

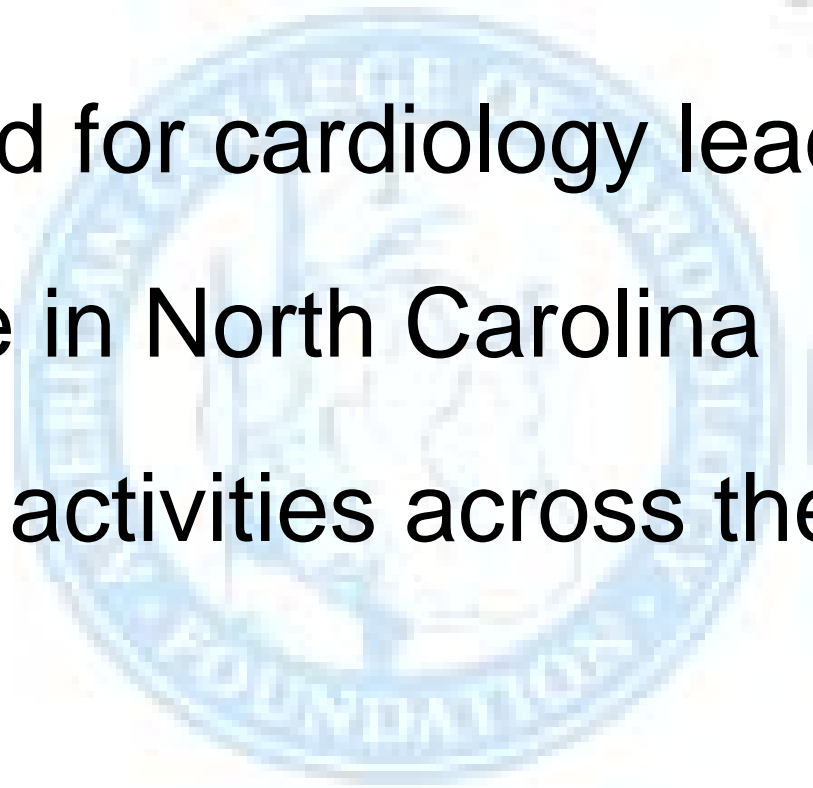


ACC State Chapters: How Can They Impact STEMI Systems Development?

James G. Jollis, MD, FACC

ACC Chapters / STEMI systems

- The need for cardiology leadership
- Example in North Carolina
- Chapter activities across the U.S.



The need for cardiology leadership

- Leadership in the hospital





An Alliance for Quality

A Guidelines Applied in Practice Program



You Are Here: :: What is D2B? » D2B Core Strategies ::

Core Strategies

1. ED physician activates the cath lab;
 2. One call activates the cath lab;
 3. Cath lab team ready in 20 – 30 minutes;
 4. Prompt data feedback;
 5. Senior management commitment;
 6. Team-based approach.
- Optional.* EMS activates the cath lab.

A pre-hospital ECG to activate the cath lab is optional. While other strategies exist, including having a cardiologist in the hospital 24/7, they are not required for participation in the D2B campaign.

<http://www.d2balliance.org/>



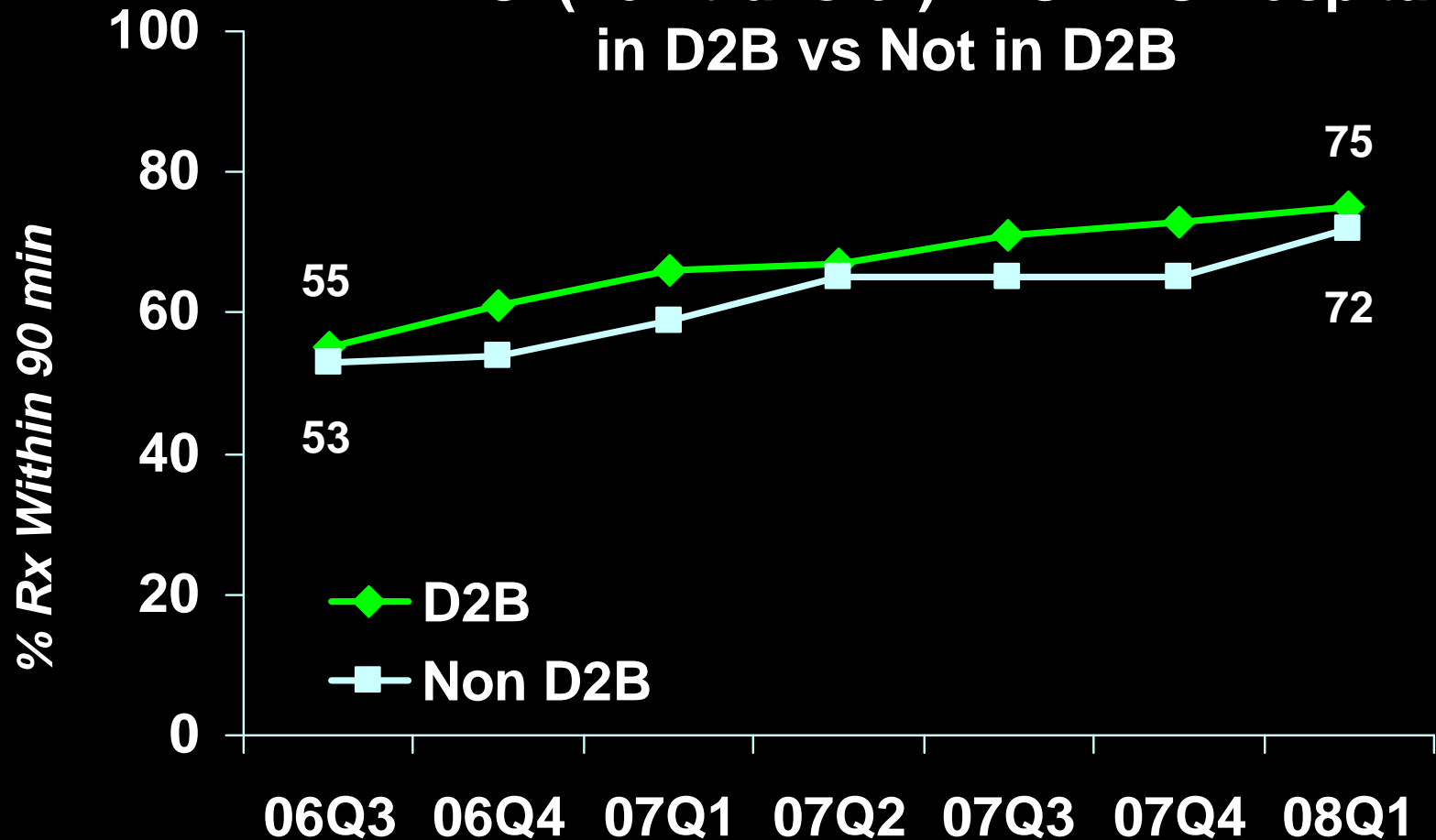
An Alliance for Quality

A Guidelines Applied in Practice Program



You Are Here: .: What is D2B? » D2B Core Strategies :.

