

**Big Country
Regional Advisory Council**

Trauma Service Area-D

Regional ST Segment Elevation
Myocardial Infarction (STEMI) Plan

2012

**Big County Regional Advisory Council
Regional STEMI Plan**

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Regional STEMI Plan

Summary

As directed by the Governors EMS and Trauma Advisory Council (GETAC), the Big County Regional Advisory Council (BCRAC) has been charged with developing and maintaining a region-wide system and standard of care for patients experiencing an ST elevation myocardial infarction (STEMI). Guidelines from The American Heart Association (AHA), American College of Cardiology (ACC) and the Society of Chest Pain Centers (SCPC) have been incorporated into this document.

The purpose of the Regional STEMI Plan is to establish a uniform set of criteria for triage and transport of acute STEMI patients.

It is important to note that STEMI patients should be recognized as quickly as possible to identify those eligible for thrombolytic or invasive therapy. Copious data have shown that both morbidity and mortality can be reduced by an approach of rapid interventional reperfusion targeted to within ninety minutes of “first medical contact”. Further data have demonstrated that in-the-field recognition by pre-hospital providers utilizing 12-lead ECG coupled with pre-hospital notification of the receiving facilities can further reduce time to reperfusion, and is associated with further improvement in outcomes. EMS personnel must be trained to recognize, treat and transport ST Elevation Myocardial Infarction (STEMI) patients in a timely manner.

Several studies have also demonstrated that many patients are not treated quickly enough to derive the clinical benefits of reperfusion therapy. System barriers can cause significant delays in treating patients quickly and efficiently. Our goal is to mitigate system related issues and enact the recommendations in this plan.

The primary goal of the BCRAC Regional STEMI Plan is: **To develop a STEMI Emergency Care System that, when implemented, will result in decreased cardiac mortality and morbidity in the BCRAC Region.** In order to accomplish this, a number of specific processes are essential. These are:

- 1) The ability to rapidly and accurately identify patients suffering from STEMI.
- 2) Patients who have sustained a STEMI event must receive care in a hospital that has a STEMI treatment program in place which is capable of providing immediate and comprehensive assessment, resuscitation, intervention, and definitive care.
- 3) The BCRAC must assist in the coordination of a process for continuous and effective region-wide coordination of pre-hospital and hospital care resources, so that STEMI patients will be most expeditiously transported to the closest available interventional facility capable of performing PCI, so patient care can be provided in a manner that is both appropriate and timely, while establishing and maintaining continuity. To accomplish this process there must be a method of tracking the care capability for STEMI patients and reviewing the quality of the process itself.

Definitions

12-lead electrocardiogram (ECG/EKG) - A test using a device that measures the electrical activity of the heartbeat and can help medical personnel determine if a heart attack has occurred and whether the heart attack was a STEMI or non-STEMI event. When a 12-lead ECG is done, 10 wires ("12 leads") are attached to the arms, legs and chest. These wires each record electrical impulses, but from a different position in relation to the heart.

Acute Coronary Syndrome (ACS) – Is usually one of three disease processes involving the coronary arteries: STEMI, NSTEMI or Unstable Angina.

Acute Myocardial Infarction (AMI) - The medical term for a heart attack, which occurs when the blood supply to part of the heart muscle itself - the myocardium — is severely reduced or stopped. An AMI should be documented as a STEMI or NSTEMI.

Angina / Unstable Angina– Generally termed “Chest Pain” Angina is chest pain or discomfort that occurs when an area of the heart is deprived of oxygen.

Angioplasty - A procedure used to treat patients with a partially or completely blocked artery that restricts blood flow through the heart. A type of percutaneous coronary intervention (PCI), this procedure requires a slender balloon-tipped tube to be threaded from an artery in the groin to a trouble spot in the artery of the heart. The balloon is then inflated, which compresses the blockage and widens the narrowed artery to restore blood flow.

Balloon Inflation - Another name for angioplasty, which is a surgical procedure used to treat patients with a partially or completely blocked artery that restricts blood flow through the heart. A type of percutaneous coronary intervention (PCI), this procedure requires a slender balloon-tipped tube to be threaded from an artery in the groin to a trouble spot in the artery of the heart. The balloon is then inflated, which compresses the blockage and widens the narrowed artery to restore blood flow.

Cath Lab - The department in a medical facility that specializes in cardiac catheterization, which is a procedure to examine blood flow to the heart and test how well the heart is pumping.

Door-to-Balloon Time (D2B) - The amount of time between a heart attack patient’s arrival at the hospital to the time he/she receives percutaneous coronary intervention (PCI), such as angioplasty.

