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

Sunday, November 23, 2014 2:30 p.m.
Fort Worth, TX

The meeting was called to order at 2:30pm by the Chairman, Dr. Smalling.

Members attending: Richard W. Smalling, MD, PhD, Catherine Bissell, RN, Craig Cooley, MD, David Persse, MD, David Wampler, PhD, Karen Pickard, RN, Neil White, RN, and Loni Denne, RN

Members unable to attend: Todd Haugen, Robert Wozniak, MD, Christine Yuhas

1) The committee service of Karen Pickard, RN and David Persse, MD were gratefully acknowledged.

2) The previous accomplishments of the Cardiac Care Committee were noted are as follows:

The committee reviewed issues, concerns and progress made since its first meeting in February of 2009. The common themes that emerged were:

- Data on regional STEMI care is important but not all RACS have robust data collection and reporting.
- Pre-hospital data collection remains a challenge.
- Very few STEMI patients receive reperfusion therapy within 120 minutes – and the current average is 180 minutes which precludes significant salvage of ischemic myocardium and virtually guarantees the mortality rate will be 10% or more.
- Pre-hospital ECGs improve STEMI outcomes.
- Transfers from non-PCI hospitals take much too long.
- In-hospital mortality in STEMI patients remains unacceptably high.

The following priorities were all voted on and passed unanimously:

1. We need to provide a framework for STEMI referral and STEMI PCI centers
    a. Designation, re-designation and de-designation
    b. Q/A and Q/I standards for STEMI centers
2. We need to establish and maintain a Statewide STEMI registry

a. Database which is compatible with NCDR/ ACTION Registries and includes pre-hospital critical information

b. Blinded or un-blinded feedback on performance

c. Require designated STEMI PCI Centers to participate in the State and National registries

3. We need to provide mechanisms for standardization and potential funding of STEMI Care in EMS units

    a. 12-lead ECG machines with capability of transmission to STEMI referral or receiving centers should be required/ provided for all paramedic EMS units

    b. Capability of stocking and administering advanced pharmacologic agents for STEMI care including fibrinolytics and anti-platelet drugs as well as other drugs identified for pre-hospital STEMI care should be allowed.

3) Dr. Smalling provided a report on the landscape of STEMI Care in Texas and introduced the Texas Heart Attack Coalition effort **(need to provide link to SETRAC website for whole presentation)**

The highlights for this presentation included:

4) Data from the ACTION database suggested that in patients presenting to a PCI hospital in Texas 96% of the participating institutions met the guidelines which is well within the door to balloon time frame of less than 90 minutes. Unfortunately, in patients presenting to a non-PCI hospital, only 32% met the guidelines for a door to balloon time less than 90 minutes and only 46% met the guideline for door to needle time of less than 30 minutes. It was noted that of the 22 RACs in Texas, only 7 have significant STEMI regional reports from the AHA Mission Lifeline. Those include the Border RAC in El Paso, the CAT-RAC in Austin, the C-RAC in Corpus Christi, CT-RAC in Temple, NCT-RAC in Fort Worth, SETRAC in Houston and STRAC in San Antonio. There also seemed to be a correlation between increased mortality rates in Texas in regions not participating in the STEMI system reports. An additional new STEMI data management system was proposed which included a dual effort between the DSHS Cardiovascular Disease and Stroke Council data effort supported by Rider 97 and a consortium of the Texas Center for Clinical Translational Sciences (CCTS). The proposal suggests that the CCTS organizations would focus on pre-hospital STEMI data acquisition and analysis in a granular approach, and this information will be shared with the DSHS Cardiovascular Disease and Stroke Council database effort in a joint effort to drill down on important areas of potential improvement in STEMI care in Texas. Dr. Smalling also introduced the Texas Heart Attack Coalition which is a volunteer organization formed in an attempt to bring all STEMI stakeholders together in order to craft STEMI care legislation for the next biennium. Organizations in the effort include THA, TMA, TACC, AHA, TCEP, TETAF and others, as well as volunteer interventional cardiologists, STEMI nurse coordinators, EMS physicians, EMT paramedics and cardiovascular/EMS database experts.

5) Dr. Robert Hillert, a member of the Cardiovascular Disease and Stroke Council and a cardiologist from Dallas, presented the current findings from the DSHS survey of 44 hospitals participating in the ACTION registry which is being coordinated as a by- product of the Rider 97 activity. He noted that most hospitals were located in urban and suburban areas with only 3 rural hospitals participating. Approximately, 60% of the patients reviewed in this effort were self-transferred rather than by EMS for STEMI care. 23% did not have a pre-hospital ECG and 35% of all eligible patients did not have an ECG recorded within 10 minutes of hospital arrival. Median time from 1st medical contact ranged from 41 minutes to 120 minutes while the median time waiting for transfer from a non PCI hospital to a PCI hospital was 45 minutes.

6) Dr. Wampler then reported on progress in establishing a joint STEMI database with the DSHS Cardiovascular Disease and Stroke Council as well as results of the DSHS RAC STEMI system gap analysis.

Briefly: Areas with low incidence of EMS STEMI transport have a large variability in outcomes with a higher mortality. Three RACs have no data or administrative personnel, 2/3 of the RACs have EMS with ACLS capability while 1/3 of the RACs did not have ACLS capability. ½ of the RACS had pre-hospital/ cath lab activation.

7) A motion was made and unanimously approved to require STEMI as a reportable disease in Texas. This motion was then transmitted to the GETAC council.

8) Public comment: Dr. Neil Rutledge discussed modes of increased collaboration and coordination between GETAC CCC and DSHS Cardiovascular Disease and Stroke Council.

9) Future agenda items (see section 2)

The meeting was adjourned at 4pm.

Respectfully submitted,

Richard W. Smalling, MD, PhD

Chairman