Prim PCI (non transfer) in GWTG hospitals in D2B vs Not in D2B



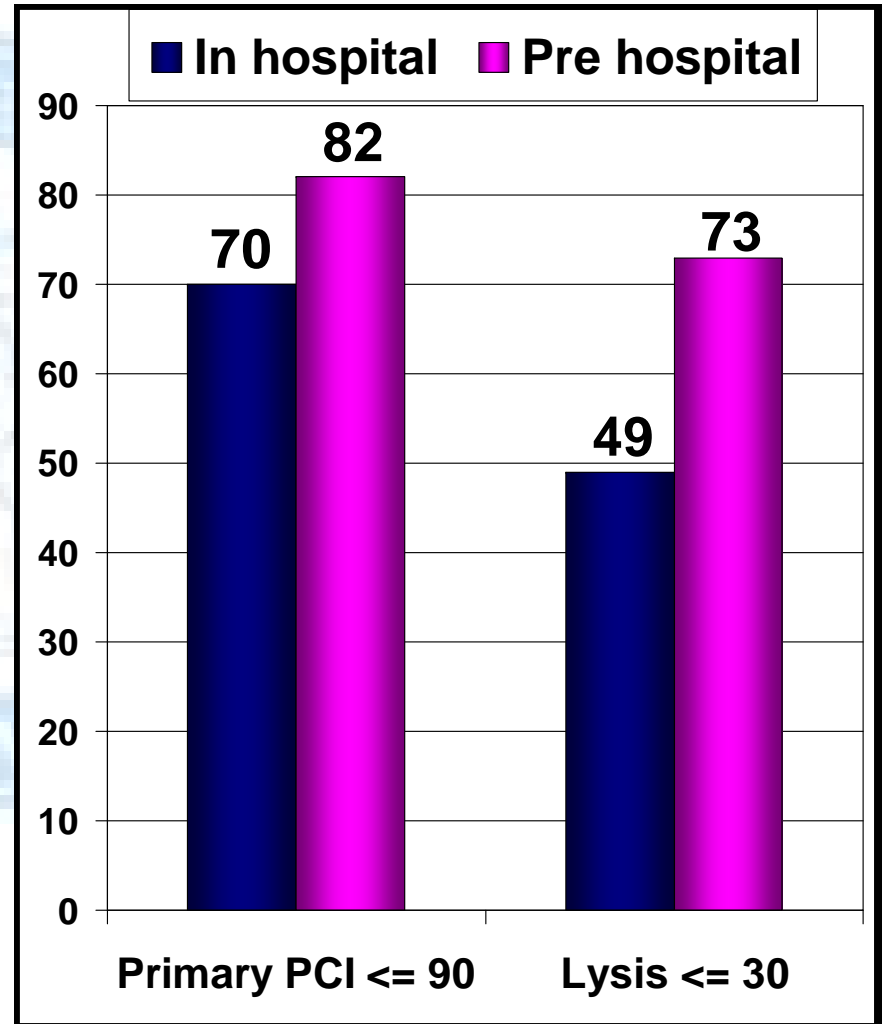
The need for cardiology leadership

- Leadership in the hospital
- Advancing pre-hospital care



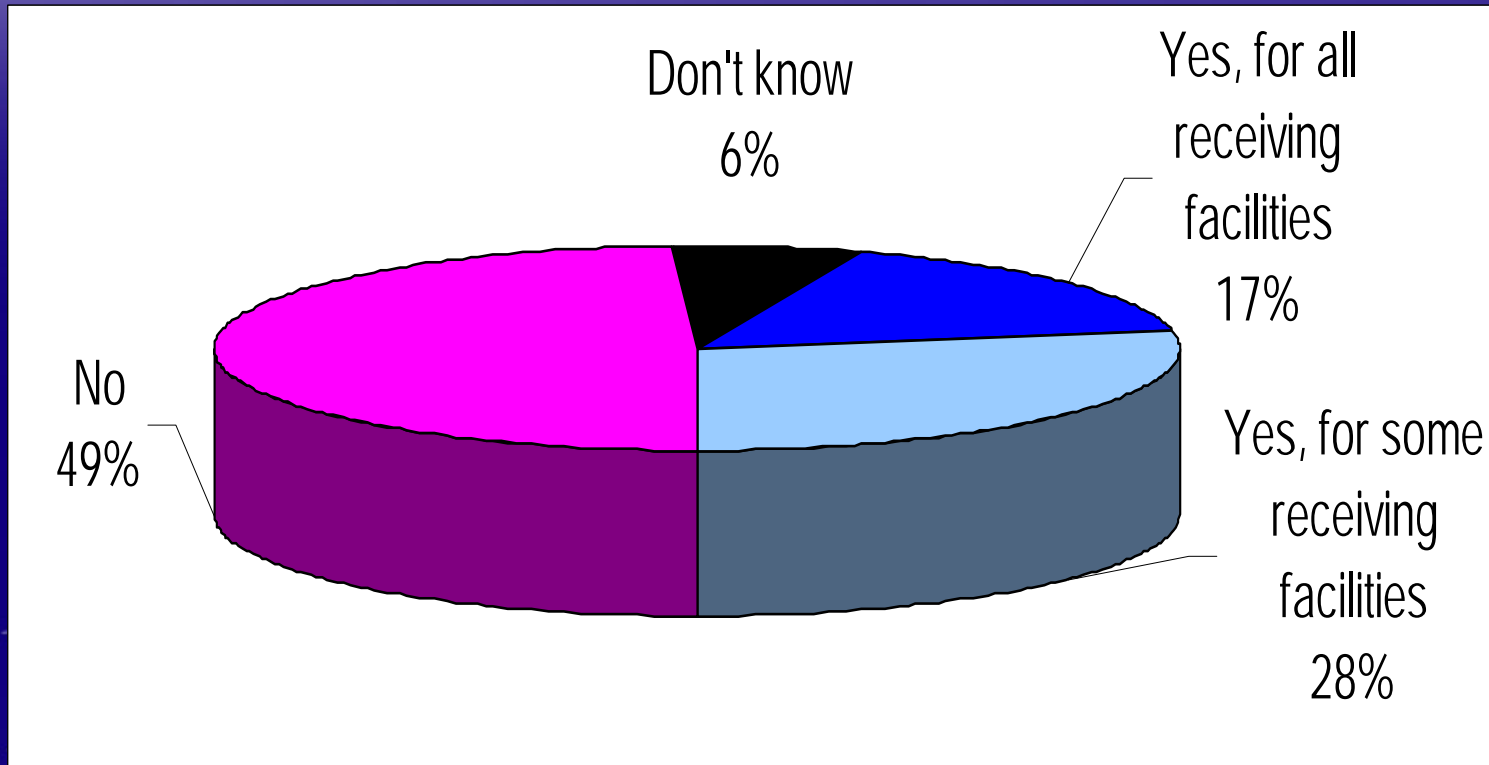
Pre-Hospital ECG

- ACTION registry - 2007
- 1,941 of 7,098 EMS transported patients had pre-hospital ECG
- Trend for lower mortality
0.85 (0.63-1.01)