Door-to-Drug Time (DTD) - The amount of time between a heart attack patient's arrival at the hospital to the time he/she receives clot-busting medications, referred to in medical terms as fibrinolytics or thrombolytics.

Electrocardiogram (ECG/EKG) - A recorded tracing of the electrical activity of the heart.

Emergency Medical Service (EMS) - A system of health care professionals, facilities and equipment providing pre-hospital emergency care.

EMS-to-Balloon Time (E2B) - The amount of time between a heart attack patient’s entry into the prehospital system (*entry into the pre-hospital system begins when they call 911*), the time he/she receives percutaneous coronary intervention (PCI), such as angioplasty.

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Fibrinolytic Therapy - The use of pharmaceuticals or injections of medication to break up a blood clot inside an artery or cavity of the heart so that blood flow can be improved or restored. Also called thrombolytics, this type of treatment is widely available at hospitals across the United States.

Helicopter Emergency Medical Service (HEMS) - A system of health care professionals, facilities and equipment providing pre-hospital emergency care by air.

Non-PCI hospital - A type of hospital that does not have the means to deliver percutaneous coronary intervention (PCI), the preferred means of treating a STEMI heart attack patient if done within the critical 90-minute window. Non-PCI hospitals can: administer clot-busting medicines that meet the health care needs of STEMI patients; refer STEMI patients to PCI hospitals, thus the name PCI-referral hospital; and treat STEMI patients with medications when it is not feasible for them to get to a PCI-capable hospital for treatment in a timely manner.

Non- ST-elevation myocardial infarction (NSTEMI) - A myocardial infarction without 1 mm of ST elevation (or more) in 2 or more contiguous leads. A NSTEMI is usually treated as unstable angina until it is identified through lab reports.

Percutaneous Coronary Intervention (PCI) - The family of medical procedures that uses a "mechanical" means to treat patients with partially or completely restricted blood flow through an artery of the heart. Examples include balloon angioplasty and stents.

PCI-Capable Hospital - A hospital that has the equipment, expertise and facilities to administer percutaneous coronary intervention (PCI), a mechanical means of treating heart attack patients. Although PCI is the preferred means of treating STEMI patients, only 25% of hospitals in the U.S. are equipped to do so. These PCI-capable hospitals are called STEMI-receiving hospitals because they are well equipped to receive and treat STEMI patients.

Point of Entry (POE) - The part of the healthcare community where treatment of a patient begins, such as when emergency medical services arrive on the scene or the patient walks into the emergency department at a hospital.

Reperfusion Therapy - One or more techniques to restore blood flow to part of the heart muscle damaged during a heart attack. It may include clot-dissolving drugs (thrombolysis), balloon angioplasty or surgery.

ST-elevation myocardial infarction (STEMI) - A severe heart attack caused by a prolonged period of blocked blood supply that affects a large area of the heart. These attacks carry a substantial risk of death and disability and call for a quick response by many individuals and systems. It will be easily identified by 1 mm ST elevation (or more) in 2 or more contiguous leads or a new onset Left Bundle Branch Block (LBBB)

STEMI System - An integrated group of separate entities focused on reperfusion therapy for STEMI within a region that typically includes emergency medical services (EMS) providers, at least one community (non-PCI or STEMI-referral) hospital and at least one tertiary (PCI-capable or STEMI receiving) hospital. The system may include one or more of the following components: leadership teams of EMS, emergency medicine, cardiology, nursing and administration; standardized communication (i.e., STEMI alert system); standardized transportation; and data collection and feedback. Please note: In

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some systems, there may be a single hospital with PCI capabilities that has established protocols with EMS providers and contains at least one of the components stated above.

Thrombolytics - The use of pharmaceuticals or injections of medication to break up a blood clot inside an artery or cavity of the heart so that blood flow can be improved or restored. Also called fibrinolytic therapy, this type of treatment is widely available at hospitals across the United States.

Role of the Hospitals

Summary

Active participation on the part of the Hospital emergency departments, catheterization labs, intensive care units and all personnel therein will eventually define the success or failure of this program. Several key activities must be undertaken for the system to be proficient:

- 1) Collect and report STEMI performance data
- 2) Assign a STEMI contact

Definition of a PCI Facility

The goal of this effort is to move patients experiencing STEMI to PCI capable hospitals that are capable of performing the procedure rapidly and immediately after the patient presents with STEMI. The definition of a PCI facility, for the purposes of this plan, is any facility that is willing and capable of accepting EMS transported patients for emergent PCI on a 24/7 basis.

