

Minutes of Meeting

Tertiary Care Advisory Committee

Date: 18 September 2007 Time: 1:00 PM

Location: Conference Room 401

ATTENDANCE:

Committee: Present: Robert S.L. Kinder, MD, Joan Kwiatkowski, Gus Manocchia, MD, Robert J. Quigley, DC (Chair), Ed Quinlan, Catherine Graziano, RN, PhD

Not Present: Gregory Allen, John Flynn, Sam Havens

Staff: Valentina D. Adamova, Jay Beuchner, Michael K. Dexter, Donald C. Williams

Public: (see attendance attached)

1. Call to Order and Approval of Minutes

The meeting was called to order at 1:10 PM. The chairman noted that the conflict of interest forms were available to any member who may have a conflict. Copies of the 21 August 2007 meeting minutes were distributed to the members. A motion was made, seconded and

passed by a vote of six in favor and none opposed to approve and accept the minutes. Those members voting in favor of the motion were: Kinder, Kwiatkowski, Manocchia, Quigley and Quinlan.

The Chairman requested a motion for the extension of time for the availability of minutes pursuant to the Open Meetings Act. A motion was made, seconded and passed by a vote of six in favor and none opposed that the availability of the minutes for this meeting be extended beyond the time frame provided for under the Open Meetings Act. Those members voting in favor of the motion were: Kinder, Kwiatkowski, Manocchia, Quigley and Quinlan.

2. General Order of Business

The Chairman introduced Harvey Zimmerman to present on Primary PCI, STEMI and “Mission Lifeline”: Aligning Heart Attack Care in RI with ACC/AHA Guidelines. Mr. Zimmerman noted that the AHA (American Heart Association) had a conference in April, in which experts from several different areas were called together to discuss the treatment of STEMI patients. Based on that conference a new program was initiated called “Mission Lifeline.” Mr. Zimmerman noted that the conference tended to favor primary PCI over thrombolytic therapy to open clogged arteries. The conference therefore identified three different options for consideration: Hospitals without PCI capability develop primary PCI capability; Non-PCI capable hospitals rapidly assess and transfer STEMI patients

to a PCI capable hospital; and communities with EMS systems develop prehospital transport protocols that bypass non-PCI capable hospitals and take the patient directly to a PCI capable hospital. Therefore, the conference assessed what the criteria would be for a Primary PCI Center. Institutional Resources, Physician Resources, and Program Features among some miscellaneous topics were criteria identified. Additionally, two non-PCI capable hospitals transferring to PCI capable hospitals were reviewed: Minnesota MI program and the North Carolina RACE (Reperfusion of Acute Myocardial Infarction) program. Mr. Zimmerman shared the findings of the reviews of those programs in his presentation. Also covered in the presentation were concerns for the non-PCI hospitals, concerns for the PCI capable hospitals, and unintended consequences. Mr. Zimmerman concluded his presentation with the expected next steps of the AHA.

The Chairman asked the members if they had questions of Mr. Zimmerman. Senator Graziano asked, with regard to PCI capable hospital concerns, if the median delay was considered from the onset of the illness or from the time the patient is transferred from the non-PCI hospital. Mr. Zimmerman noted that it is from the time the patient first sees a medical practitioner—either EMS or a referring hospital.

Donald Williams asked Mr. Zimmerman to describe what was meant by “no diversion” as criteria for primary PCI centers. Mr. Williams

noted that Rhode Island has a diversion system so he asked if it would be inappropriate for a hospital that is constantly in diversion to have a primary PCI center. Mr. Zimmerman replied that if the hospital typically diverts patients, they would need a separate chest pain unit that bypasses the emergency room which would be available to a STEMI patient.

Mr. Williams shared with the committee that the Department and the EMS Committee is currently working on a protocol to effect STEMI patients being properly delivered to a primary PCI hospital. The protocol is currently out for review in the community, and has yet to be adopted by the ambulance advisory board. The protocol will be shared with HARI for input. The Chairman asked if this protocol is going to involve all units having EKG capacity. Mr. Williams replied that while most units do have them, it is an issue that all don't have them. However, those that do have the systems could implement the protocol.

