

In a Heartbeat AMI Community Engagement (ACE) Workgroup Meeting and Conference Call

Minutes
August 22, 2006

ATTENDANCE:

Members present: Debra Wigand, Carol Bell, Dona Forke, Chuck Gill, Danielle Louder, and Cynthia Pernice.

Members absent: Dan Batsie, Lisa Letourneau, MD, Doug Libby, Connie Putnam, Bill Primmerman, and Dennise Whitley

MQF staff present: Dennis Shubert, MD, Christopher McCarthy, Carrie Hanlon, and Tish Tanski.

APPROVAL OF MINUTES:

Ms. Wigand asked for approval of the minutes of the July 25, 2006 meeting. The minutes were approved with no objection.

REASONS FOR THE IN A HEARTBEAT INITIATIVE

Dr. Shubert discussed the reasons for the In a Heartbeat initiative, emphasizing that time to treatment is crucial in cases of ST-Elevated Acute Myocardial Infarction: “time is muscle.” Data show that survival and quality of life improve significantly when the patient undergoes successful PCI treatment to open the blocked artery within two hours of symptom onset, which helps to save heart muscle. Reopening the artery even six to eight hours after symptom onset can improve mortality by a factor of two-three, even though it doesn’t save heart muscle. The more quickly the artery can be opened, the more muscle can be saved with a corresponding improvement in both survival and quality of life. All providers in the “chain of care” from dispatch to hospital discharge play an important role in expediting treatment and improving outcomes, especially since care can begin before the ambulance arrives if people call 911.

The group discussed the implications for an effective communication campaign, and briefly discussed the results of research on individual behavior. That research shows that changes in behavior require a core set of messages that reach individuals on an emotional and cognitive level, and are delivered consistently in a variety of environments. Repetition is key.

WORKGROUP GOALS AND MESSAGING WORKSHEET

The group discussed and finalized the workgroup goals and agreed that more input from EMS is needed. Ms. Wigand and Ms. Tanski will talk with Mr. Batsie, Maine EMS Education Coordinator, by phone to get the EMS perspective, and Ms. Tanski agreed to develop a draft document that summarizes the goals established by the workgroup, assets, barriers, and proposed solutions for discussion at the meeting on September 21.

The group also discussed the Messaging Worksheet developed by Mr. McCarthy. Ms. Tanski suggested that a subgroup meet before the next workgroup to prepare a draft of current and proposed messages and methods. Ms. Louder agreed to summarize major research findings to help the group identify appropriate message concepts and strategies for delivering those messages. Ms. Tanski will schedule the subgroup meeting before September 21.

REPORT ON AMI DATA

Ms. Hanlon reported that the Maine Quality Forum had requested data from the Maine Health Data Organization on STEMI AMI in Maine from 2001-2005. MQF staff questions the Primary Procedure Coding, and plans to investigate further. Using a Primary ICD-9 Diagnosis Code of 410.0-410.6, or 410.8-410.9 indicates that there might be 10,660 STEMI discharges in Maine during the five-year period. When the Primary ICD-9 Diagnosis code of 410.01, 410.21, or 410.31 is used, the number drops to 1,677. In either case, the percent of males remains the same (61%), as does the percent of females (39%). The age range is substantially similar, ranging from twenty years of age to around one hundred years of age. The most common procedure code is “none” (28%), which could mean one of the following:

- A non-invasive (Class III/IV) procedure such as a stress test was performed, but not reported (hospitals are only required to report invasive (Class I/II procedures)
- The patient refused an invasive procedure (and/or had a DNR order)
- The patient died before an invasive procedure could be performed.

Mr. Gill questioned the discharge numbers and indicated that he has previously seen much higher figures. MQF will investigate further and will keep the workgroup informed.

Note to incorporate new information MQF found after the ACE meeting on August 22: Two recent publications on coding indicate suggest that it is not possible to accurately separate data on STEMI AMI from overall AMI data due to coding irregularities prior to October of 2005. Corrections that went into effect in October of 2005 will make it possible to distinguish STEMI AMI beginning with data that was collected in the last quarter of 2005. MQF plans to request this data again, but will ask for additional data fields to strengthen the subsequent data analysis. Citations for the publications are as follows:

- Cannon, C. P. (2005). "Update to International Classification of Diseases, 9th Revision Codes: Distinguishes STEMI From NSTEMI." Critical Pathways in Cardiology 4(4): 185-186.
- Steinberg, B. A., W. J. French, et al. (2006). "Missed Diagnosis of the Diagnosis Codes: Comparison of International Classification of Diseases, 9th Revision Coding and ST- Versus Non-ST-Elevation Myocardial Infarction Diagnosis in the National Registry of Myocardial Infarction." Critical Pathways in Cardiology 5(1): 59-63.

WORKGROUP PRODUCTS AND TIMETABLE

The workgroup discussed the work products, assignments and timetables.

- A summary of current efforts to inform and engage the public and communities, a comparison of current efforts to the goals the workgroup has established, and identification of gaps.
- A set of recommended strategies for addressing the gaps.
- Input to EMS on the 12-lead curriculum and dispatch regulations and protocols that are currently under development.

Ms. Tanski will work with Ms. Louder and other interested workgroup members to develop a draft for the next ACE meeting. The draft will be based on the information on assets developed by the workgroup, along with information on current efforts underway (developed by Ms. Louder). The overall goal will be to develop a set of recommendations, strategies and products for the stakeholder meeting scheduled for November 9.