

Emergency Cardiovascular Care 2010: Transforming STEMI Care (1.5 day mtg in Chicago @ Airport)

NCDR shows improvements:

- Death rate 5.8%
- Reinfarction rate 1%
- Bleeding is increased
- No reperfusion – 6%
- Not eligible for perfusion – 13%
- D2B <90 min for transfer-in patients
- Not enough upstream clopidogrel

Controversies:

- Ideal reperfusion strategy when D2B >90 but <120
- Ideal time for PCI when has successful lytic rx
- PCI without SOS vs. Center of Excellence

Pre-Hospital Activation

- RapidSTEMIID.com = interactive STEMI ECG interpretation tool
- ML EMS survey – 36% EMS agencies responded (91% of US pop)

“Diagnosis of STEMI needs to be made by EMS...& ED doc has to get over it.”

- Dr. Tim Henry

Mayo Clinic

- Definite STEMI = EMS + computer
- Possible STEMI = LBBB or EMS + computer discord
- Not STEMI = EMS + computer agree not a STEMI

No agreement of False positive (“over activation”)

- Dr. Lee Garvey – “No uniform agreement that ECG is c?w STEMI or if patient is deemed not appropriate for cath lab.”
- Dr. Brent Myers – “We can’t be concerned about false positives until we understand the amount of missed STEMIs (false negative).”

DATA

- EMS data
- Compliance with EMS
- NEMISIS
- ...

ROKOS STEMI V2.0

1. Decrease false positive + using WIPI (wireless transmission & physical interpretation)
2. False + reliable inter-hospital trans
3. National database
4. Cardiac resuscitation
5. Pharm

Hypothermia Conference – Oct 29th

- get to level of places that do higher volume
- earlier coding; an increase in time it takes to cool by 1 hour

Education Subgroups	
Public Awareness and Education: <ul style="list-style-type: none">a. Heart attack symptom awareness data and 911 use data from DSHSb. The Agency Plus marketing and communication agency researchc. Updates and next steps	T.Moseley/Schmelzer
Professional Education: <ul style="list-style-type: none">a. Developing kits for EMS agencies with newly acquired 12 Lead ECG equipmentb. Possible STEMI conference 2011c. Goal #4 (below) update	Behrhorst/Flores

EDUCATION

Public Awareness Campaign

- longest phase of delay in chain is public's failure to recognize symptoms
- Analyze the problem & identify audience
- Dr. Wehwa Li (Epidemiologist); data collected from Tx Behavioral Risk Factor Surveil 2005 – 2008
- Test & refine concepts, messages & materials
- Jayshree Vakil & Bill Edgel of Agency Plus
- Implement, monitor & improve campaign
- Measure outcomes

Table 1 - % of adults that recognize MI symptoms by select characteristics

- data from 2001, 2003, 2005
- African Americans fared worst

Table 2 - 1st thing to do

- hosp, call doctor, call 911, call spouse, other
- lowest rates in African American population (911 calls)

► More than half of MI deaths occur before patient reaches the hospital, clinic or other ◀

- Recognize factors in developing message
- Adults 18+ but skewed toward 18-20 yr olds (lowest rate of symptom recognition)
- Females (who run homes)
- African Americans & Hispanics (less likely to call 911)

- 2 age groups
 - 45+ (higher risk) & 18-24 (less likely to call)
 - Both skewed toward African American & Hispanic population
 - Overall goal is to buy exposure that is wide spread

- Approaches
 - must connect with each group distinctly using varied venues
 - develop campaign: passion for initiative, trusted by community, local connection, willing to change own health behavior as a model

- Media Campaign
 - being developed currently by Agency Plus
 - Aug 31st – slogan presentation to non-medical focus group
- Public Presentation
 - core message being developed by Education Sub Group

Professional Education

Biggest challenge is with protocols.

Went to all non-PCI centers w/:

- STEMI protocols
- Back-up plan
- Goal: out door within 30 mins.

Without drips, trying to do too much.

Flores: go to new units; newly acquired ECG & to establish units to verify/make sure they understand

Protocol/Planning Sub-group/ EMS Subgroup a. Non-PCI hospital STEMI guidelines b. Update on goal #3 (below) c. Discussion and next steps 1. Lytic protocol	Forister/Ramming J.Moseley/King	10 min.
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PROTOCOL/PLANNING

Goals Achieved:

Goals for 2010 established: Fall 09

ECG screening guidelines: Fall 09

Non-PCI guidelines: Spring 10

- Next Meeting (lytic protocol & EMS transfer guidelines): Wed, Aug 11th @ 8am

- if 1st medical contact to 1st device used can be acq
- Zidar: need those experienced in triage, etc. need to get better understanding of what the needs are, who are candidates, 6-7% needing lytic therapy being sat on.

- Wozniak: don't have to know about lytics, but know about timing & where you are. We don't know your neighborhood...very helpful for you to come.
- Trauma Medical Directors meeting tomorrow.

<p>QI Subgroup</p> <ul style="list-style-type: none"> a. Status of Measure Data Points b. Concerns/Challenges/Roadblocks for Measures and Data Collection c. Next Steps <ul style="list-style-type: none"> 1. PCI Hospital Survey 2. Non-PCI Hospital Data Points 3. Data Point Descriptions 4. Brainstorming for Data Collection/Measures 	Gonzales/Mackey	10 min.
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* (insert Louis' slides here)

- Next Meeting: July 28th @ 8:30am
- TAKE HEART "Sudden Cardiac Arrest Survival Initiative"
 - AT&T Executive Education & Conference Center
 - \$50 Non-physicians, \$110 Physicians
 - Oct 29th @ 7:30am-4:30p

Update on Goal #5 (below)	All	5 min.
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- Need to get all hospitals to participate (& sign data sharing agreements)
- Wozniak: info not known is in pre-hosp phase
- Llano EMS – have nothing & have applied
- San Saba - \$6k short, 60 volunteers + 1 paid
 - Dave Rheimer was going to write into CATRAC if don't get all the money
- Lexington EMS – Ruth (med dir); initial stages, checking to see if interesting

- GTAC – Cardiac Care Committee @ Marriott South: Aug 18th, 2:30-4p
- Next Leadership Meeting: Oct. 20th @ 8am
- Hypothermia Conference: Oct. 29th

Mission: Lifeline Community

- <http://missionlifelinecommunity.americanheart.org/home>