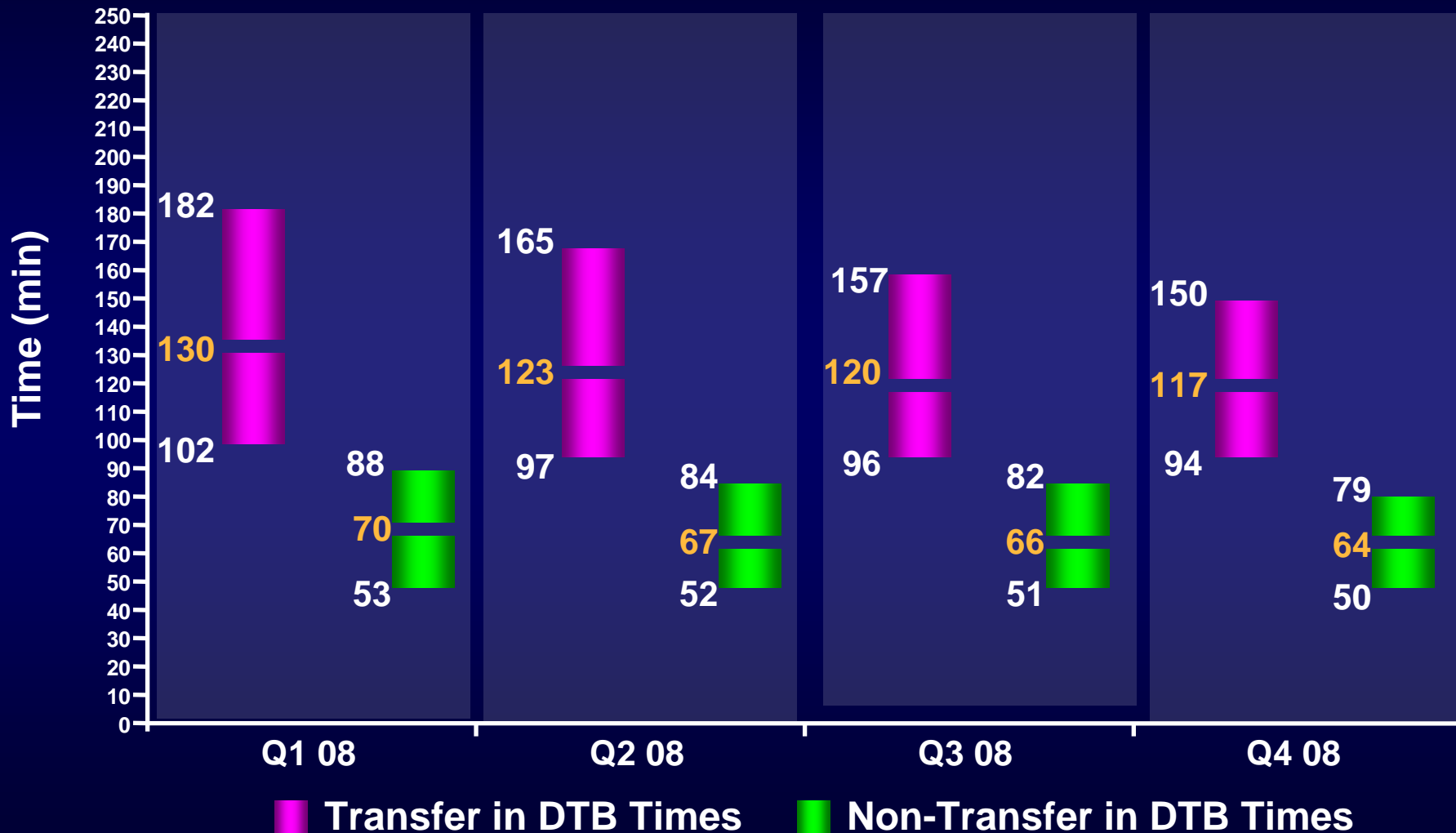
% treated within goal

12 Lead Activates the Cath Lab

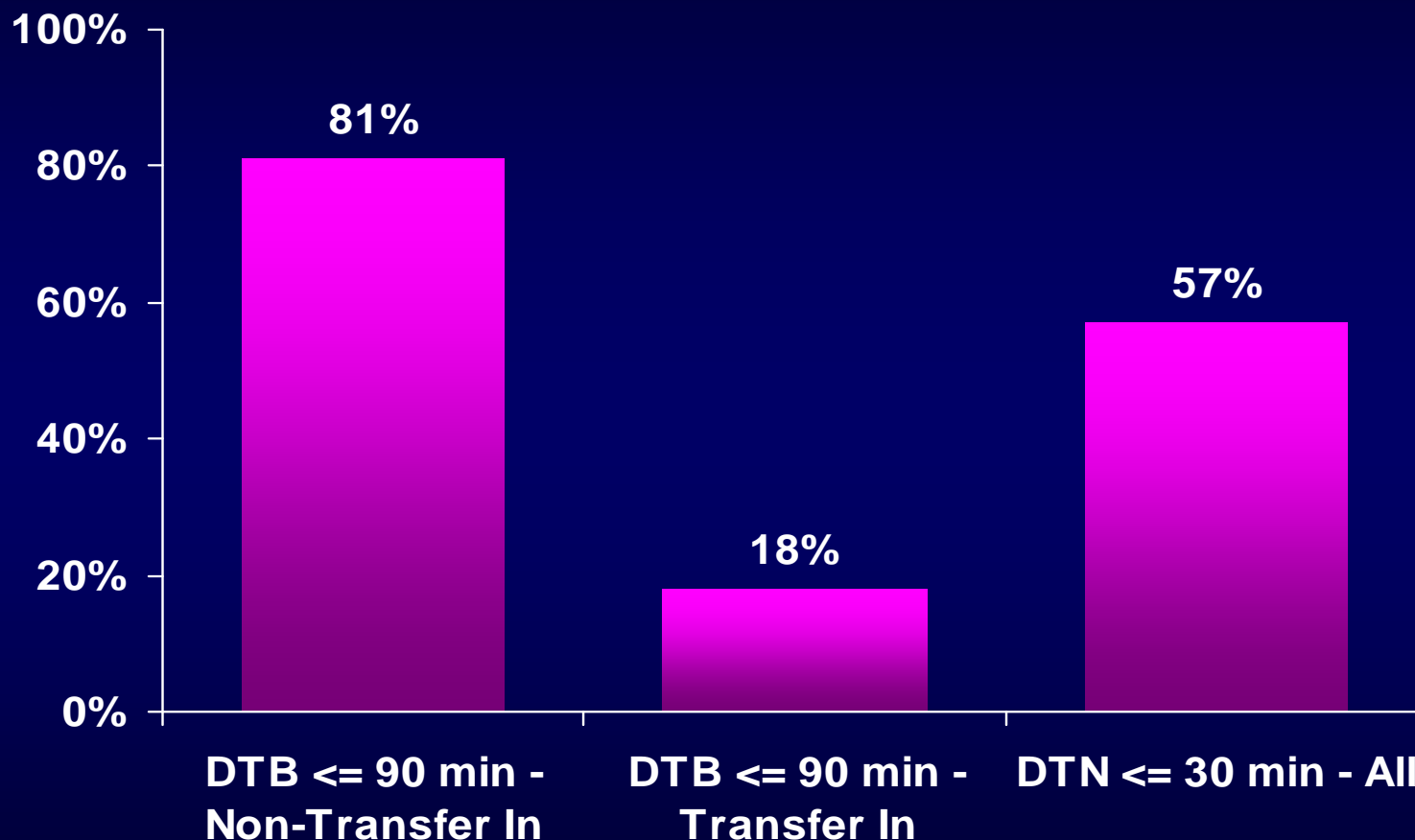


In your Agency/Organization, is the field provider's 12-lead ECG information used to activate the cath lab prior to arrival at the receiving facility?

STEMI Door-to-Balloon Times – Median Times for Transfer In and Non-Transfer In Patients



STEMI – Door to Balloon and Door to Needle Times: Cumulative 12 Month Data



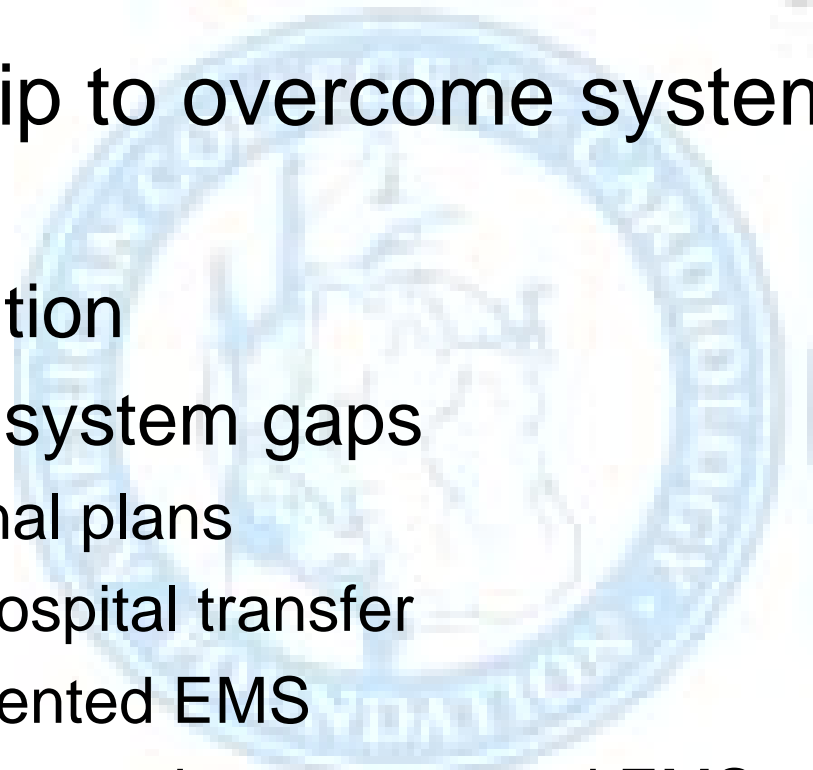
ACTION Registry-GWTG DATA: January 1 – December 31, 2008

The need for cardiology leadership

- Leadership in the hospital - D2B
- Advancing pre-hospital care
 - Enable and train EMS to activate cath. lab appropriately.
 - Establish protocols for rapid transfer of patients from outside hospitals.

The need for cardiology leadership

- Leadership to overcome systematic barriers
 - Competition
 - Medical system gaps
 - Regional plans
 - Inter-hospital transfer
 - Fragmented EMS
 - Emergency department and EMS training

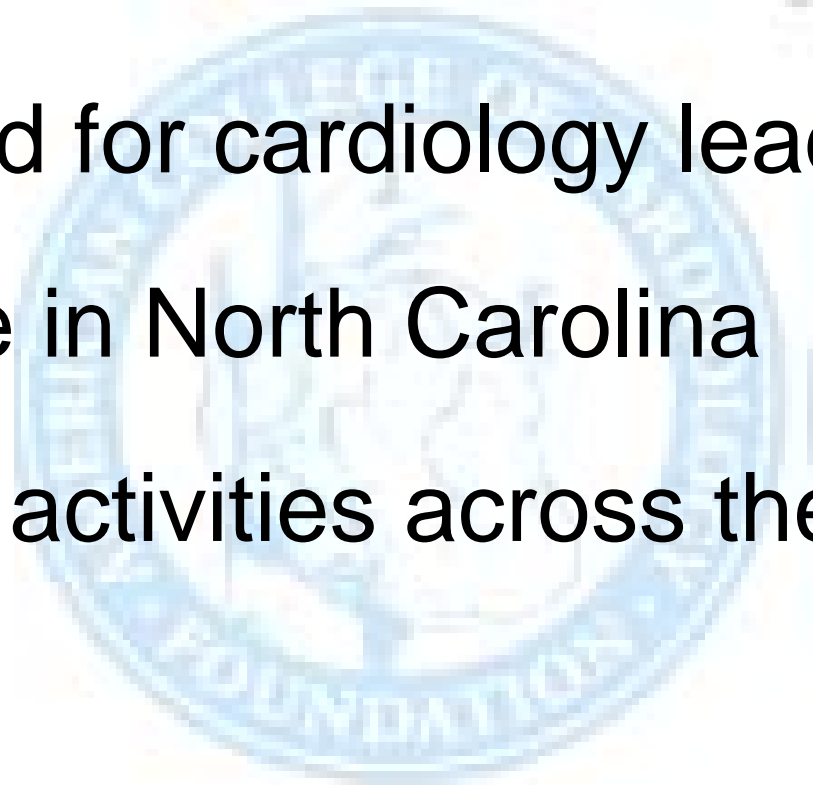


The need for cardiology leadership

- With a focus on the patient and intimate knowledge of the medical system, cardiology has the unique ability to markedly improve STEMI care without the need for regulatory oversight or legislation.

ACC Chapters / STEMI systems

- The need for cardiology leadership
- Example in North Carolina
- Chapter activities across the U.S.



How we established a STEMI system

- Interested Councilors and members form STEMI system leadership
 - Geographically disperse
 - Leaders in the interventional lab, hospital, and community
 - Appoint members from each closely competing hospital.