Dr. Gus Manocchia asked if the Boston EMS triage to PCI Centers is an ongoing study and if so, when it would be complete. Mr. Zimmerman replied that it is an ongoing study and he is not certain if it has a completion date. Dr. Manocchia also asked if the three criteria for these hospitals – at least 36 primary PCIs per year, immediate angiography on at least 90% of transported patients, and door-to-balloon time within 90 minutes for at least 75% of ideal candidates for PCI – were all being met by the 9 participating

hospitals. Mr. Zimmerman responded that that is the standard or expectation, but he is not sure if those criteria were being met.

The Chairman asked Mr. Zimmerman to speak to the Minnesota Program with regard to how it would relate to Rhode Island, as essentially all of Rhode Island would be in a zone 1. Mr. Zimmerman agreed that Rhode Island would be in zone 1 and if a good transfer system exists, then anyone, with the exception of Block Island residents, would be at a PCI capable hospital within 90 minutes. The Chairman asked if programs such as Charlton Memorial, Aquidneck Island and parts of Bristol should be considered as well. Mr. Zimmerman said that we should be looking at the treatment of all RI residents and the quality of care being received at out of state hospitals should be similar to that being received for patients of in state hospitals. Joan Kwiatkowski noted that Little Compton uses 911 to St. Anne's.

Mr. Williams noted that the 90 minutes is used as a standard for door-to-balloon time. He asked how significant is 90 minutes versus 120 minutes. H. Zimmerman replied that literature points to 90 minutes as the "golden hour." Treating patients within the first 60 minutes is the ideal. When you go beyond 90 minutes to 120 minutes there is a slow fall off – not an abrupt threshold effect. If this timeframe is missed by 5 minutes, it's probably not going to have a traumatic effect on the outcome.

Ms. Kwiatkowski asked if the committee was going receive data about diversion activities the hospitals. Mr. Williams responded that HARI maintains a diversion monitoring system and that information can be provided to the committee. Gina Rocha, VP of Clinical Affairs at HARI noted that the diversion monitoring system, i.e. the hospital capacity system, has been up and running since last February. The diversion data is about twelve months long.

Michael Dexter asked if the “Mission Lifeline” initiative, launched in May of 2007, has a timeframe. Mr.. Zimmerman said that a timeframe has not been announced.

Mr. Dexter noted that when the AHA/ACC reviewed this service in 2005, it was classified as a level II-B (Primary PCI). He asked if that classification was still in effect or if it had changed. Mr. Zimmerman said that it has not changed.

Ed Quinlan asked if anything suggests Rhode Island is atypical with regard to MI incident rates. Mr. Zimmerman said that the actual incident rate is quite similar, although we have more elderly so we probably have more incidents per unit population. Rhode Island is also atypical in terms of the size of the state as well as in terms of treatment hospitals. We have a greater percentage of hospitals that can do angiography than is true nationwide. Approximately 25% of hospitals nationwide can do angiographies, compared to all of Rhode Island’s hospitals with the exception of two. In terms of distances to

hospitals, we're a shorter distance to a PCI receiving hospital and more hospitals have the capability of becoming primary PCI hospitals without actually equipping a cath lab completely.

Dr. Manocchia expressed that the concept of utilizing EMS more efficiently makes sense, especially with the EKG availability to make a diagnosis of STEMI in the ambulance, allowing a decision to be made as to where the patient is transported. Dr. Manocchia also shared that he could envision us deciding to move in this direction and publicizing to try to make citizens aware of the appropriate way of dealing with any symptoms that could represent a cardiac event (calling 911 rather than driving). Ultimately would have the EMS system absolutely overwhelmed with people coming into the ER for things that are clearly not related to a heart attack so that would be a major issue to deal with from an EMS standpoint in terms of their capacity to deal with those kinds of things. Dr. Manocchia shared that he thinks it is a very good idea to look at this more in the future.

Dr. Robert Baute of Care New England asked Mr. Zimmerman if there was any additional data that he has relative to what goes on in other Massachusetts hospitals, with respect to PCI hospitals that are either hospitals with open heart or without open heart. There are certain hospitals in Massachusetts without open-heart backup that perform PCI. Mr. Zimmerman stated that he didn't look at any articles covering such information. Dr. Baute expressed that there is data from the state of Massachusetts and Mr. Zimmerman noted that he

would look for it.

