

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI)**
PATIENT DESTINATION

(PARAMEDIC, MICN)
REFERENCE NO. 513

PURPOSE: To ensure that 9-1-1 patients with ST-elevation myocardial infarction (STEMI) are transported to the most appropriate facility that is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of a STEMI patient.

AUTHORITY: Health & Safety Code, Division 2.5, Sections, 1798

DEFINITIONS:

ST-Elevation Myocardial Infarction (STEMI): An acute myocardial infarction that generates ST-segment elevation on the prehospital 12-lead electrocardiogram (ECG).

STEMI Receiving Center (SRC): A facility licensed for a cardiac catheterization laboratory and cardiovascular surgery by the Department of Public Health, Health Facilities Inspection Division, and approved by the Los Angeles County EMS Agency as a SRC.

PRINCIPLES:

1. STEMI is a clinical diagnosis that is made based on the patient's presentation and the presence of ST-elevation on the electrocardiogram (ECG). The 12-lead ECG in the prehospital care setting plays a key role in determining the most appropriate treatment and destination for patients with suspected cardiac symptoms.
2. In all cases, the health and wellbeing of the patient is the overriding consideration in determining patient destination. Factors to be considered include: clinical presentation, severity, and stability of the patient's condition; current status of the SRC; anticipation of transport time; and request by the patient, family, guardian, or physician.
3. Prehospital identification and communication of STEMI can reduce critical "door-to-intervention" times for STEMI patients.


POLICY:

- I. A prehospital 12-lead ECG should be performed in accordance with the Ref. No. 1308, Cardiac Monitoring/12-lead ECG Medical Control Guideline.
- II. If the 12-lead ECG demonstrates STEMI (or manufacturer's equivalent) and this is consistent with the paramedic interpretation and/or the clinical presentation of the patient, transmit the 12-lead ECG directly to the receiving SRC. The provider impression is Chest Pain – STEMI (CPMI).
- III. For any patient with a software interpretation of STEMI on the 12-lead ECG where the paramedic provider impression differs or is uncertain, base contact should be

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APPROVED: 
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established to clarify the provider impression and to determine the destination, including whether transport to the SRC is required.

- IV. In general, patients with a provider impression of Chest Pain – STEMI (CPMI), (including hypotensive patients with signs and symptoms consistent with cardiogenic shock) shall be transported to the most accessible open SRC if ground transport is 30 minutes or less regardless of service area boundaries.
- V. Paramedics shall notify the receiving SRC and discuss catheterization (cath) lab activation criteria for all patients with a provider impression of Chest Pain – STEMI (CPMI), including 9-1-1 interfacility transports of patients with a STEMI 12-lead ECG from a non-SRC ED to an SRC.
- VI. Provide properly labeled, at a minimum patient name and sequence number, 12-lead ECGs to the receiving facility (in either paper or electronic format) as part of the patient's prehospital medical record.
- VII. Document the findings of the 12-lead ECG on the Patient Care Record.
- VIII. STEMI patients should be transported to the most accessible SRC regardless of **ED Diversion** status.
- IX. If ground transport time to **any** SRC is greater than 30 minutes, the patient shall be transported to the most accessible receiving facility.
- X. If the closest SRC has requested **STEMI Diversion** (as per Ref. No. 503), STEMI patients, including STEMI patients complicated by out-of-hospital cardiac arrest (OHCA) should be transported to the **next** most accessible **open** SRC if ground transport time is less than 30 minutes.
- XI. Interfacility Transfer of STEMI patients from a STEMI Referral Facility (SRF) Emergency Department to a SRC via the 9-1-1 system: SRFs are strongly encouraged to enter into interfacility transfer agreements with the most accessible SRC (See Ref. No. 320.2).
 - A. Patients are to be transported to the SRC as directed by the SRF physician (base hospital contact/notification guidelines apply).
 - B. Transport units may bypass the most accessible SRC to the prearranged receiving SRC within 30 minutes, if the EMS provider resources at the time of transport allow.

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 506, **Trauma Triage**
Ref. No. 513.1, **Interfacility Transport of the ST-Elevation Myocardial Infarction Patient**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 517, **Private Provider Agency Transport/Response Guidelines**

Ref. No. 1210, **Cardiac Arrest**
Ref. No. 1211, **Cardiac Chest Pain**
Ref. No. 1212, **Cardiac Dysrhythmia – Bradycardia**
Ref. No. 1213, **Cardiac Dysrhythmia – Tachycardia**
Ref. No. 1303, **Cath Lab Activation Algorithm**
Ref. No. 1308, **Cardiac Monitoring/12-Lead ECG**