Primary PCI is available 24/7 at the following facilities in TSA-D:

- 1) Abilene Regional Medical Center, Abilene, Texas
- 2) Hendrick Medical Center, Abilene, Texas

Primary PCI is not available at the following facilities:

- 1) Anson General Hospital
- 2) Brownwood Regional Medical Center
- 3) Colman County Medical Center
- 4) Comanche County Medical Center
- 5) Eastland Memorial Hospital
- 6) Fisher County Hospital
- 7) Hamlin Memorial Hospital
- 8) Haskell Memorial Hospital
- 9) Knox County Hospital
- 10) Mitchell County Hospital
- 11) Rolling Plains Memorial Hospital
- 12) Stamford Memorial Hospital
- 13) Stephens Memorial Hospital
- 14) Stonewall Memorial Hospital
- 15) Throckmorton County Hospital

Data Reporting By Facilities

EMS agencies must have accurate knowledge of a specific facility's ability to perform emergent PCI. It is recommended that hospitals be held to the same standard as required by the American College of Cardiology (ACC). All PCI facilities currently report STEMI performance data based on the ACC criteria to CMS to receive reimbursement. The American College of Cardiology (ACC) has established a minimum standard for performance as door to balloon time of 90 minutes or less 85% of the time.

Additionally, inpatient mortality rates will be tracked.

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For the first year, the facility performance data will be sent to BCRAC on a quarterly basis. In the first year of this process the only information that will be reported out, in a blinded fashion, to BCRAC members is whether the facility has met the minimum ACC standards.

Facility Representation

Each PCI capable facility should designate a BCRAC contact person.

Facility Diversion

TSA-D facilities will communicate “facility diversion” status promptly and clearly to the regional EMS and other facilities through the EMSsystems in order to ensure that STEMI patients are transported to the closest appropriate facility.

All facilities and pre-hospital providers will use EMSsystems to notify and track diversion status.

Facility Triage Criteria

The goal of establishing and implementing facility triage criteria in TSA-D is to ensure that all regional hospitals use standard definitions to classify STEMI patients in order to ensure uniform patient reporting and facilitate inter-hospital transfer decisions.

A confirmed 12-lead should activate a facility’s STEMI protocol. After confirming a STEMI, the patient should be transferred immediately to the closest PCI capable hospital.

Inter-Facility Hospital Transfers

STEMI patients require specialized care and treatment beyond a non-PCI hospital’s capability. STEMI patients require rapid identification and transfer to a PCI capable hospital as soon as possible.

The level of cardiac care resources required for STEMI patients is outlined in the TSA-D facility triage criteria and pre-hospital triage criteria. When a suspected STEMI patient is identified, activation of a Code STEMI should be initiated. A transferring facility should state that the patient is a “Code STEMI” when calling EMS and the accepting PCI capable hospitals.

These criterions (see attached Regional STEMI Form) are monitored through the regional PI program.

Identification of STEMI Patients & STEMI Transfers - STEMI patients and their treatment requirements for optimal care are identified in the TSA-D facility triage criteria and pre-hospital triage criteria.

STEMI Patient Transport - STEMI patients in TSA-D are transported according to patient need, availability of resources, and environmental conditions. EMS transport via BLS, ALS, MICU or SCT ground ambulance is available throughout the Region. HEMS transport is also available in this Region.

Role of the EMS

Develop Acute Coronary Syndrome (ACS) Protocols

It is important to develop a standardized ACS protocol for all EMS agencies. There are several standards, considered quality of care measures that should be instituted on all ACS cases (i.e. immediate administration of oxygen & aspirin). For a summary of evidence to construct an ACS protocol based on scientific evidence EMS agencies lacking a protocol should consult with a local BCRAC EMS provider.

The purpose of an ACS protocol is to rapidly recognize STEMI and other cardiac emergencies, treat with appropriate medications, notify the receiving facility as soon as possible, and provide rapid transportation to a PCI facility when indicated.

Acquire 12 Lead ECG Analysis

The ability to rapidly treat a STEMI is predicated on an accurate prehospital assessment to include a 12-lead ECG analysis by EMS providers in the field. The early recognition of a STEMI in the field, allows early activation of the PCI facility. All EMS agencies should acquire 12-lead technology and training.

Report Performance Data

The American College of Cardiology (ACC) launched the D2B initiative in 2006 to emphasize the goal of 90-minute door to balloon time. In March 2007, an EMS initiative sought to assist the hospitals in meeting this goal by minimizing EMS patient contact time to 30 minutes. This 30-minute goal should also be the goal of EMS agencies participating in this endeavor. This is part of the overall 30-30-30 concept that means 30 minutes or less in the field pre-hospital arrival, 30 minutes or less in the hospital ED, and 30 minutes or less from arrival in the cardiac catheterization laboratory until the artery is open. Similar to the requirements on the hospitals, EMS agencies should prepare to collect and report performance data to the BCRAC. The data requirements are listed below.