Mr. Dexter asked if Mr. Zimmerman had plans to look at additional research and

materials. Mr. Zimmerman stated that as part of Dr. Baute's CON application,

he would be gathering some additional materials. Dr. Baute noted that

some questionnaires have gone out to get some additional utilization data on

primary PCI and heart attack STEMI's in general so all of that data will be updated. The Chairman asked if that information would be available for the committee before we make a final decision or would it be prudent for us to wait for some of that information.

Mr. Zimmerman noted that when we looked at this before we got data up through 2003 so we could certainly get that information to the committee. It shows the number of heart attacks being treated at various emergency rooms in Rhode Island and the estimated number of STEMI patients that would be included in that group. The Chairman asked when that data would be available and Mr. Zimmerman said he could have it in six weeks.

The Chairman asked the committee if it would be more appropriate to wait to meet until after that information is available. Mr. Dexter noted that another option would be to still meet next month and have the

committee members discuss the issue, allowing more input from the public. However, if the information is important perhaps the discussion could wait until we have all the data. It would also be good to allow a couple of weeks for the public to comment in writing on everything that occurs in the meeting.

The Chairman noted that the members represented were notified, and asked if the public should be notified. Mr. Dexter noted that the committee was pretty well represented and that there was not a need to formally call for comments

The Chairman asked if the committee wanted to wait to meet next in November when all the information will be available and Mr. Zimmerman had further information for CON (certificate of need) which should inform what is being done here. Mr. Dexter noted that we are identifying what the current standards are and assessing whether or not Rhode Island should amend it's rules and regulations based on what the most up to date standards are. He noted that the CON is separate matter that can be addressed separately. The CON is going to be heard for the first meeting Tuesday at 3:00 (9/25/07) and meetings will continue until it is resolved. Mr. Dexter noted that the issue at hand does not have to wait for the CON resolution and that it would be better to get this resolved before the CON is resolved. If there is more data we need to look at that may be data that also will be looked at for the CON, we should take advantage of that.

Ms. Kwiatkowski asked that the minutes be reviewed from all previous meetings to ensure that any of the data elements that have been requested by the committee be compiled in advance for that November meeting, as there have been additional requests from the committee. Mr. Dexter noted this would be done so Mr. Zimmerman will have all requests to present information on. The Chairman noted that if there are specific requests they should be given to Mr. Dexter and he would address them.

Mr. Quinlan noted that the potential for site visits was something that was discussed previously. Mr. Quinlan asked if this was still under consideration. M. Dexter asked who would take the lead and where would the visit be. He asked Mr. Quinlan if he would recommend Rhode Island Hospital. Mr. Quinlan suggested that the offer be extended to everyone and see who responds. Mr. Dexter asked if October 16th was the date for consideration. Mr. Quinlan affirmed. The Chairman also noted that the hospital could make a presentation as well.

Rachel Schwartz of Lifespan asked if the proposal was for one site visit or multiple, to which the Chairman responded it would be one visit.

Mr. Zimmerman noted that this visit would probably be for elective angioplasty, rather than primary because Dr. David Williams does not want any distractions. Mr. Zimmerman shared that they don't even

have their fellows in when they are performing primary angioplasty. The Chairman asked Mr. Zimmerman what he thought they would be looking at. Mr. Zimmerman stated that the facilities and the way things are organized could be reviewed.

Ms. Schwartz asked if the group would like to come to the emergency room at Rhode Island hospital. The Chairman responded that the would like to go to the ED or chest pain unit as well as cath lab and that it would be good to see the door-to-balloon time. The Chairman noted that anyone from any of the facilities not visited would certainly be able to make comments at that time. Ms. Schwartz noted that the visit should be to Rhode Island Hospital's chest pain unit if the group really wanted to see the chest pain unit and the door-to-balloon time that was introduced at Rhode Island Hospital. She expressed that she thought they would really be able to talk about what they did on the ground at that location

Dr. Catherine Graziano asked if the group would be getting some continuous reports on the "Mission Lifeline." Mr. Zimmerman noted that they have not announced a schedule as of yet, but he anticipated they would be doing so, as it is a major undertaking of the AHA. The Chairman asked Mr. Zimmerman to keep the committee informed on any findings.

Adjournment

The next meeting of the TCAC will be held on October 16, 2007 in the form of a site visit to Rhode Island Hospital. The group will be informed of the location of the site visit in advance. There being no further business the meeting was adjourned at 2:00 PM.

Respectfully submitted,

Loreen Angell