts: Training (EMS) & Outreach (patients)?
HR: We don't want to dilute efforts with adding EMS training…more passionate about public education.
TF: Have education as part of the EMS group & EMS can also be part of outreach.
Samson Jesudass: they are interrelated & it makes sense to combine efforts
Dave Reimer: terminology: guidelines v protocols?
FZ: Words are important & "protocols" can sound like something being forced through.

LD: Public Awareness campaigns must be careful (ie, 911 calls: can often increase call volume, but in the wrong way because inappropriate).

STEMI Committee Update: Robert Wozniak

Wanted to start with something "easy" – agree on the definition of what activated the cath lab…..
…….yet not so easy.

- Difficulty with false positive rate – depends on who reads the EKG.
- In Minnesota, they chuckle if >30%, because education not doing a good job. They have a 10-15% false positive rate.

<u>BBB</u>
- in effort to keep it simple, easiest to eliminate; want to keep as black & white as possible
- let technology catch up with transmission
- if not performing 12 lead, tough to focus on BBB.

<u>Classic Symptoms:</u>
- Project Upstart is fairly easy & well defined for places starting out
- "ST-elevation ***" : increase 1mm of 2 contiguous leads

Simplicity dovetailed with education

Paul Roach: Seems simple because we do it all day - start with a good history & you can often filter out the false positives. Interventional cardiologists have it easy because they see the continuum, perhaps more feedback should be provided back to ER & EMS.

- Closing the Loop – why is this happening? False activation rate should be kept under double digits; patient history & education key.

Sam Roberts: Sometimes have elevation in 2 contiguous leads & not STEMI…asks them to get on the phone & talk to doctor, describe what sees (changes in inferior leads, etc.).

- What other tools do we have? If we don't have sophisticated communication, let's not focus on …What do we have?

FEEDBACK & COMMUNICATION KEY

Buddy Owen: Verbal description of EKG may push more possible STEMIs to missed STEMIs – subtleties lost in discussion; feels LBBB should be included & is an education opportunity.

H: How do you define “false activation”?

PR: Have to marry up history & EKG…
ie, proper history & abnormal EKG, but negative cath = appropriate

TF: People take for granted that EMS knows how to take a proper history.

Bob Harding: Keep LBBB in criteria; EMS does a good job of picking those out.

Helen Raab: 1. History, 2. EKG, 3. Feedback. Quick turnaround time as educational opportunity (24-48 hours). Seton does great on good patients (with feedback).

BO: What about patients not going to cath lab?

SJ: 30% false positive wastes resources. There is a timeline for patients (in treatment), there should be a timeline for EMS feedback also.

LG: Reasonable timeline: mid November

<u>NCDR</u>

- When you have no control over how to analyze data, loses utility.
- The NCDR has room to add other elements – what should be added?
- St. David’s – tracks EP ICD implants for NCDR Action
- Seton – NCDR

Carol Winick: will distribute addendum & FAQs; gaps become evident & then determine next steps.

ACTION going to be required for STEMI designation & recognition.
(AHA Get with the Guidelines is sun-setting soon, so AHA has joined ACC, keeper of the tool)

FZ: In closing, to summarize:

- complete list of contacts
- follow-up on survey
- education – public & internal
- protocol – clarify which RACE protocol adopting.