Adopt the STEMI Bypass Guideline

All EMS agencies that do not have a STEMI Bypass Guideline should introduce the BCRAC STEMI Bypass Guideline to their medical directors and administration. The Bypass Guideline has been developed with the thought that most EMS agencies have an ACS protocol currently in place. The recommended guideline (shown below) assumes the care of the patient is still governed by the local medical director; however this guideline will serve as a regional standard of care. This guideline serves as a template to be used by EMS agencies when formulating their individual plans.

ECG Transmission

There are conflicting opinions on the value of transmitted ECGs from the field vs. voice notification of an incoming STEMI. It is clear that early hospital notification by EMS significantly reduces the door-to-balloon time. In this region, only 3% of the EMS agencies currently transmit an ECG to the hospital while 75% of EMS providers in the region report having 12-Lead capability.

There are a variety of EMS agencies in the region and each may utilize a different type of cardiac monitor. Each type of monitor requires its own proprietary software to transmit and receive its own data

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and these different monitor systems do NOT interface with each other. Specifically, you cannot transmit an ECG from a Phillips system and receive the data on a Zoll receiving station. The weakness is obvious in that if a hospital wants to receive ECG data from the several different EMS agencies it will require them to purchase multiple brands of ECG receiving stations at considerable expense. Moreover, there is little hope that all EMS agencies will agree on using one type of monitor. A question regarding this situation was submitted to a national EMS list serve with a thousand members to solicit. The response received was that a viable ECG transmission solution does not exist that can handle the three plus ECG monitor vendors.

Pre-hospital Triage

To ensure the best possible patient care and utilization of resources, every patient suspected of ACS will be assessed for abnormal vital signs; concurrent disease/predisposing factors; and abnormal EKG or 12-lead if available.

- 1) If a provider is unable to complete an ECG or 12-lead, suspected cardiac patient should be taken to the nearest non-PCI hospital.
- 2) If a provider suspects a STEMI (confirm by 12-lead), the patient should be taken directly to a PCI capable hospital.
- 3) If a provider is unable to provide MICU care to the suspected cardiac patient, paramedic intercept should be considered. Paramedic intercept may be by ground or air.
- 4) If transport by ground to the nearest appropriate facility is more than 30 minutes, consider activating the closest HEMS.

Facility Bypass

Regional transport treatment guidelines ensure that patients who meet the triage criteria for activation of the TSA-D Regional STEMI Plan will be transported directly to the closest appropriate PCI capable hospital rather than to the nearest hospital except under the following circumstances:

- 1) If unable to establish and/or maintain an adequate airway, the patient should be taken to the closest non-PCI hospital for stabilization.
- 2) Medical Control may wish to order bypass in any of the above situations as appropriate, such as when a facility is unable to meet hospital resource criteria or when there are patients in need of specialty care.
- 3) If expected transport time to the nearest appropriate PCI capable hospital is excessive (> 30 minutes), the EMS crew on scene should consider activating HEMS or transport to the closest non-PCI capable facility for fibrinolytic therapy. Should there be any question regarding whether or not to bypass a facility consult with your Base Station Physician (BSP).

