

**Subject: INPUT REQUESTED: STEMI SYSTEMS OF CARE LEGISLATION**

*September 10, 2015*

*Frank Ryan, JD, ACC Staff (fryan@acc.org)*

Dear Governors: In an effort to arm chapter advocates with the best resources and information available, we are drafting Principles for State Legislation that outline the College's positions on key issues. In order to address the specific challenges you and your patients face on a regular basis your input is critical. As circumstances dictate, the documents will be adopted for a range of purposes such as:

- Committee hearing testimony
- Letters to state lawmakers from ACC leaders
- Communications to stakeholders and partners such as state medical societies, AHA affiliates and hospital systems
- Leave-behinds (for lawmakers) and talking points (for advocates) on state lobby days
- Action alerts
- Chapter publications
- Social media messages
- Patient advocacy
- Public education
- Press releases, statements
- Talking points for media interviews
- Thank you for your input and support. Please contact me any time with questions.

**The first issue for your consideration, Improving STEMI Systems of Care, can be found in the attached document and the background narrative below provides context for current challenges.** The Advocacy Steering Committee has weighed in and after we incorporate your suggestions a final version will be sent to the ACC Executive Committee for approval. Your comments on use of data and registries would be extremely helpful. Please submit comments by COB, Wed., Sept. 16 and feel free to contact me at your convenience.

**IMPROVING STEMI SYSTEMS OF CARE: BACKGROUND AND RECENT HISTORY – PLEASE SEE ATTACHMENT FOR DRAFT PRINCIPLES**

In the past month BOG members have been asked by AHA affiliates to work on improving STEMI systems of care, with at least one affiliate proposing legislation. You may recall that two years ago there was a disagreement with AHA when they sought to incorporate the hospital recognition component of their Mission: Lifeline program into law by requiring state health departments to list, and essentially promote, the AHA participating hospitals. The Board of Governors felt this approach would negatively impact non-participating hospitals, in particular those who already deliver excellent STEMI care.

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A bill in Texas was defeated and a Colorado bill was amended to create an advisory panel to study the issue. In both instances we cited North Carolina's and L.A. County's successful programs as examples of successful AHA/ACC collaboration.

Part of the problem in Texas and Colorado was a lack of communication prior to the bills being introduced. ACC leaders stressed that we wished to partner with them to improve STEMI systems of care, but that the approach embodied in the bills assessed hospitals individually and failed to address communication, workforce, and protocols from a system-wide perspective. Moreover, ACC had stated this concern in 2007 with regard to AHA's model STEMI legislation.

***September 15, 2015***

***Matthew Phillips, MD, FACC (mattphillips1@me.com)***

Agree

As the Texas Governor it was a major headache. I was yelled at (no joke) by a state senator. I had to then donate to his re election to make peace and then he lost. A bad deal any way you look it at

The problem was not all the hospitals. I rode an ambulance with my neighbor having an inferior MI on Labor Day night. His pain started at 10:14 pm (he called me) and his artery was open at 11:14 pm. The D2B was 16 minutes.

The delay is obvious it's EMS. We saw that in our efforts with the STEMI program. In this case 7 EMT showed up. I told them upon arrival what he had, they had ECG confirming in a few minutes yet it was about 30 minutes to get to hospital. (13 miles away)

This was light speed compared to reality. Most people do not have a cardiologist riding the ambulance and calling the call team to get to hospital via cell phone (I did).

The smaller towns and rural area are much less equipped

Even more interesting the patient and wife were given a choice - go to local hospital (which almost lost Medicare license this July (on the web) and whose cardiologist was featured in Business week for putting in 10 stents per vessel OR go to the Heart Hospital of Austin with all of the attributes we built over a decade. I was there so the choice was made.

The EMS preference for the heart hospital was obvious to the patient (they know the deal) but this is also why some NCDR data needs to be public. The other hospital is not participating. They would have routed him appropriately I think despite the script they had to use

The bill in Texas was to focus on systems of care in the hospitals. There is more to be gained focusing on the whole from home to open vessel. We have a way of evaluating hospitals and EMS already has the data

***September 15, 2015***

***Huon Gray, MD, FACC (huon@cardiology.co.uk)***

Matt

This is interesting and I hope you will not mind a comment from 'across the pond'.

As you know, we have the advantage over here of having a single ambulance system (albeit with regional geographies) and in 2008 determined a national policy that dictated all patients with STEMI being taken to a Heart Attack Centre. By and large this has worked well, though we still have some problems with centres providing daytime only PPCI.

The main reason prompting this contribution, and relevant to your comment on NCDR, is that we routinely publish Call to Balloon as well as Door to Balloon times, for all heart attack centres. This has "encouraged" their respective ambulance provider to raise their game and shorten the times from call to arrival at the hospital. We have seen these decline over the years and the latest [2013] data

[http://www.ucl.ac.uk/nicor/audits/adultpercutaneous/documents/2013\\_annual\\_report\\_pdf](http://www.ucl.ac.uk/nicor/audits/adultpercutaneous/documents/2013_annual_report_pdf)) showed that the median CTB time for those being admitted directly to a heart attack centre (thus excluding the inter-hospital transfers; self presenters, those who have an MI whilst in a non-PPCI hospital etc.) was 108 minutes. Of all people having a STEMI 79% of those having PPCI had a CTB time of <150 minutes, and 91% had a DTB time of <90 minutes. Urban admissions directly to heart attack centres had better times.

As you point out good performance is easier to achieve in an urban area and we have some fairly rural areas here (albeit MUCH shorter distances involved than in the USA!). All I can say is that having the data published has undoubtedly raised everyone's performance, and combined with the publication of NICE guidelines for STEMI over here, has forced payers and hospitals to do what's best for patients, even if it means loss of some admissions.

Hope this is of some interest.

*September 15, 2015*

*Matthew Phillips, MD, FACC (mattphillips1@me.com)*

Huon

Really appreciate it

Next nuance of Texas. It's easy to become an ambulance service. It's ripe for fraud and abuse specifically for transports from nursing homes

The rural areas are challenged. The urban centers have EMS funded by the city and are usually quite good

That said, it took about 8 minutes for them to show up from first call. It was at night so no traffic. It took time to get IV access ( they do it before they drive) and get into gurney etc.

Our health system mandated NCDR at all hospitals (my suggestion as a QA program). It is fascinating to see the reaction to the public data.

Initially it's denial and documentation played a part in the data. It has morphed now into process improvement.

In our world though data can become litigation and financial ruin which is the "cost" that politicians deny exists

*September 15, 2015*

*Thad Waites, MD, FACC (thadwaites@gmail.com)*

Dear Frank, in the document you mention the affected stakeholders. I recommend adding state health departments to the list of stakeholders. This is for several reasons but the main one is that the health department is an entity that can contract with NCDR and thus lead to STEMI systems being able to fully utilize ACTION/GWTG registry data.

*September 15, 2015*

*Frank Ryan, JD, ACC Staff (fryan@acc.org)*

Thank you Dr. Waites. That is most helpful. I have health departments as you explained.

We are receiving excellent comments for this document as well as detailed explanations of specific hurdles in designing reforming STEMI systems. The latter will allow us to create a separate document to help chapters strategize. Thanks for your input!