

ACC KENTUCKY CHAPTER MEETING · OCTOBER 18, 2026

STEMI Systems of Care

Evidence, guidelines and the race from first medical contact to reperfusion

Akshay Khandelwal MD MBA FACC FSCAI · System Chair, CV Medicine, Allegheny Health Network · Treasurer, ACC Board of Trustees

Greetings from upriver!



THE EVIDENCE BASE

Timely primary PCI beats fibrinolysis — and the benefit lasts

Keeley meta-analysis · 23 RCTs, ~7,700 patients

Short-term outcome	PCI	Lytics
Death	7%	9%
Nonfatal reinfarction	3%	7%
Stroke	1%	2%

DANAMI-2 at 16 years · n = 1,572

Outcome	PCI vs lytics	HR
Death or re-MI	58.7 vs 62.3%	0.86
Reinfarction	19.0 vs 24.5%	0.75
Cardiac death	18.3 vs 22.7%	0.78
All-cause death	50.5 vs 51.3%	NS

The advantage depends on **timely** delivery — which is what a system of care is built to guarantee.

Time targets: 2025 ACC/AHA and 2023 ESC

Interval	2025 ACC/AHA	2023 ESC
Time zero	First medical contact	STEMI diagnosis (ECG)
FMC to 12-lead ECG	≤ 10 min	≤ 10 min
Primary PCI, at a PCI center	FMC to device ≤ 90 min	Diagnosis to wire ≤ 60 min
Primary PCI, transferred	FMC to device ≤ 120 min	Diagnosis to wire ≤ 90 min
Choose fibrinolysis when	PCI not possible within 120 min	PCI not possible within 120 min
Lytic timing	Door to needle ≤ 30 min	Bolus ≤ 10 min of diagnosis
Referring hospital	Door-in–door-out ≤ 30 min	Transfer immediately
After successful lysis	Angiography 2–24 h	Angiography 2–24 h

Every community should build and maintain a regional STEMI system

EMS

911 activation, prehospital 12-lead, field cath lab activation, direct to PCI center with ED bypass

Referring hospital

Predefined strategy (transfer or lytics), ECG read in 10 min, STEMI box, DIDO $\leq$ 30 min

Transfer

One call, automatic acceptance, primary and backup transport, request to arrival $\leq$ 15 min

Receiving center

24/7 PCI, ICU, ideally surgical and hemodynamic support; leads regional QI

The ESC describes the same design as hub-and-spoke: EMS alerts the hub as soon as the reperfusion strategy is chosen.

THE CHAIN OF SURVIVAL

A STEMI chain is only as strong as its weakest link



THE ANALOGY · CHURCHILL DOWNS, 1¼ MILES, ABOUT TWO MINUTES

Four roles, one race

OWNER

The patient

Decides to enter the race. If the owner never calls, the horse never leaves the barn.

HORSE

EMS

Carries the patient the whole distance and sets the early pace.

TRAINER

Emergency dept

Confirms readiness and gets the horse to the gate on time — not a minute late.

JOCKEY

Interventional cardiologist

Rides the final stretch and opens the artery.

Behind them: the barn crew — Transfer Center, cath lab team, nurses and techs — and the stewards who review every race.

KENTUCKY DERBY · MAY 4, 2019

The fastest horse crossed first — and still didn't win

Maximum Security led wire to wire but drifted out on the far turn and forced rivals to check.

After an objection and a stewards' review of about 20 minutes, he was disqualified for interference.

Country House, a 65-1 long shot, was declared the winner.

LESSONS FOR STEM

- Speed only counts inside the rules — follow the protocol
- One drifting runner can hurt everyone in the field
- Stewards review every race: so should case review



Source: NBC News/AP coverage, May 5, 2019 · 07

The longest stretch of ischemic time happens before anyone calls

60%

of STEMI patients arrived by EMS —
4 in 10 self-transported

89 vs 120

median min, symptom onset to
arrival: EMS vs self-transport

63 vs 76

median door-to-balloon min: EMS vs
self-transport

Our lever: counsel every patient with CAD at discharge and in clinic — atypical symptoms in women, older adults and diabetes; call 911, don't drive.

Prehospital diagnosis is the single biggest system lever

EMS AND AIR PROTOCOLS

- Paramedics activate from the field, even if the ECG won't transmit
- BLS crews send an ECG if able; activation waits for arrival
- Stable activated patients bypass the ED on the EMS stretcher
- Air crews activate and fly directly to receiving, bypassing outlying sites
- Follow-up to ground and air crews within 72 hours

BEST PRACTICE

- 12-lead $\leq$ 10 min of contact
- Field cath lab activation
- Direct to nearest PCI center, bypassing non-PCI hospitals and the ED
- Mission: Lifeline: pre-arrival notice $\leq$ 10 min of a positive ECG; $\geq$ 75% compliance

The trainer gets the horse to the gate on time

WALK-IN CODE STEMI

- ECG obtained and read, signed and timed by the ED physician in under 10 minutes *sometimes before registration*
- ED physician activates through one call
- Recorded line connects ED physician and interventionalist
- Aspirin 324 mg, two IVs, O₂ to keep saturation ≥ 90%
- Radiolucent dots, pads applied in some cases

GATE RULES

No diversion — every STEMI is accepted.