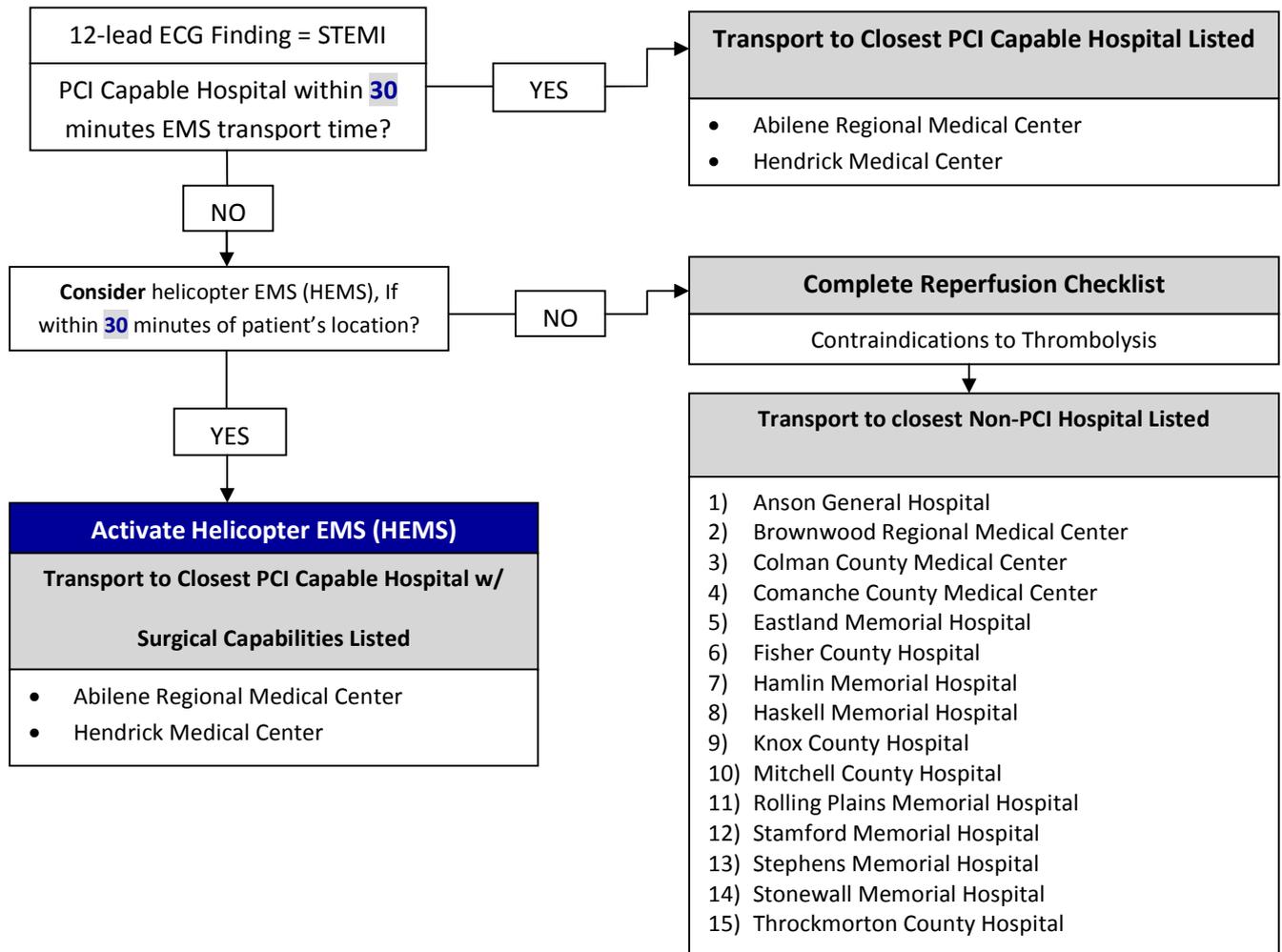
Field STEMI Triage Decision Scheme

The Purpose of this Decision Scheme is to:

- 1) Rapidly identify STEMI patients who call 911 or present to EMS
- 2) Minimize the time from onset of STEMI symptoms to coronary reperfusion
- 3) Quickly recognize a potential STEMI by 12-lead ECG
- 4) Complete a reperfusion checklist (unless being transported directly to a PCI hospital) to determine thrombolytic eligibility
- 5) Rapidly identify the best hospital destination based on symptom onset time, reperfusion checklist, and predicted transport time
- 6) Early activation/notification to the hospital prior to patient arrival
- 7) Minimize scene time to 15 minutes or less (including a 12-lead ECG)

STEMI Patient (ST Elevation Myocardial Infarction)

- 1) Cardiac symptoms **AND**
 - a) 12-lead ECG criteria of 1 mm ST elevation (or more) in 2 or more contiguous leads OR
 - b) 12-lead ECG interpretation with an “ACUTE MI” statement OR
 - c) Left Bundle Branch Block **NOT KNOWN** to be present in the past



Any patient with a compromised airway or impending circulatory collapse must be transported to the closest hospital Emergency Department.

ECG/EKG Screening Guide

Patients > 20 years old experiencing any of the following:

- 1) Chest pain (any pain between the navel and jaw)
- 2) Chest pressure, discomfort, or tightness
- 3) "Heartburn" or epigastric pain
- 4) Complaints of "heart racing" or "heart too slow"
- 5) Syncope
- 6) Severe weakness
- 7) New onset stroke symptoms
- 8) Difficulty breathing (with no obvious non-cardiac cause)

Above patients require ECG in 5 minutes!

Patients (regardless of age) with any of the above symptoms and history of:

- 1) Prior cardiac disease such as heart attack
- 2) A family history of early heart disease
- 3) Diabetes mellitus
- 4) Severe obesity
- 5) Recent cocaine use

These patients also require an ECG within 5 minutes!

Present ECG for immediate interpretation!

