Comments on the STEMI System of Care Policy Update
Public Comment Period
June 24, 2019 through July 23rd, 2019
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SECTION # PAGE #	AGENCY	COMMENT	EMS RESPONSE
Designation A/3 pg. 2	AHBD	Is EMS going to update the "STEMI System of Care Memorandum of Understanding" that is outdated?	
SRC designated pg 5 D / 1	AHBD	EMS is going to dictate who we are accredited by and can change that at any time? Please clarify	
Pg 7 EMS Performance A/ 2	AHBD	These minutes are required for accreditation so when is EMS going to start providing minutes and sign in sheets of meetings?	
Pg 7 EMS Performance A/ 4	AHBD	Will new transfer agreements within all hospitals be made by EMS for STEMI?	
Concept of Operations pg. 7 A/2	AHBD	Can you remove the word "suspected" I Do not believe ECG machines say that? It just says ***ACUTE MI***	
Concept of Operations pg. 7 1 STEMI ALERT	AHBD	Where it says "if equipment is capable" can you add "or present ECG on arrival. If we activate from the field, we need an ECG to verify STEMI activation	
Destination Pg 7 ii	AHBD	Please provide evidence- base of this requirement or can it read if extended transport time	
Public reporting pg. 9 iii	AHBD	The national guideline on this is "FMC to activation" not activation from 12 lead. It was educated that way to paramedics last year. Please change	
Hospital services pg 11 Inter-facility transfers	AHBD	Please clarify is this is another transfer agreement? Or just the policy if an SRC transfer for higher level of care	
Hospital services pg 12 Plan for transfer within 1 hour	AHBD	Please clarify this is for CV surgery within the policy	
Pg 14 Physician volume	AHBD	AHA and ACC require a minimum of 50 PCI cases for physician volume. Please change or show	

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		evidence of 75. I believe that is an older number from outdated guidelines.	
Pg. 14 PCI and Use of Fibrinolytics	AHBD	Please change sentence to clearly state: Fibrinolytic's within 30 minutes of arrival or PCI Door-to-balloon within 90 minutes of direct presentation.	
Pg. 15 Systematic Prehospital Review Program	AHBD	Please clarify: Hospitals do not make pre-hospital policies but do have PI / Quality plans that include EMS requirements along with charters. Isn't this what the STEMI QI team does? It is hard to have a pre-hospital policy when EMS and ambulance providers do not go to the hospitals for meetings. Should this be located within STEMI QI meetings where a plan can be established for a pre-hospitals program accepted by all?	
Mechanism field feedback pg 15	AHBD	Please clarify this feedback is just sent to EMS and it will be distributed?	
Prehospital education pg 15	AHBD	Pre-hospital education: Where is the EMS yearly required education plan to include STEMI and all the hospitals. Clarify expectations	
Pg 17 Bylaws	AHBD	We applaud EMS for the statement of purpose b. that you require *evidence-based STEMI care*, so all evidence should be provided for changes.to processes	
Pg. 20 Meetings, voting 8/a	AHBD	Meetings were canceled last year, so it did not meet accreditation standards while we were going through our surveys. Is it possible we could add to this, that if one is canceled, it would be rescheduled to have at least 4 for the year?	
Pg. 20 Meetings, voting 8/f	AHBD	Fair and professional manner: Does this include no favoritism among any hospitals, showing respect to all, and a non-threatening environment? If there is a	

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		disagreement it should be taken out of a public meeting.	
Pg 22 Assessment worksheet/ checklist	AHBD	Please provide evidenced base documentation of the change to 60 minutes AHA says 45 min. and ACC does not accept this. Liability issues when national guidelines are not followed.	
Pg. 25 Appendix F Bypassing	AHBD	Please provide evidenced base documentation of the change to 60 minutes, which ACC does not recognize this and the evidence from AHA is just a recommendation of possible future guidelines. We need to act on evidenced-based Class 1 recommendations of the use of TNK or why even have it in the policy. Also has the other SRH agreed to this policy change, because the last time this was tried the Hospital Council had to get involved and it is common courtesy to ask them and give them a choice. Would like to recommend suspending this change until all hospitals agree up to but not more than 1 year. (Cardiology request) If this change is made it will hurt all 3 hospitals accreditations here in KC with ACC because it is not guideline driven care. EMS should be helping the county sustain that powerful accreditations we do to prove we provide that caliber of care and not hindering us and /or choosing between AHA and ACC. You will still get your system reports you are so desperately seeking either way. We own 4 Adventists Health ACC Accredited Chest Pain Centers and our policies and procedures are all	

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		based with documented proof of the evidenced base care for our patients.	
Evidence The appropriate and timely use of some form of reperfusion therapy is likely more important than the choice of therapy" Greatest emphasis is to be placed on the delivery of reperfusion therapy to the individual patient as rapidly as possible…….. That being said, 60 minutes transport does more harm than good.		*3.4.1.1. Regional Systems of STEMI Care and Goals for Reperfusion Therapy* Any regional medical system must seek to enable rapid recognition and timely reperfusion of patients with STEMI. System delays to reperfusion are correlated with higher rates of mortality and morbidity.[96–100] Although attention to certain performance metrics, such as D2B, door-to-needle, and door-in–door-out times, have catalyzed important institutional quality improvement efforts, broader initiatives at a systems level are required to reduce total ischemic time, the principal determinant of outcome.[101,102] Questions have been raised about the overreliance on primary PCI for reperfusion, especially in the United States, and the unintended consequences that have evolved as familiarity with fibrinolysis has waned.[101] The writing committee reiterates the principle highlighted in the 2004 ACC/AHA STEMI guideline, namely that "the appropriate and timely use of some form of reperfusion therapy is likely more important than the choice of therapy."[4] Greatest emphasis is to be placed on the delivery of reperfusion therapy to the individual patient as rapidly as possible.	

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		lysis.[103,130] The term *pharmacoinvasive strategy* refers to the administration of fibrinolytic therapy either in the prehospital setting or at a non–PCI-capable hospital, followed by immediate transfer to a PCI-capable hospital for early coronary angiography and PCI when appropriate. Patients with STEMI who are best suited for immediate interhospital transfer for primary PCI without fibrinolysis are those patients who present with shock or other high-risk features, those with high bleeding risk with fibrinolytic therapy, and those who present >3 to 4 hours after symptom onset and who have short transfer times. Patients best suited for initial fibrinolytic therapy are those with low bleeding risk who present very early after symptom onset (<2 to 3 hours) to a non–PCI-capable hospital and who have longer delay to PCI.	
		Just because the patient gets TNK does not mean they do not go to Cath Lab for PCI…. They still go but hopefully at that time it is safer then while the vessel is acutely occluded starving the heart of oxygen, which is what is happening with long transport times. Total ischemic time is what is measured not choice of intervention. Please keep in mind there are different answers from all specialty's, which is why evidence is needed. For an example: if you consult with a surgeon, guess what? He will want to do surgery. If you ask an Interventional Cardiologist what the best treatment is…they want to do the PCI. PCI is always better when it can be done timely….. but as the guidelines say, "timely use of some form of reperfusion is likely more important than the choice of therapy." This new proposal is only focusing on choice of reperfusion not what is BEST for the patient.	

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