



Surviving MI

AN ACC QUALITY INITIATIVE

Questions-and-Answers from “Cardiology Presence Around the Clock” Webinar

Presentations by:

Eric R. Bates, MD, FACC - University of Michigan Medical Center (Ann Arbor, Michigan)

John E. Brush, Jr., MD, FACC - Sentara Cardiology Specialists (Norfolk, VA)

Susan Farkas, MD, FACC - Sanford Heart Center (Fargo, ND)

Q: Do any of the presenters cover STEMI calls at multiple hospitals simultaneously? If yes, how do you manage that?

A: Dr. Brush- Each night my private practice group covers 4 hospitals for STEMI care with 2 on-call interventionalists (one serves as the back-up). Simultaneous STEMIs are rare and only occur about once or twice a year, but when it does happen, the back-up interventionalist is called in.

Q: How do you handle cardiac arrest patients with return of spontaneous circulation?

A: Dr. Farkas- These patients used to be sent to intensive care and never to the Cath Lab. The change in protocol based on data supports immediate hypothermia, most of the time started in the field so the patient is transported in that way. Decision making between ED physician and intensivist occurs. If there is ST elevation, an abnormal EKG, or any hint of ventricular arrhythmia, we very easily take the patient to the Cath Lab. If the EKG is completely normal, we usually follow the patient and make a decision at a later time.

Dr. Brush- This is one of the hardest things that I deal with because it's not a clean decision and depends upon a lot of factors (i.e. patient age, co-morbidities, estimate of down time and evidence of any neurologic activity). The patient must have ST elevation for me to take them to the lab emergently. I will come in and assess the patient at the bedside, but we don't always take them to the Cath Lab when there doesn't seem to be any hope of a positive result or an added risk.

Dr. Bates- Down time, neurologic status, and resuscitation time are very important. It's also important to note that anyone who arrests a short time before coming in to the hospital will have ST elevation; therefore I will often wait 15 minutes to get another EKG.

Q: Are your cardiologists incentivized to provide 24/7 coverage, and if so, how?

A: Dr. Bates- No, our cardiologists are not incentivized or reimbursed. We work on an academic model and it's our job responsibility to provide on-call coverage.

Dr. Brush- As a group, we understand that STEMI coverage is what we do. For the 4 hospitals that are designated as STEMI receiving hospitals, we cover it and that's just the way it is.

Dr. Farkas- Part of it has to do with the way that our interventionalists grew up. Anyone who has come out of an interventionalist program in the last 10-15 years understands that STEMI coverage is a way of

life, it's an obligation. We have pride in it and there is good feedback and discussion, but no incentives. It also helps that there is healthy competition around door to balloon time.

Q: Is the One Call nurse hospital based or emergency department (ED) based?

A: Dr. Farkas- Yes, the One Call nurse is hospital based. We have multiple One Call nurses and they used to sit in the ED, but now they are a little bit further away in the basement. But we know where they are and can easily go to them with questions.

Q: How do you get the cardiologists comfortable with EMS activated STEMI's in the field? Most of our cardiologists don't necessarily have enough trust that our EMS crews can accurately read EKG's to activate STEMI. Yet, the data shows they recognize STEMI on EKGs and notify our EC before arrival.

A: Dr. Brush- The EKG (de-identified to comply with HIPPA) is transmitted to the emergency room and then the ED physician looks at it and makes the call to activate the STEMI alert. In some instances, EMS has been unable to transmit an EKG, but they are sure that it is a STEMI, so the STEMI alert does get activated without physician input (but this is a rare occurrence).