Competition

COMPETITION

Don't change referral lines

ED physicians, paramedics, and patients choose their hospitals

Everyone in the tent

Non-partisan

Avoided legislation

A few great leaders were key



Organization



Central Steering Committee and Statistics

- James Jollis, MD
- Chris Granger, MD
- Mayme Roettig, RN, MSN
- Kevin Anstrom, PhD

Regional Coordinators

- Marla Jordan, RN
- Lourdes Lorenz, RN, MSN
- Lisa Monk, RN, MSN
- Mary Printz, RN, FNP-C
- Stephanie Starling-Edwards, RN
- Jenny Undewood, RN

Physician leaders

- Akinyele Aluko
- Robert Applegate
- Joseph Babb
- Peter Berger
- David Bohle
- Sidney Fletcher
- J. Lee Garvey
- Robert Hathaway
- James Hoekstra
- Robert Kelly
- William Maddox

Physician leaders (continued)

- Joseph Shiber
- F. Scott Valeri
- Bradley Watling
- Hadley Wilson

Oversight Board

- Robert M. Califf
- Pamela Douglas
- Robert Harris
- Greg Mears
- William O'Neill

Organization



Central Steering Committee and Statistics

- **James Jollis, MD**
- **Chris Granger, MD**
- Mayme Roettig, RN, MSN
- Kevin Anstrom, PhD

Regional Coordinators

- Marla Jordan, RN
- Lourdes Lorenz, RN, MSN
- Lisa Monk, RN, MSN
- Mary Printz, RN, FNP-C
- Stephanie Starling-Edwards, RN
- Jenny Undewood, RN

Physician leaders

- **Akinyele Aluko**
- **Robert Applegate**
- **Joseph Babb**
- Peter Berger
- **David Bohle**
- Sidney Fletcher
- J. Lee Garvey
- **William Hathaway**
- James Hoekstra
- **Robert Kelly**
- **William Maddox**

Physician leaders (continued)

- Joseph Shiber
- **F. Scott Valeri**
- Bradley Watling
- **Hadley Wilson**

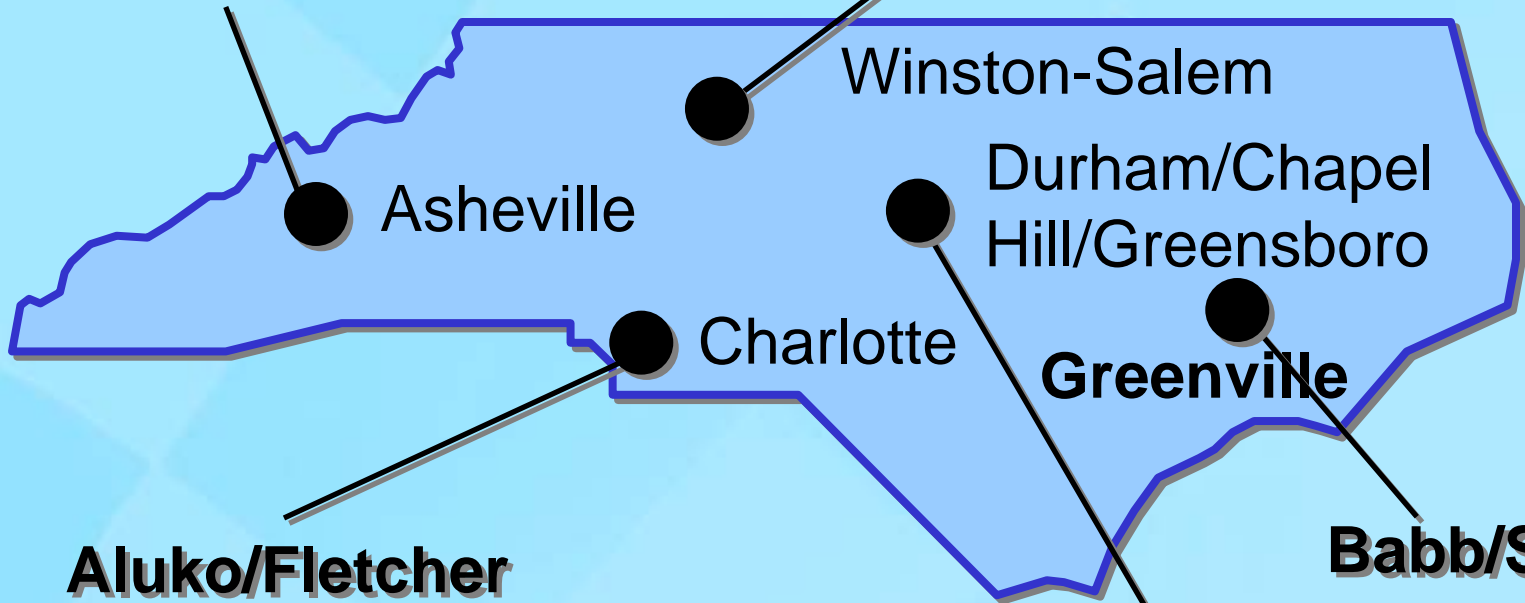
Oversight Board

- **Robert M. Califf**
- **Pamela Douglas**
- Robert Harris
- Greg Mears
- **William O'Neill**



**Maddox/Hathaway
Hunt/Horrine**

**Bohle
Hoekstra/Applegate**



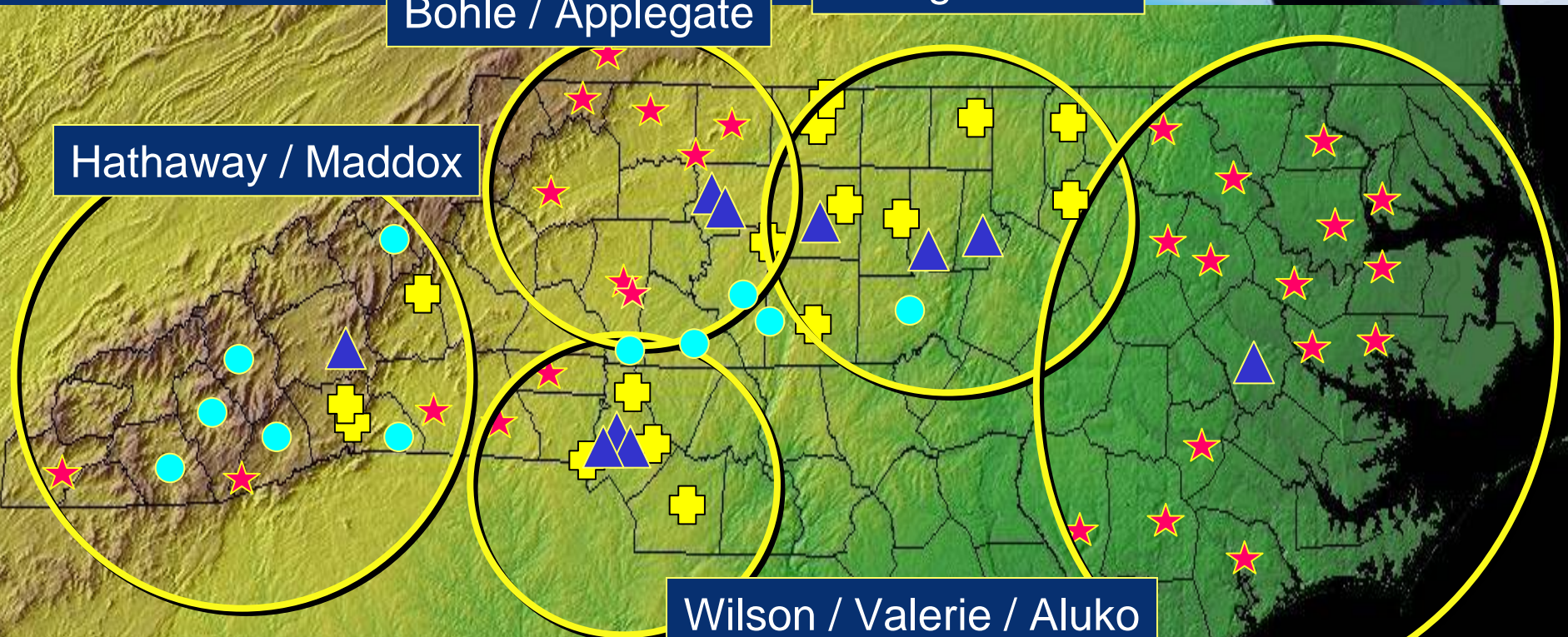
**Aluko/Fletcher
Valerie/Watling
Wilson/Garvey**

**Granger/Jollis/Berger/Stoufer
Wilson/Pulsipher/Beaton**

Babb/Shiber

RACE Centers and Regions

65 hospitals (10 PCI, 55 non PCI)



- ▲ 10 PCI centers
- ✚ 16 Transfer for PCI
- ★ 28 Lytics
- 11 Mixed

How we established a STEMI system

- Use Chapter website as STEMI system communication site



nccacc.org



North Carolina
CHAPTER



[Home](#)
[About the Chapter](#)
[Benefits of Membership](#)
[Career Center](#)
[Calendar of Events](#)
[Officers and Councilors](#)
[Annual Conference/Sponsors](#)
[Newsletters](#)
[Member Directory](#)
[Links](#)
[Contact Us](#)



Reperfusion of Acute Myocardial Infarction in Carolina Emergency Departments (RACE) project is a collaborative effort to increase the rate and speed of coronary reperfusion through systemic changes in emergency care. The project is based upon the collaborative efforts of EMS personnel, physicians, nurses, administrators, and payers from five regions and 68 hospitals throughout North Carolina. The

recommendations of this project are based upon established guidelines, published data, and the knowledge and experience of numerous individuals specializing acute myocardial infarction care. Visit www.race-er.org for more information.