Partial team in the lab before the ED nurse leaves.

Outcome follow-up back to the ED in 24–72 hours.

Door-in–door-out is where transfer systems win or lose

UOFL HEALTH INTERFACILITY TRANSFER

- ECG $\leq$ 10 min of arrival (goal 5); $\geq$ 1 mm ST elevation in 2 contiguous leads or new LBBB
 - Some sites exclude LBBB
- EMS alerted *first*
- Transfer center contacted, ECG sent electronically to the interventionalist
- Aspirin 324 mg; UFH 60 U/kg bolus (max 4,000 U); pads on
- Never hold transfer for labs or records

WHAT THE EVIDENCE ASKS

- Predefined strategy: transfer or lytics
- DIDO $\leq$ 30 min — longer DIDO is associated with higher mortality
- Automatic acceptance, primary and backup transport
- Request to arrival $\leq$ 15 min

The jockey has to be in the saddle before the gate opens

5 min

to answer the activation call — or the backup is paged

20-30 min

from the electronic alert to the cath lab, for local patients

Before

the patient arrives, when the referring site is more than 30 min away

Arrival times are monitored; late responses reviewed by STEMI committee meeting.

One call saddles the whole barn

- 1. Activating physician calls the Transfer Center
- 2. ECG to the interventionalist; recorded three-way call
- 3. Electronic Code STEMI alert — the 30-minute clock starts
- 4. Team confirms receipt; in the lab in under 30 minutes

THE ALERT PAGES

Cath lab call team	House manager
Bed control	CCU charge nurse
CVICU charge nurse	ED charge nurse
Respiratory therapy	Angioplasty recovery
Security	

A STEMI on the floor still needs the full team

INPATIENT CHEST PAIN ALGORITHM

- STAT 12-lead, read by a physician within 10 minutes
- Immediate activation of Code STEMI
- Vitals, monitor, IV, oxygen if saturation < 90%, nitroglycerin (if not contraindicated) per standing order
- No physician/cardiology/cath lab callback in 10 minutes? Notify house manager and Transfer Center
- STEMI: Transfer Center STAT; travel to the lab on a monitor
- "FLOOR TO BALLOON"

< 10 min, symptom onset to 12-lead

< 5 min, 12-lead to Code STEMI

< 90 min, 12-lead to reperfusion

Choosing the right race to run

PREFERRED

Primary PCI

- Device within 90 min of FMC, or 120 min on transfer
- Best choice in shock, uncertain diagnosis, or lytic contraindication
- ED physician decides; cardiology consult only when uncertain

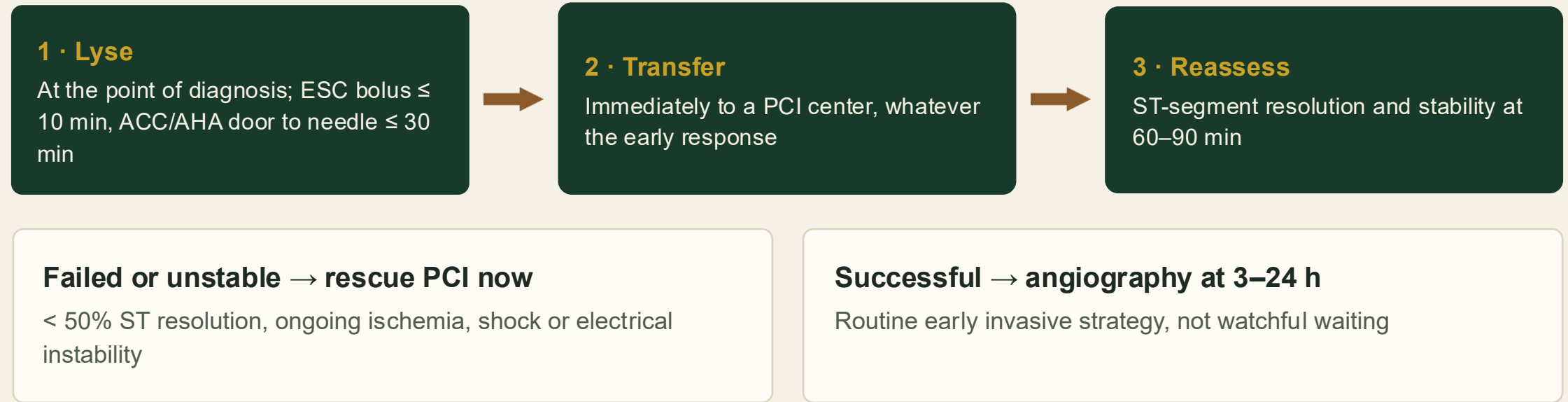
SECONDARY

Tenecteplase (TNK)

- Patient ineligible for timely PCI, or special circumstances
- Within 12 hours of onset, no contraindications
- Given within 30 min of STEMI diagnosis; then transfer for angiography

WHEN THE TRACK IS TOO LONG · PHARMACOVASIVE STRATEGY

No PCI within 120 minutes? Lyse, then move



Abandoned: facilitated PCI (full-dose lytics then routine immediate PCI) — more bleeding, no benefit in ASSENT-4 PCI and FINESSE.