Remember:

- 1) **Women and diabetic patients are more likely to present with atypical symptoms**
- 2) Elderly patients may have symptoms such as generalized weakness, altered mental status, nausea/vomiting, shortness of breath, diaphoresis, or syncope as their only sign of acute heart attack
- 3) Atypical pain can be in jaw, neck, arm, or upper back.

When in doubt, do the ECG

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Regional Goal: 90 minutes or less from initial medical contact to balloon inflation.

Patient Name: _____			Date: _____
DOB: _____	AGE: _____	Symptom Onset Time: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
EMS to complete this section (Provider Name) _____			
<input type="checkbox"/> Patient contact time: _____ <input type="checkbox"/> O ₂ _____ Lpm, via _____ <input type="checkbox"/> Started IV w/ _____ gauge <input type="checkbox"/> 12-lead administered Time: _____ <input type="checkbox"/> 12-lead transmitted or called to facility Time: _____ <input type="checkbox"/> 4 chewable baby aspirin (or equivalent) PO, unless contraindicated Time: _____		<input type="checkbox"/> NTG 0.4 mg SL q 5 minutes x 3, unless contraindicated <input type="checkbox"/> Time: _____/_____/_____ <input type="checkbox"/> Other Treatment: _____ _____ Medic Name (Printed): _____ Signature: _____	
RURAL HOSPITAL to complete this section (Provider Name) _____			
<input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Patient arrival time: _____ <input type="checkbox"/> Activate Code STEMI Time: _____ <input type="checkbox"/> STAT EKG & continuous cardiac monitoring. Notify ED Physician: _____ Time: _____ <input type="checkbox"/> O ₂ _____ Lpm, via _____ <input type="checkbox"/> Ensure 2 IV lines <input type="checkbox"/> STAT lab: CBC, CMP, PT/PTT, CK, CKMB, Troponin I <input type="checkbox"/> Chest X-ray completed Time: _____ <input type="checkbox"/> 4 chewable baby aspirin (or equivalent) PO, unless contraindicated Time: _____ <input type="checkbox"/> NTG 0.4 mg SL q 5 minutes x 3, unless contraindicated <input type="checkbox"/> Time: _____		<input type="checkbox"/> Other Treatment: _____ <input type="checkbox"/> IF STEMI or left bundle branch block, call for acceptance of CODE STEMI Time Called: _____ Time Accept: _____ <input type="checkbox"/> Receiving Hospital: _____ <input type="checkbox"/> If thrombolytics given, please use Heparin - Drug/Dose: _____ Route: _____ Time: _____ <input type="checkbox"/> Contact EMS (ground or air) for priority transfer Provider: _____ Time called: _____ <input type="checkbox"/> EMS arrived Time: _____ Patient leaves ED Time: _____ <input type="checkbox"/> Call Cardiologist when patient has left facility. Nurse Name (Printed): _____ Signature: _____	
TRANSFER EMS to complete this section (Provider Name) _____			
Patient arrival time: _____ Notes: _____			
STEMI FACILITY to complete this section (Provider Name) _____			
<input type="checkbox"/> Patient arrival time: _____ <input type="checkbox"/> Activate Code STEMI Time: _____ <input type="checkbox"/> STAT EKG Time: _____ & continuous cardiac monitoring. Notify Cardiologist: _____ <input type="checkbox"/> Time called: _____ Time Arrived: _____ <input type="checkbox"/> O ₂ _____ Lpm, via _____ <input type="checkbox"/> Ensure 2 IV lines <input type="checkbox"/> STAT lab: CBC, CMP, PT/PTT, AMIP <input type="checkbox"/> Chest X-ray completed Time: _____ <input type="checkbox"/> 4 chewable baby aspirin (or equivalent) PO, unless contraindicated Time: _____ <input type="checkbox"/> NTG 0.4 mg SL q 5 minutes x 3, unless contraindicated Time: _____ <input type="checkbox"/> Heparin Bolus: Dose _____ Time _____ <input type="checkbox"/> Heparin Drip: Dose _____ Time _____ <input type="checkbox"/> Morphine: Dose _____ Time _____		<input type="checkbox"/> Other Treatment: _____ <input type="checkbox"/> If thrombolytics given - Drug/Dose: _____ Route: _____ Time: _____ <input type="checkbox"/> Prep Patient for Cath: <input type="checkbox"/> Remove all patient's clothes; hospital gown only <input type="checkbox"/> Name/allergy bands on patient <input type="checkbox"/> IV x 2 with extension tubing <input type="checkbox"/> IV: NS at KVO rate for primary line <input type="checkbox"/> Connect patient to the portable monitor <input type="checkbox"/> Portable O ₂ tank on stretcher <input type="checkbox"/> Place consent on chart; ensure patient has signed consent after explanation from cardiologist <input type="checkbox"/> Patient leaves ED for Cath Lab. Time: _____ Nurse Name (Printed): _____ Signature: _____	
CATH LAB to complete this section (Provider Name) _____			
<input type="checkbox"/> Patient arrives in Cath Lab: _____ <input type="checkbox"/> Arrival of Interventionalist: _____ <input type="checkbox"/> First Lesion Access: _____ <input type="checkbox"/> Reperfusion time/intervention complete: _____/_____		<input type="checkbox"/> ICU Notified for Room: _____ <input type="checkbox"/> Patient leaves Cath Lab: _____ Nurse Name (Printed): _____ Signature: _____	

