Meeting Minutes:
Cardiac Care Committee
of the
Governor's EMS Trauma Advisory Council (GETAC)

Thursday, May 14, 2015 4:00 p.m.
Austin, TX

The meeting was called to order at 4:15pm.

Members attending: Richard W. Smalling, MD, PhD, Catherine Bissell, RN, Craig Cooley, MD, David Wampler, PhD, Todd Haughen, Timothy Mixon, MD, Neil White, RN, Robert Wozniak, MD, Christine Yuhas

Members unable to attend: Jamie McCarthy, MD, Loni Denne, RN

1) The report on the current results of the American Heart Association ACTION Registry was given by Dr. Smalling in Loni Denne's absence. The ACTION Registry from the national data set for 2014 included 77,000 STEMI patients. This was contrasted to the CDC data which reported that approximately 500,000 STEMIs occurred in 2014. The mortality in the ACTION data set was 6%, in the hospital which the CDC reported 15% with an additional 20% of the survivors developing congestive heart failure symptoms within the first 5 years after their index event. As previously demonstrated, the in-hospital performance at the STEMI PCI centers was excellent, achieving goals 96% of the time. In contrast, however, patients presenting to STEMI referral hospitals (non-PCI facilities) only met guidelines approximately 30% of the time reaffirming the increasing information suggesting that the pre-hospital phase of STEMI care is the next frontier for improving STEMI outcomes at least in the United States.

2) Karla Granado reported on the Rider 97 STEMI data initiative from DSHS. Approximately 55 hospitals out of a total of 135 PCI centers in ACTION allowed their data to be analyzed by DSHS. It has been previously reported that if the patient receives a pre-hospital ECG by the EMS provider the subsequent STEMI care is dramatically improved in terms of lower mortality, smaller infarct size, and lower incidence of subsequent heart failure. Unfortunately, only 23% of the patients reported by the Rider 97 effort had pre-hospital ECGs. If a patient presented to a STEMI receiving hospital (non-PCI center) there was a 40-50 minute dwell time prior to arrival by the patient to departure for transport to a STEMI PCI center. This is excessive and certainly not in compliance with the current guidelines. Similarly the dwell time in the emergency room of a STEMI receiving hospital (PCI centers) ranges from 35-51 minutes in the transport patient cohort compared to approximately 40 minutes in patients who presented directly to the emergency PCI center. In patients presenting to a STEMI referral center without PCI capability only 32% got fibrinolytic therapy within 30 minutes which is clearly well outside the guidelines. In contrast, patients admitted directly to a STEMI PCI center reported that approximately 95% received PCI within 90 minutes. Patients presenting to a STEMI referral center had a first door to balloon time within 120 minutes in only 70% of cases. Once again, these data paralleled the ACTION registry data from the

national report and underscored the importance of the pre-hospital STEMI care in non-PCI centers and in rural areas.

3) Dr. Cooley and Dr. David Wampler discussed the proposed revisions to the strategic plan for the Texas EMS Trauma System. Both of the subcommittees made proposed revisions to the strategic plan which would incorporate cardiac care into the general EMS/trauma plan previously published. After these subcommittees did their work, Dr. Bryan Eastridge of San Antonio submitted a significantly new version of the EMS strategic plan which will now require additional revisions of the materials submitted by the subcommittees chaired by Drs. Cooley and Wampler. It was felt that Dr. Eastridge's document was a much improved version, and it is anticipated that appropriate changes would be relatively simple given the previous work performed by the subcommittee.

4. Dr. Tim Mixon reported on the efforts of the Texas Heart Attack Coalition to encourage participation of all stakeholders on improving STEMI care to sit at a common table and discuss the potential optimization of STEMI care as well as potential legislative and funding initiatives. The net result of these meetings found that current STEMI care is essentially optimal in the STEMI PCI centers as evidenced by the ACTION registry data. The next focus should be on pre-hospital care, increasing the proliferation of pre-hospital ECG capability in all communities in Texas as well as improving STEMI systems of care in regions of Texas that do not have a well-developed STEMI system of care. He reminded the Cardiac Care Committee that heart disease is the leading cause of death in Texas killing approximately three times as many Texas as stroke and seven times as many as trauma/injury.

5. Dr. Mixon reported that the STEMI Texas Meeting held annually will occur this year in Dallas on the dates of October 29th and 30th and encouraged all interested parties to attend.

The meeting was concluded at 5:30pm.