



## CATRAC Mission: Lifeline Cardiac Care Protocol Sub-Workgroup

Wednesday, August 12, 2009, 7:30- 9:30am  
AHA Office 1700 Rutherford Austin, Tx

### *Minutes*

Attendees: John Moseley, *EMS Director, Hayes County EMS*; Susan Youngblood, *CTMC* ; Eden Flanders, *ED Manager - Westlake*; Barbara Borman, *Director CV Services – Seton*; Toni Fuller, *Director of CCS - St. David's SAH*; Holly Weber-Johnson, *Director of Critical Care – St. David's MC*; Pat Ramming, *Director of Transfer Center – Seton*; Nancy Maschal; Mike Howell, *CV Service Line Director – St. David's RRMC*; Lynn Castorena, *Cardiopulmonary Supervisor – St. David's RRMC*; Loni Denne, *Sr. Director Mission: Lifeline – AHA*; Ana Pechenik, *AHA volunteer* Cathy Cloud, *Cath Lab Director – Westlake*; Melissa Juarez, *STEMI coordinator - Scott & White RR*; Dr. Ken Mitchell – *CMO, St. David's NAMC*; Dr. Frank Zidar, *Cath Lab Director- Heart Hospital*; Angie Sierra, *RRT, RCP, Seton Highland Lakes*

- I. Discussed past & current regional/national initiatives
- II. Reviewed data from 2004 ACC/AHA Guidelines & 2007 updates
- III. Reviewed other regional/statewide STEMI plans/protocols

Overall goal is to develop a regional STEMI plan for our area. One of the best examples of this is the RACE STEMI plan, a guidebook that outlines AHA/ACC approved STEMI treatments/pathways. Objective would be to create a clear and concise guideline based plan/protocols with goal of improving patient outcomes & decrease time to treatment.

Discussed North Carolina plan.

Nation-wide treatment protocols are numerous & varied...would be great if we could look at the basics & say this must happen at the very least...

John:

- Current protocol (copies handed out) has been in place 2 years & they have only missed 2 STEMIs (1 pt had ST depression & was loaded w/heparin & Plavix; other pt was an evolving MI that medics didn't treat).

- Paramedics are required to take a 12 lead EKG & STEMI refresher course every 6 months.
- Unable to transmit 12 leads so reading has to be done in the field & call made into facility prior to departure

Issues: Who gets 12 lead? Who fits in that population? Currently, there's no standard protocol. Dr. Graft wrote a triage protocol & in Europe everyone gets a 12 lead.

Facilities w/current protocols : Seton Highland Lakes, Seton facilities, Scott & White Round Rock (Melissa to bring to next meeting), St. David's facilities, Heart Hospital.

Frank Zidar (FZ): believes the subgroup should develop a strategy from point of contact to facility; there is no need to develop a hospital protocol.

John Moseley (JM): Austin EMS currently uses ASA, nitro, morphine; not very aggressive b/c not far from hospital; unfortunately, the further you get out, the less continuing education available b/c of lower volume.

Loni: *Review of mission statement, geography, working groups, POE protocol, reperfusion checklist.*

FZ: Heart Hospital sorts STEMI traffic into 2 categories - EMS delivered & Transfer; they see about 1 STEMI every other day.

How does EMS distribute patients?

- 50% network choice of patient
- If no preference, goes to closest available....but trumped by network (closest hosp in network)

Loni: If the goal is under 90 mins from 1<sup>st</sup> point of contact to balloon, there needs to be another plan in place if whole deal can't be done within the 90 minute window. At most of the East Coast facilities, either EMS gives treatment or patient is taken to a non-PCI facility for lytics, then transferred emergently for cath.

FZ: Main concern is triage plan, which is currently vague. Certain questions need to be addressed:

- Who are the players – PCI, non-PCI, etc?
- How handled in Houston, other areas?
- What criteria before administering therapy?
- Who's in power to make that call?

JM: EMS should make assessment 1<sup>st</sup> before call (how is pt getting there, by air or ground), therefore possibly anticipating unnecessary weather related delays. Skytrack got rid of diversions so no longer using EMS systems.

Possible solutions:

- Dispatch has 3 mins to say “fly or no fly” – shouldn’t have to wait 20 mins for an answer b/c that’s time they could be traveling to facility.
- Protocols should be BASE RECOMMENDATIONS only b/c you can’t get everyone in a room, nor to agree.

Issue: How do you add treatment on protocols w/o education to support usage?

Ken Mitchell: Put pressure on to bring up standard. Hospitals can facilitate making resources available through current offerings like the EKG course.

Holly: EMS & flight staff will provide great insight & should be included in next mtg. The assessment is a great start, but it’s the rural areas that are a challenge. It would be difficult to enforce a protocol.

#### 4 PROTOCOLS (+1)

- EMS chest pain protocol
- Non-PCI center protocol - <90 mins
- Non-PCI center protocol - >90 mins
- PCI center
- Triage – who gets a 12 lead? signs/symptoms? Age?

KM: Doesn’t think any hospital would have a problem adopting RACE, but treatment protocols are where it will be tough to gain agreement. There are a lot more interventional cardiologists than those doing interventional stroke work; and more facilities are doing interventional cardiology, compared to only 2 that are able to do interventional stroke care. STEMI Center Designation is coming soon, but currently patients are being diverted to other facilities based on political reasons.

FZ: That’s why this group is stepping in...to do what’s in the best interest of the patient & above politics. Using the structure & framework of CATRAC will get things done.

KM: Suggested to break down 4 protocols into 4 mtgs & recruit the necessary participants (ie, EMS subgroup to attend mtg to cover EMS protocol). If a facility still chooses to do their own thing, down the road they may lose credit as PCI cert hospital. For certain hospitals, separate protocols may mean that now they only have 1 protocol to follow rather than multiple.

- SIMPLIFY
- “Easy button” – where does it live now? What is the mechanism to activate the button?
- Protocol the same w/in facility, but which one? Treatment should be the same regardless of designated facility.

JM: EMS CAPcOG provides all training w/in region; they teach (& certify) in National Standard (not all call centers are). Dawn Adams from National Association of Emergency Dispatchers may be willing to attend meeting/provide input.

FZ: Over the last 18 months, Heart Hosp has lost a lot of data capture due to patients being loaded w/heparin & plavix in transfer b/c they are kicked out of D2B assessment b/c reperfused. Ok w/the fact b/c it's what's best for the patients. Because the surgeons have been educated, it's not a big deal anymore.

**Next Meeting: Sept 16<sup>th</sup>**

- Joint meeting w/EMS subgroup.
- Attempt to tackle all items w/EMS in front of it.
- RACE, Project UPSTART, Assessment forms, Mission Lifeline Recommendations
- Will have a clear cut expectations, agenda
- Pat Ramming & Traci Forister to be co-facilitators (Ana P. to help w/admin & reminders)