North Carolina Interventional Summit: Focus on STEMI

June 2, 9:00am - 4:30pm

Forysth Medical Conference Center

3333 Silas Creek Pkwy

Winston-Salem, NC

A maximum of 6 AMA PRA category 1 CME credits have been designated for this educational activity.

[View the agenda](#)

[Click here for more information about RACE and to read the press releases.](#)



Announcements

This Week at ACC

[American Imaging Management Clinical Information Worksheet](#)

NC/ SC 16th Annual Joint Meeting
September 11-13, 2009
Grove Park Inn
Asheville, NC

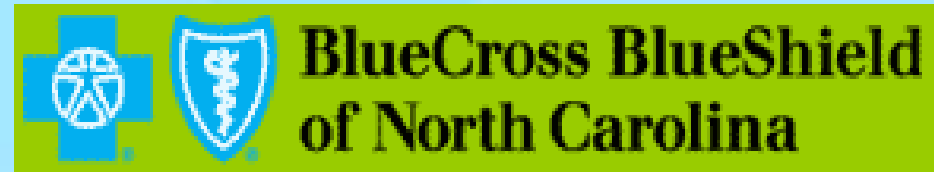
[UHC: Premium Physician Designation Program](#)

[CIGNA Revises Modifier \(-25 and -59\) Policy](#)

How we established a STEMI system

- Reach out to other professions / professional societies
 - emergency medicine / ACEP / SAEM
 - EMS / State / Medical directors / training directors
 - nursing / cath. lab supervisors / staff
 - hospital administrators
 - payers

RACE Partners



How we established a STEMI system

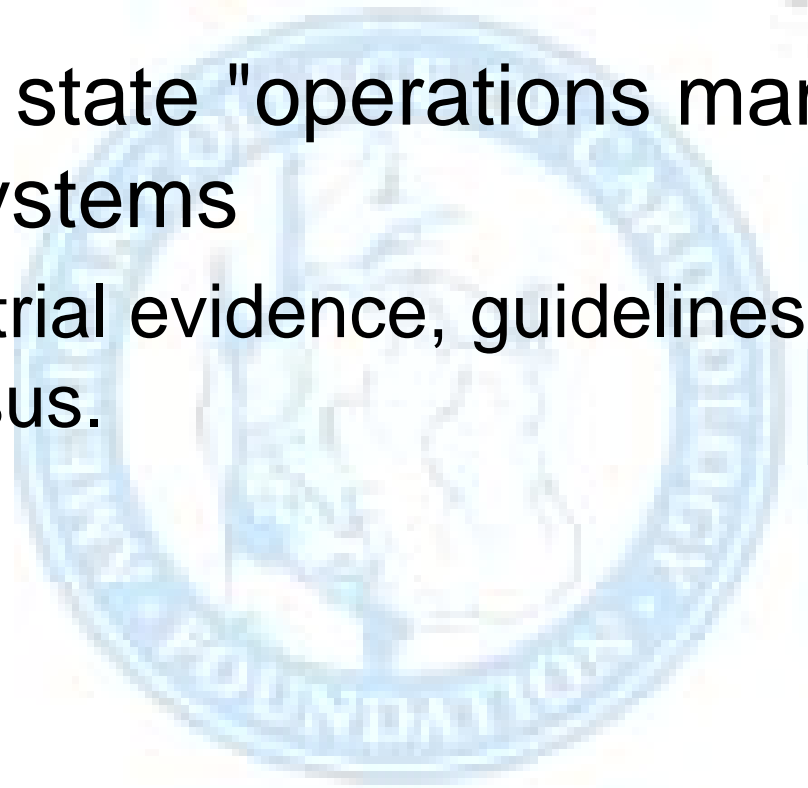
- Organize leadership and system meetings around Chapter activities / annual meetings.





How we established a STEMI system

- Publish a state "operations manual" for STEMI systems
 - Clinical trial evidence, guidelines, regional consensus.



Establish a plan



Single best plan per hospital

OPERATIONS MANUAL



Regimen A – Primary PCI

Preferred if able to meet time goals

(To be used with institution specific standing orders/protocols for ST-elevation myocardial infarction patients)

ELIGIBLE PATIENTS

- Within 12 hours of symptom onset.
- ST-segment elevation in 2 or more contiguous leads >1mm or left bundle branch block.
- Primary angioplasty is also the best option for:
 - Cardiogenic Shock; Killip class III or >.
 - Possible ST-elevation MI but uncertain of diagnosis.
 - Contraindication to fibrinolysis.
 - Physician or patient preference.

Goal is to open artery with angioplasty balloon within 90 minutes of arrival to first hospital or first medical contact.

- Emergency department physician makes the decision about need for primary angioplasty, if possible. Consultation should be limited to situations of uncertainty.
- Notify PCI hospital of an ST-elevation MI in need of primary angioplasty.
- Complete EMTALA form as a priority.
- Fax patient records including ECG to receiving hospital WHILE PATIENT IN TRANSFER.
- Continuous IV infusions should only be used if required for stability during transfer.

OTHER MEDICATIONS

1. Heparin: Bolus at 70 IU/kg IV bolus. No maintenance infusion during transfer.
2. Aspirin: 325 mg chewed.

PRN Medications:

1. Nitroglycerin paste 1 to 2 inches topically PRN chest pain.
2. Morphine Sulfate 2-10mg IV for chest pain unrelieved by Nitroglycerin PRN.

Reperfusion Regimen B – Fibrinolysis

(To be used with institution specific standing orders/protocols for ST-elevation myocardial infarction patients)

ELIGIBLE PATIENTS

- Within 12 hours of symptom onset.
- ST-segment elevation in 2 or more contiguous leads >1mm or left bundle branch block.
- Absence of contraindications (see below).

FIBRINOLYTIC [tenecteplase (TNK) or reteplase (rPA)]

Tenecteplase (TNK) regimen

Single IV bolus over 5 seconds

Use TNK dose chart at right to determine dose. ➡

Patient weight _____ kg
 Patient-specific dose _____ mg
 (NOT TO EXCEED 50mg)

OR

Reteplase (rPA) regimen

10 units IV over 2 minutes given twice at 30-minute intervals.

Patient Weight (kg)	TNK (mg)	Volume TNK to be administered (ml)
< 60	30	6
≥ 60 to < 70	35	7
≥ 70 to < 80	40	8
≥ 80 to < 90	45	9
≥ 90	50	10

In nurses' notes and MAR, please note EXACT TIME of fibrinolytic administration, and obtain ECG 30 minutes after fibrinolytic administered.

OTHER MEDICATIONS:

1. Heparin:
 - a. Bolus at initiation of TNK or rPA - 60 IU/kg IV bolus (maximum 4,000 IU).
 - b. Maintenance 12 IU/kg/h (maximum 1,000 IU) to achieve activated partial thromboplastin time (APTT) 1.5 to 2 times control, maintained for 48 hrs.
2. Aspirin 325 mg chewed.