Regional STEMI Alert Form Instructions

Each facility within the BCRAC Region will maintain copies of the BCRAC Regional STEMI Alert Form in the Emergency Department.

The BCRAC Regional STEMI Alert Form will be completed on any patient with a suspected STEMI or suspected new onset Left Bundle Branch Blockage.

For the purposes of this program the 'STEMI patient' shall be defined as any patient presenting with symptoms of an acute myocardial infarction and/or left bundle branch blockage and/or 1mm of ST-elevation in two contiguous ECG/EKG leads (STEMI).

The BCRAC Regional STEMI Alert Form is intended to document required information for the regional STEMI facilities as well as serve as the tool for the regional STEMI quality improvement process.

When a suspected STEMI patient presents in the ED of a BCRAC facility, that facility will initiate the BCRAC Regional STEMI Alert Form by completing the top portion of the STEMI Alert Form.

Initial EMS Provider

- 1) The EMS provider will obtain a STEMI Alert form from the facility and complete the top portion of the form titled "EMS to complete this section".
- 2) The EMS provider shall complete the section fully.
- 3) The EMS provider shall attach a copy of the initial 12 lead. The 12 lead shall be noted with the patient's name and date of birth.
- 4) If additional documentation is required, a copy of the run sheet may be attached to the EMS copy and forwarded to BCRAC. BCRAC will forward copies of additional documentation as appropriate.
- 5) The paramedic must sign the completed section.
- 6) Upon signature, the bottom copy shall be removed by EMS provider and maintained by the provider as part of their records for QI purposes.
- 7) Once the EMS copy is removed, the form shall be given to the facility.

Rural BCRAC Facility

- 1) When the patient arrives at a rural BCRAC facility, the rural facility shall complete the section titled "Rural Facility to complete this section".
- 2) If the patient presents directly at the facility by his/her own means, the facility shall mark "N/A" across the EMS Section.
- 3) The attending nurse must sign the completed section.
- 4) Upon signature, the bottom copy shall be removed by the rural facility; a patient label is placed at bottom of the facility's copy, and maintained by the facility as part of their records.
- 5) Once the rural facility has removed its copy, the form shall follow the patient to the Interventional Cardiac Facility

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Transferring EMS Provider

- 1) When the patient is transferred from a rural facility to a regional Interventional Cardiac Facility, the transferring EMS provider (ground or air medical) shall complete the section titled "Transfer-Transporting Agency".
- 2) If additional documentation is required, a copy of the run sheet shall be attached to the EMS copy and forwarded to BCRAC to be attached to the regional copy. BCRAC will forward copies of additional documentation as appropriate.
- 3) The paramedic must sign the completed section.
- 4) Upon signature, the bottom copy shall be removed by EMS provider and maintained by the provider as part of their records for QI purposes.
- 5) Once the EMS copy is removed, the form shall be given to the Interventional Cardiac Facility.

BCRAC Interventional Cardiac Facility

- 1) When the patient arrives at a regional Interventional Cardiac Facility, the Interventional Cardiac Facility shall complete the section titled "Interventional Cardiac Facility to complete this section".
- 2) If the patient presents directly at the facility by his/her own means, the facility shall mark "N/A" across the EMS, Rural Facility, and Transfer Section.
- 3) The attending nurse must sign the completed section and place a patient label at the bottom of the form.
- 4) Upon signature, the form shall follow the patient to the cath lab.

Cath Lab

- 1) Once the patient arrives in the cath lab, the section titled "Cath Lab to complete this section" shall be completed by cath lab staff.
- 2) The attending nurse must sign the completed section.
- 3) Upon signature, the BCRAC copy shall be forwarded to BCRAC upon completion for the regional quality improvement process.

The Interventional Cardiac Facility shall maintain the original (top) sheet as part of the facility's record.

System Performance Improvement

Goal

The goals for system performance improvement in TSA-D are to establish a method for monitoring and evaluating system performance over time and to assess the impact of STEMI system development.