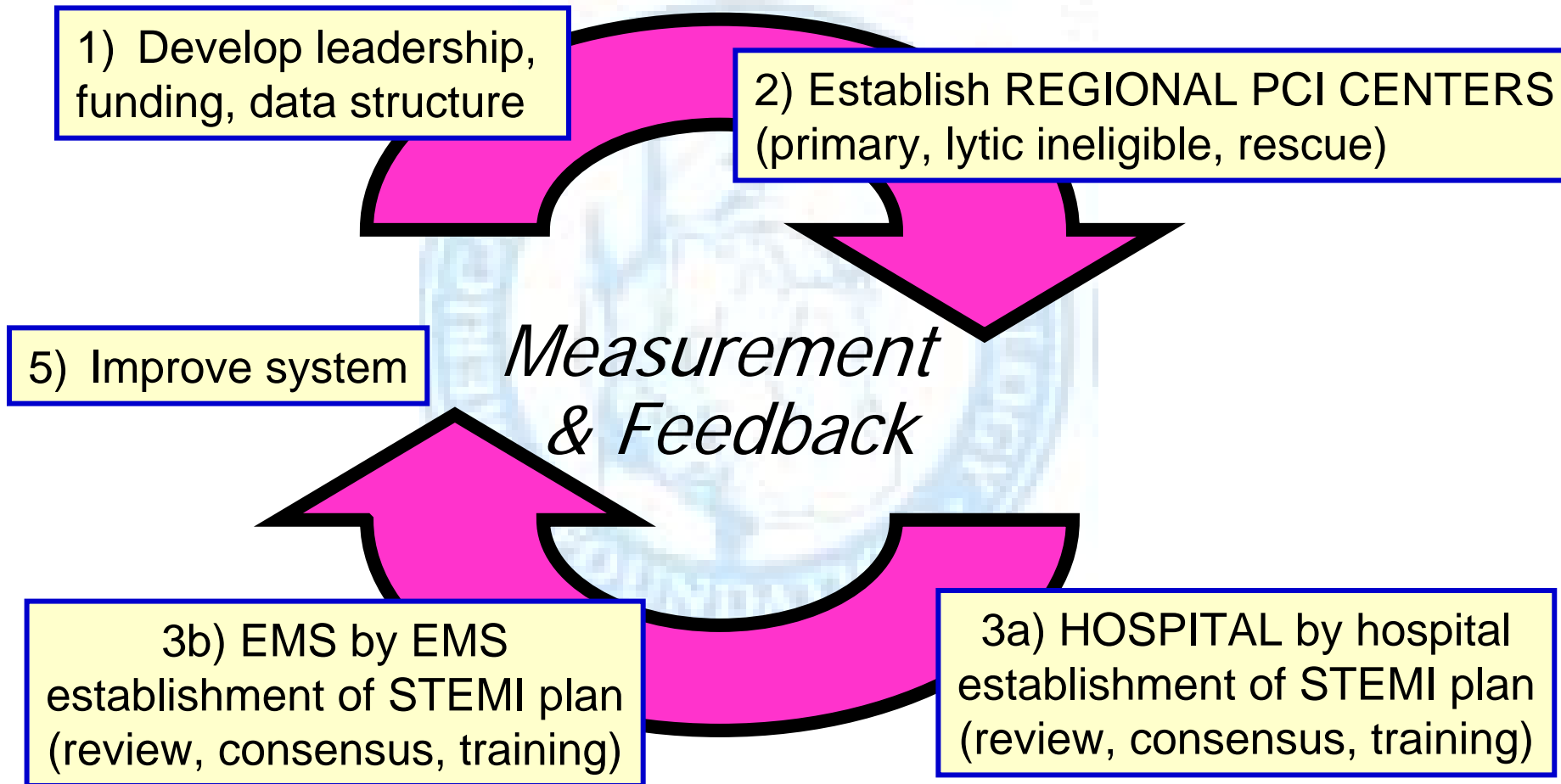
Absolute contraindications

- Any prior intracranial hemorrhage
- Known structural cerebral vascular lesion (for example arteriovenous malformation)
- Known malignant intracranial neoplasm (primary or metastatic)
- Ischemic stroke within 3 months EXCEPT acute ischemic stroke within 3 hours
- Suspected aortic dissection
- Active bleeding or bleeding diathesis (excluding menses)
- Significant closed head or facial trauma within 3 months

Relative contraindications

- History of chronic severe, poorly controlled hypertension
- Severe hypertension on presentation (systolic blood pressure greater than 180 mm Hg or diastolic blood pressure greater than 110 mm Hg)
- History of prior ischemic stroke greater than 3 months, dementia, or known intracranial pathology not covered in contraindications
- Traumatic or prolonged (greater than 10 minutes) CPR or major surgery (less than 3 weeks)
- Recent (within 2 to 4 weeks) internal bleeding
- Noncompressible vascular punctures
- Pregnancy

How we established a STEMI system



RACE PRIMARY PCI Center*



1. 24/7 PCI capability within 30 minutes
2. Single number activation (immediate)
3. Accept patients regardless of bed availability
4. Ongoing data monitoring and feedback (ACTION-GWTG, “cath lab activation” registry)
5. STEMI Team with strong administrative support and dedicated STEMI coordinator
6. Improve STEMI care for all hospitals in region regardless of affiliation

** Must be fully operating to be a RACE regional PCI center*

RACE Interventions



RACE Hospital - Non PCI*



1. STEMI Team with strong administrative support
2. Establish a single plan for STEMI reperfusion
3. Periodic data collection and review by RACE regional coordinator

** Must be in place to be a RACE hospital*

EMS

Acute Cardiac Toolkit



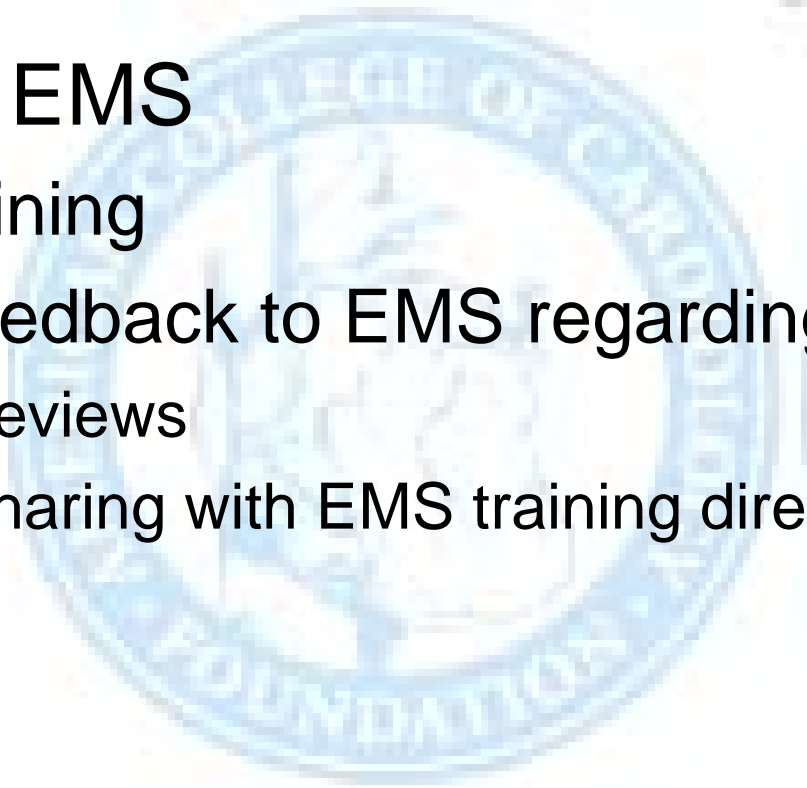
Established STEMI system quality standards:

- 1) In the field ECG
- 2) Under 15 minute scene time
- 3) Hospital pre-notification
- 4) Standing STEMI plan / destination protocols

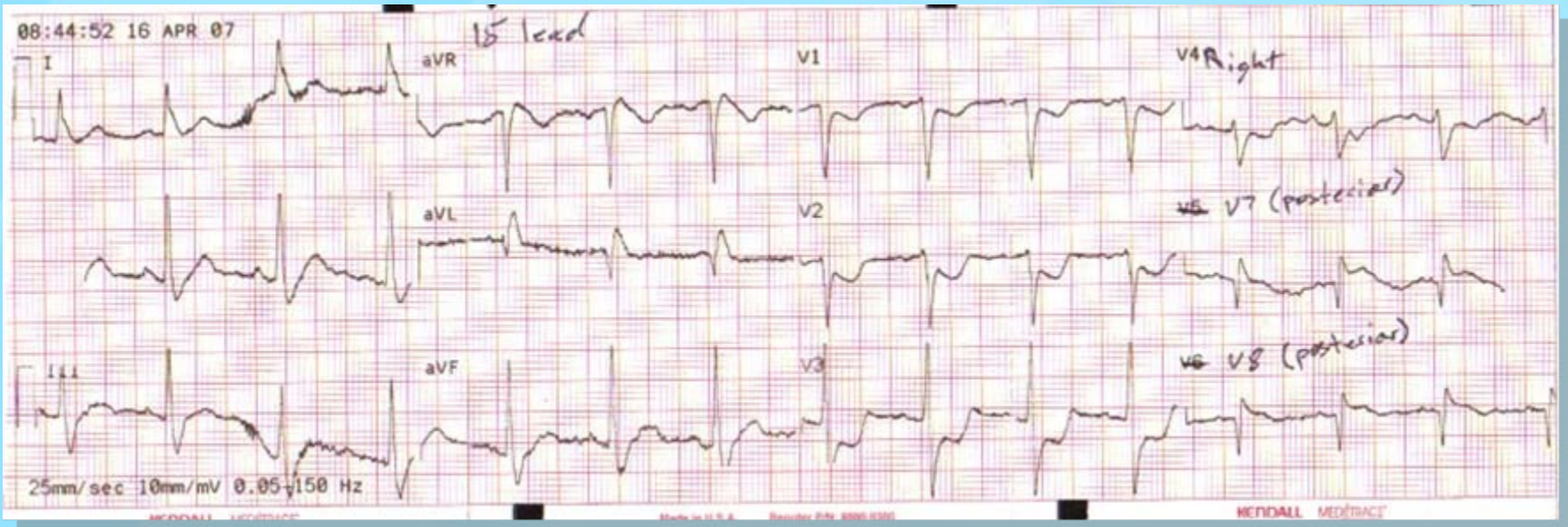
A screenshot of the EMS Performance Improvement Center website navigation menu. The menu is a dark grey bar with a white header on the left containing the "EMS PERFORMANCE IMPROVEMENT CENTER" logo. On the right side of the header are links for "Support", "Login", and "Feedback". Below the header are four colored buttons: a red button for "EMS TOOLKITS" with the "EMS TOOLKITS" logo, a blue button for "PREMIS" with the "PreMiS" logo, a yellow button for "NC Hospital Status System" with the "NORTH CAROLINA HOSPITAL STATUS SYSTEM" logo, and a green button for "NEMISIS" with the "NEMISIS" logo.

How we established a STEMI system

- Focus on EMS
 - ECG training
 - Direct feedback to EMS regarding reperfusion
 - Case reviews
 - Data sharing with EMS training director



ECG training



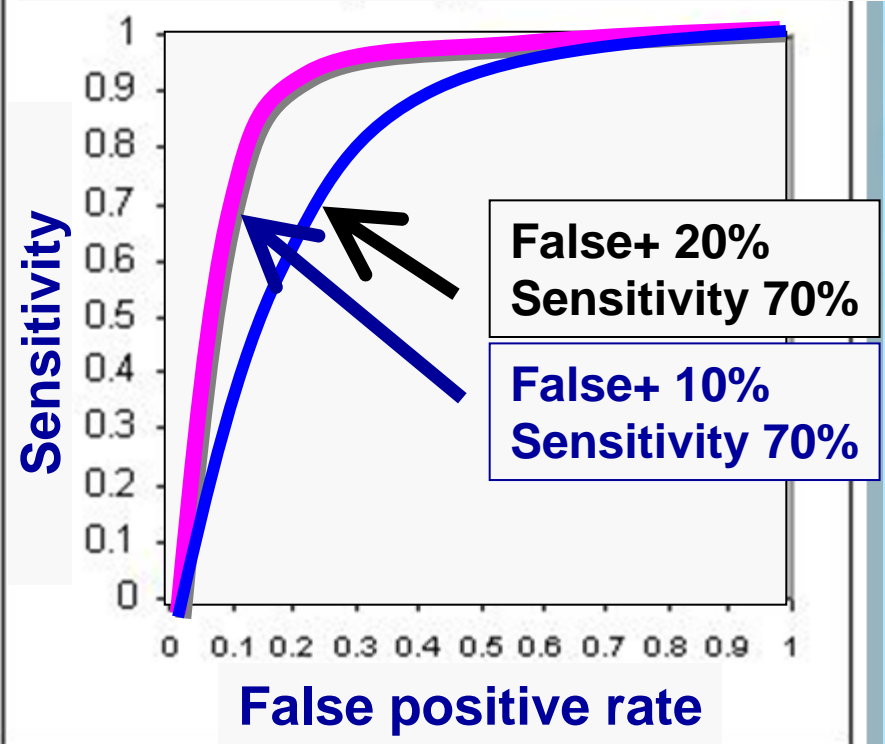
ECG training / case review



IMPROVE ECG
PERFORMANCE

*Fewer false activations
without missing
more STEMI's*

Receiver Operating
Characteristic Curve



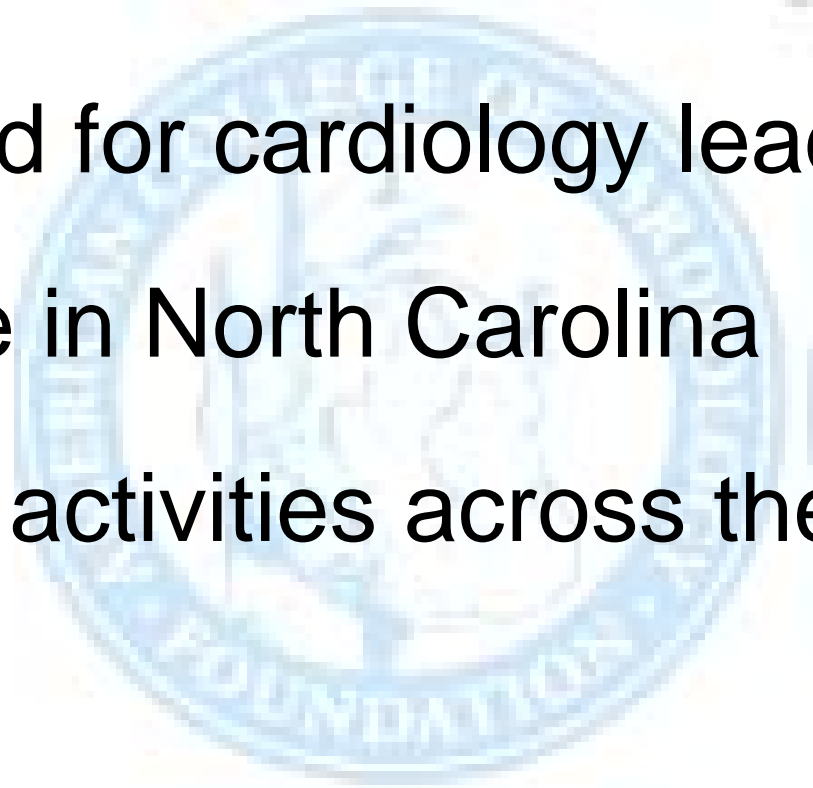
How we established a STEMI system

- Monitor regulatory / legislative activities.



ACC Chapters / STEMI systems

- The need for cardiology leadership
- Example in North Carolina
- Chapter activities across the U.S.



MISSION: Lifeline™

➔ Improving the System of Care for STEMI Patients





MissionLifeline Criteria

Primary PCI Hospital/ STEMI-Receiving Center

- 1) Protocols for triage, diagnosis and Cardiac Catheterization Laboratory activation should be established within the primary PCI hospital/STEMI Receiving Center. A single activation phone call should alert the STEMI team. Criteria for EMS activation of the Cardiac Catheterization Laboratory should be established in conjunction with EMS offices.
- 2) The STEMI-Receiving Center should be available 24 hours/7 days a week to perform primary PCI.
- 3) The Cardiac Catheterization Laboratory staff including interventional cardiologist should arrive within 30 minutes of activation call.
- 4) There should be universal acceptance of STEMI patients (no diversion). There should be a plan for triage & treatment for simultaneous presentation of STEMI patients.
- 5) Interventional cardiologists should meet ACC/AHA criteria for competence. Interventional cardiologists should perform at least 11 primary PCI procedures per year and 75 total PCI procedures per year.



MissionLifeline Criteria

Primary PCI Hospital/ STEMI-Receiving Center

- 1) Protocols for triage, diagnosis and Cardiac Catheterization Laboratory activation should be established within the primary PCI hospital/STEMI Receiving Center. A single activation phone call should alert the STEMI team. Criteria for EMS activation of the Cardiac Catheterization Laboratory should be established in conjunction with EMS offices.
- 2) The STEMI-Receiving Center should be available 24 hours/7 days a week to perform primary PCI.
- 3) The Cardiac Catheterization Laboratory staff including interventional cardiologist should arrive within 30 minutes of activation call.
- 4) There should be universal acceptance of STEMI patients (no diversion). There should be a plan for triage & treatment for simultaneous presentation of STEMI patients.
- 5) Interventional cardiologists should meet ACC/AHA criteria for competence. Interventional cardiologists should perform at least 11 primary PCI procedures per year and 75 total PCI procedures per year.



MissionLifeline Criteria

Primary PCI Hospital/ STEMI-Receiving Center

- 6) The STEMI-Receiving Center should meet ACC/AHA criteria for volume and perform a minimum of 36 primary PCI procedures and 200 total PCI procedures annually.
- 7) The STEMI-Receiving Center should participate in the Mission: Lifeline-approved data collection tool, ACTION Registry – GWTG.
- 8) A program should be in place to track and improve treatment (acutely & at discharge) with ACC/AHA guideline based Class I therapies.
- 9) There should be a recognized STEMI-Receiving Center liaison/system coordinator to the system and a recognized physician champion.

MissionLifeline Criteria



Primary PCI Hospital/ STEMI-Receiving Center

10) There should be monthly multidisciplinary team meetings to evaluate outcomes and quality improvement data. Operational issues should be reviewed, problems identified, and solutions implemented. The following measurements should be evaluated on an ongoing basis:

- a) Door-to-balloon (first device used) time, non-transfer within 90 minutes
- b) STEMI Referral Hospital ED door-to-balloon (first device used) time, transfer within 90 minutes
- c) First Medical contact to balloon inflation (first device used) non-transfer within 90 minutes
- d) First Medical contact to balloon inflation (first device used) transfer
- e) Proportion of eligible patients receiving reperfusion therapy
- f) Proportion of eligible patients administered guideline-based Class I therapies
- g) Proportion of patients with field diagnosis of STEMI and activation of the Cardiac Catheterization Laboratory for intended primary PCI that
 - i) do not undergo acute catheterization because of misdiagnosis
 - ii) undergo acute catheterization and found to have no elevation in cardiac biomarkers and no revascularization in the first 24 hours
- h) Inhospital mortality



MissionLifeline Criteria

Non-PCI Hospital/ STEMI Referral Center

- 1) Appropriate protocols and standing orders should be in place for the identification of STEMI. At a minimum, these protocols should be present in the Intensive Care Unit/Coronary Care Unit and Emergency Department (ED)
- 2) Each ED should maintain a standardized reperfusion STEMI care pathway that designates primary PCI as the preferred reperfusion strategy if transfer of patients to a primary PCI hospital/STEMI-Receiving Center can be achieved within times consistent with ACC/AHA guidelines.
- 3) Each ED should maintain a standardized reperfusion STEMI care pathway that designates fibrinolysis in the ED (for eligible patients) when the system cannot achieve times consistent with ACC/AHA guidelines for primary PCI.
- 4) If reperfusion strategy is for primary PCI transfer, a streamlined, standardized protocol for rapid transfer and transport to a STEMI-Receiving Center should be operational.