Objectives

- 1) To provide a multidisciplinary forum for STEMI care providers to evaluate STEMI patient outcomes from a system perspective and to assure the optimal delivery of cardiac care.
- 2) To facilitate the sharing of information, knowledge, and scientific data.
- 3) To provide a process for medical oversight of regional STEMI and EMS operations.

Discussion

In order to assess the impact of regional STEMI development, system performance must be monitored and evaluated from an outcomes perspective. A plan for the evaluation of operations is needed to determine if system development is meeting its stated goals.

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Authority - The authority and responsibility for regional quality improvement rests with the Regional Advisory Council. This will be accomplished in a comprehensive, integrated manner through the work of the Cardiac, and Pre-hospital committees.

Scope & Process - The STEMI Committee will determine the type of data and manner of collection, set the agenda for the PI process within the regularly-scheduled meetings of the committee, and identify the events and indicators to be evaluated and monitored. Indicator identification will be based on high risk, high volume, and problem prone parameters. Indicators will be objective, measurable markers that reflect STEMI resources, procedural/patient care techniques, and or systems/process outcomes. Indicator identification may be deferred to Primary PCI hospitals.

Occurrences will be evaluated from a system, outcomes prospective and sentinel events will be evaluated on a case by case basis. Activities and educational offerings will be presented to address knowledge deficits and case presentations or other appropriate mediums will be designed to address systems and behavioral problems. All actions will focus on the opportunity to improve patient care and systems operation. The results from committee activities will be summarized and communicated to the RAC membership. Problems identified that require further action will be shared with the persons and entities involved, for follow-up and loop closure. Committee follow-up and outcome reports will be communicated on a standard format (please see attached).

The functions and effectiveness of BCRAC performance improvement process will be evaluated on an annual basis in conjunction with the annual evaluation of the BCRAC bylaws. All PI activities and committee proceedings are strictly confidential. Individuals involved in performance management activities will not be asked to review cases in which they are professionally involved, but will be given the opportunity to participate in the review process.

Data Collection - PI data will be collected by the PCI capable hospitals. Non-PCI capable hospitals and EMS will not be responsible for reporting directly to the BCRAC, but will be responsible for providing the PCI capable hospitals with information that they are in need of or that is lacking from patient charts. Sentinel events will be used to focus attention on specific situations/occurrences of major significance to patient care outcomes.

Confidentiality - All information and materials provided and/or presented during PI meetings are strictly confidential. See attached form.

BCRAC facility and EMS provider data related to the following PI indicators are reviewed during the quarterly ST EMI Committee meetings. The STEMI Alert Form is reviewed and will be updated as needed annually.

STEMI Plan Maintenance – The medical field is ever changing for a multitude of reasons. Due to this, there may be need for both minor and major changes. The STEMI Committee will conduct ongoing and annual reviews of the STEMI Plan. The STEMI Committee will make minor corrections and revisions as needed and agreed upon by the STEMI Committee. Major changes will be brought before the general assembly. The General Assembly will be advised of minor changes or corrections and the website will be updated with the most up-to-date plan.

Reporting Quarters

BCRAC regional PI data-reporting will be done quarterly and in accordance with the Primary PCI hospitals quarters to ensure that all information is up-to-date and accurate.

Statement of Confidentiality

Medical Performance Improvement provides an objective mechanism to evaluate trauma and emergency care, facilitates the sharing of information, knowledge, and scientific data, and provides a forum for medical directors and other physicians to review the performance of the regional systems to assure the optimal delivery of trauma and emergency care. The direction of the committee comes from the Texas EMS Rules: Section 157.124 Regional EMS Trauma Systems: (3) (k) of the EMS Rules (effective 2/17/92) requires the development of a “performance management program that evaluates outcome from a system perspective”

Committee members engaged in medical care review have protection from disclosure of proceedings, under Section 773.095 RECORDS OF PROCEEDINGS CONFIDENTIAL of the Texas Health and Safety Code as follows:

- 1) The proceedings and records of organized committees of hospitals, medical societies, emergency medical service providers, or first responder organizations relating to the review, evaluation, or improvement of an emergency medical services provider, a first responder organization, or emergency medical services personnel are confidential and not subject to disclosure by court subpoena or otherwise.
- 2) The records and proceedings may be used by the committee only in exercise of proper committee functions.
- 3) This section does not apply to records made or maintained in the regular course of business by an emergency medical services provider, a first responder organization, or emergency medical services personnel.

Section 773.096 IMMUNITY FOR COMMITTEE MEMBERS

“A member of an organized committee under Section 773.095 is not liable for damages to a person for an action taken or recommendation made within the scope of the functions of the committee if the committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the committee member.”