MissionLifeline Criteria

Non-PCI Hospital/ STEMI Referral Center

- 5) If reperfusion strategy is for primary PCI transfer, all patients should be transported to the most appropriate STEMI-Receiving Center where the expected first door-to-balloon (first device used) time should be within 90 minutes (considering ground versus air transport, weather, traffic).
- 6) The STEMI Referral Center should have an ongoing quality improvement process, including data measurement and feedback, for the STEMI population and collect and submit Mission: Lifeline required data elements (using the Mission: Lifeline Bridging form*).
- 7) A program should be in place to track and improve treatment (acutely and at discharge) with ACC/AHA guideline based Class I therapies.
- 8) A multidisciplinary STEMI team, including EMS, should review hospital specific STEMI data on a quarterly basis.
 - a) Door-to-first ECG time (goal <10 minutes)
 - b) Proportion of STEMI-eligible patients receiving any reperfusion (PCI or fibrinolysis) therapy.
 - c) STEMI Referral Center ED door-to-balloon (first device used) time for patients transferred to PCI center
 - i) STEMI Referral Center ED door to ED discharges
 - ii) STEMI Referral Center ED door-to-balloon (first device used) time within 90 minutes (including transport time)

MissionLifeline Criteria

EMS



- 1) Each EMS system should maintain a standardized algorithm for evaluation and treatment of patients with symptoms suggestive of myocardial ischemia that should include acquisition of a 12-lead ECG and appropriate **communication of the ECG findings** (via direct paramedic interpretation/voice communication, automated computer algorithm interpretation, wireless transmission and physician interpretation, or any combination of these three strategies) to the receiving hospital.
- 2) **Each EMS system should maintain a standardized reperfusion STEMI care pathway that designates primary PCI as the preferred reperfusion strategy if initiated within 90 minutes of first medical contact or fibrinolytic therapy in eligible patients when primary PCI within 90 minutes is not possible.**
- 3) **Prearranged EMS destination protocols for STEMI patients should include:**
 - a) Bypassing non-PCI hospitals/STEMI Referral Centers and going directly to primary PCI hospitals/STEMI-Receiving Centers for patients with anticipated short transport interval (e.g. <30 minutes in urban/suburban settings, so as to achieve primary PCI within 90 minutes)
 - b) Emergency transfer by EMS or other agencies to a STEMI-Receiving Center of patients with STEMI who transport themselves to a STEMI Referral Center.
 - c) Air transport if possible (or default to ground transport) to STEMI-Receiving Center or stabilization in STEMI Referral Center for patients with anticipated long transport time and/or either fibrinolytic ineligible and/or in cardiogenic shock
 - d) Administration of fibrinolytic therapy prehospital or in a STEMI Referral Center for fibrinolytic eligible patients with anticipated time to primary PCI exceeding 90 minutes
 - e) Emergency transfer to a STEMI-Receiving Center of patients who develop STEMI while in hospital at STEMI Referral Center (non-PCI hospital).

MissionLifeline Criteria

EMS



- 4) When taken directly to a STEMI-Receiving Center, all STEMI patients should be transported to the most appropriate facility as determined by Mission: Lifeline hospital criteria, with a system goal of first medical contact to balloon inflation (initial device used) within 90 minutes.
- 5) EMS medical director or designate should monitor care related to EMS patients with STEMI by meeting at least quarterly with prehospital providers, emergency physicians, [interventional cardiologists](#), nursing staff, receiving hospital representatives, and other appropriate individuals (i.e. STEMI Survivor).
- 6) The following measurements should be evaluated on an ongoing basis:
 - a) Symptom onset to 911 call
 - b) Time 911 call is first received by primary public safety answering point to vehicle arrival at hospital door
 - c) [Time from first medical contact to balloon inflation \(first device used\).](#)
 - d) [Time from prehospital ECG to balloon inflation \(first device used\).](#)
 - e) Proportion of patients with non-traumatic chest pain > 35 years treated by EMS for whom 12-lead ECGs were obtained
 - f) Proportion of patients with STEMI treated by EMS for whom 12-lead ECGs were obtained
 - g) [Proportion of patients with field diagnosis of STEMI and activation of the Cardiac Catheterization Laboratory for intended primary PCI that](#)
 - i) [do not undergo acute catheterization because of misdiagnosis](#)
 - ii) [undergo acute catheterization and found to have no elevation in cardiac biomarkers and no revascularization in the first 24 hours](#)
 - h) [Proportion of patients with EMS treated ventricular fibrillation \(VF\) who are taken to the Cardiac Catheterization Laboratory](#)
 - i) Survival to hospital discharge of all STEMI patients and of patients with VF (EMS and STEMI-Receiving Center to monitor jointly)

MissionLifeline Criteria

STEMI System



- 1) The System should be registered with Mission: Lifeline.
- 2) There should be on-going multidisciplinary team meetings that include EMS, non-PCI hospitals/STEMI Referral Centers, and PCI hospitals/STEMI Receiving Centers to evaluate outcomes and quality improvement data. Operational issues should be reviewed, problems identified, and solutions implemented.
- 3) Each STEMI System should include a process for pre-hospital identification and activation, destination protocols to STEMI Receiving Centers, and transfer for patients who arrive at STEMI Referral Centers and are primary PCI candidates, and/or are fibrinolytic ineligible and/or in cardiogenic shock.
- 4) Each system should have a recognized system coordinator, [physician champion](#), and EMS medical director.
- 5) Each system component (EMS, STEMI Referral Centers and STEMI-Receiving Centers) should meet the appropriate criteria listed above.



ACC Chapters and AHA Mission: Lifeline STEMI Efforts 2009

This document captures information from ACC Chapter Presidents and Governors, Chapter Executives and ACC members and staff, and will be updated on a rolling basis as activities are reported.

HIGHLIGHTS

- Most Chapters reported difficulty in promoting the AHA Legislation to their lawmakers due to financial crisis.
- Many projects and meetings are scheduled already in 2009 to move MLL/STEMI efforts forward.

ALABAMA

Governor Michael B. Honan, M.D., F.A.C.C.
Dr. Paine Sothie, Recommended STEMI Champion

- The Chapter held a STEMI organizational meeting in November 2008 and is presenting the Mission Lifeline at the Chapter Annual Meeting June 4, 2009.
- The Alabama Chapter has opted to initiate its generalization of MLL care in the Birmingham area in cooperation with an ongoing effort of the Birmingham Regional Emergency Medical Services System (BREMSS).
 - This is a volunteer organization that acts as an extension of the Alabama Department of Public Health serving a seven county area in and around the Birmingham metropolitan area, with CEO Joe Acker who has been very active with Mission Lifeline, and serves as the President of the local Chapter of AHA.
- Paine Sothie, MD, FACC, was appointed STEMI Committee chair by Chapter governor, Mike Honan, to serve as their liaison to the process and representing cardiac care in the area.

1

- Dr. Sothie has created a virtual community with cardiac care representing each of the nine interventional hospitals in the BREMSS area, and has communicated with them. He now co-chairs the STEMI Implementation Committee of BREMSS with an emergency physician Dr. Sarah Neffinger, with 22 multi-disciplinary members including three other cardiac care who serve on the Chapter council.
 - Subcommittees include (1) a data collection committee, (2) A group to investigate EKG transmission from the field, (3) A group to credential prospective STEMI centers. Initial plans are for paramedics to be trained in EKG interpretation, although currently the plan seems to be to have medical staff on computerized interpretation.
- The STEMI Plan Implementation Committee of the Birmingham Regional Emergency Medical Services System is currently credentialing STEMI centers in the seven county area around Birmingham where half of the hospitals are PCI-capable. The organization is under the umbrella of the Alabama Dept of Public Health and the committee is co-chaired by our chapter STEMI chair and an emergency medicine physician from UAB. The plan modeled on our Indiana and Idaho systems.
 - When the AL ACC considered trying to advance legislation to mandate this, we felt that since AHA had developed the program based on sound scientific evidence of better patient outcomes from many communities around the country and around the world, that this could be done without legislation in the name of quality care.
 - We have not very little of the resistance that many were anticipating thus far. Most of the physicians in community hospitals without cardiac care I suspect are inclined to not have to participate in the care of these patients.
 - We are hoping to roll this process out to the rest of the state after it is a little more developed. We felt that legislation would just politicize what is really a quality initiative, and mandate trying to standard of care of 2008 (no 2009), and would make the process less final and potentially more prone to hostility.

ARIZONA

Governor Steven F. Moniz, M.D., F.A.C.C.

- The Chapter is organizing and trying ground work for a 2009 MLL meeting in the greater Phoenix area.

CALIFORNIA

Governor Gordon L. Fung, M.D., F.A.C.C.
Governor John Harold, M.D., F.A.C.C.

- 3rd Annual STEMI Summit in partnership with ACEP
 - June 5-6, 2009, La Grana, Palm Springs

2



MissionLifeline Criteria

Primary PCI Hospital/ STEMI-Receiving Center

- 1) Protocols for triage, diagnosis and Cardiac Catheterization Laboratory activation should be established within the primary PCI hospital/STEMI Receiving Center. A single activation phone call should alert the STEMI team. Criteria for EMS activation of the Cardiac Catheterization Laboratory should be established in conjunction with EMS offices.
- 2) The STEMI-Receiving Center should be available 24 hours/7 days a week to perform primary PCI.
- 3) The Cardiac Catheterization Laboratory staff including interventional cardiologist should arrive within 30 minutes of activation call.
- 4) There should be universal acceptance of STEMI patients (no diversion). There should be a plan for triage & treatment for simultaneous presentation of STEMI patients.
- 5) Interventional cardiologists should meet ACC/AHA criteria for competence. Interventional cardiologists should perform at least 11 primary PCI procedures per year and 75 total PCI procedures per year.

ACC Chapters / STEMI systems

- The need for cardiology leadership
- Example in North Carolina
- Chapter activities across the U.S.