When a second STEMI arrives



Cath lab lead and interventionalist decide: can the lab take STEMI #2 **within 30 minutes**? Yes — activate as usual.
No — choose by where the patient is:

In-house or in the ED

Start TNK eligibility screening immediately

Ground EMS or transfer

Divert to a second PCI center

By air

Divert the helicopter to a second PCI center

The Transfer Center re-activates the STEMI process at the new site; repeat for any further STEMIs.

TWO RACING JURISDICTIONS

Same finish line, different starting gates

Issue	United States (ACC/AHA)	Europe (ESC)
Preferred strategy	Primary PCI	Primary PCI
Time zero	First medical contact	STEMI diagnosis
Prehospital lytics	More cautious; rural resource constraints cited	Strong (Class I) emphasis on prehospital logistics, including prehospital lytics
Lytic speed	Door to needle ≤ 30 min	Bolus ≤ 10 min of diagnosis
Early, high-risk presenters	No separate target	Historically ≤ 60 min FMC to device (2012 ESC)

Both shorten the same thing — system delay — and both converge on 2–24 h angiography after lysis.

Regions that practiced the handoffs got faster

Hospitals using each process, before → after

Process	2012	2014
Prehospital cath lab activation	62%	91%
Single-call transfer protocol	45%	70%
ED bypass, EMS patients	48%	59%
ED bypass, transfers	56%	79%

112 vs 152 min

Median FMC-to-device, single-call transfer:
adopters vs never

88 vs 98 min

Median FMC-to-device, prehospital activation:
adopters vs never

Mission: Lifeline increased timely access to primary PCI and has been associated with declining STEMI morbidity and mortality ; the model now extends to stroke and cardiac arrest.

NOT EVERY HORSE GETS THE SAME TRACK

Regionalization's gains were not shared equally

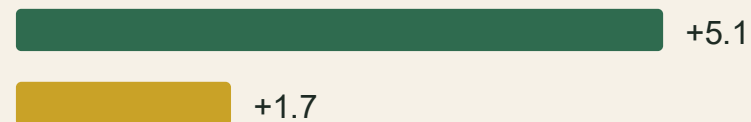
California, 2006–2015 · 139,494 STEMI patients · increase after regionalization (%)

■ Nonminority communities ■ Minority communities

Access to a PCI hospital



Same-day PCI



SURVIVAL

Mortality benefit only for White patients in nonminority communities.

No measurable benefit for Black or Hispanic patients, or for residents of minority communities.

Barriers: community education, 911 activation, EMS triage, transfer, post-acute care.

Every race is timed, and every runner hears the result

INTERVALS TRACKED

FMC to reperfusion	Door to ECG
FMC to activation	Field FMC to activation
Door-in–door-out	Door-to-door-to-device
Receiving door to device	Lab arrival to reperfusion

FEEDBACK LOOPS

- Outcome to the ED in 24–72 hours
- Follow-up to air and ground crews within 72 hours
- Physician response times reviewed monthly
- Only a cardiologist or ED physician cancels a Code STEMI

The roses go to the whole barn

Owner · Horse · Trainer · Jockey

One race. One clock. One team.

A statewide system for heart attack response, written into law

2022

HB 512 → KRS 211.340–.343

Department for Public Health runs a statewide system and a continuous quality-improvement plan

3 levels

Recognized by national certification

Level I Comprehensive Cardiac Center,
Level II Primary Heart Attack Center,
Level III Acute Heart Attack Ready

EMS

Protocols and destination plan

EMS protocols expanded to heart attack;
KBEMS STEMI destination plan in the state protocols

Recognition is voluntary (902 KAR 20:470); centers are encouraged to sign coordinating agreements with transfer protocols in their service area.

Recognized heart attack centers, January 2026

Level I · Comprehensive Cardiac Center

- Baptist Health Lexington
- Baptist Health Louisville
- Baptist Health Paducah
- Norton Audubon, Louisville
- St. Elizabeth, Edgewood
- UK King's Daughters, Ashland
- UofL Health – Jewish Hospital

Level II · Primary Heart Attack Center

- Baptist Health Hardin, Elizabethtown
- Highlands ARH, Prestonsburg
- Mercy Health Paducah
- Norton Brownsboro, Louisville
- Norton Hospital, Louisville
- Saint Joseph, Lexington
- Saint Joseph East, Lexington
- Saint Joseph London
- St. Claire, Morehead
- The Medical Center, Bowling Green

Level III · Acute Heart Attack Ready

- Bluegrass Community, Versailles
- Medical Center at Russellville
- Norton Women's and Children's, Louisville

Referral role: assess, resuscitate, stabilize, and transfer quickly to Level I or II

Running the race in Louisville and beyond

196.9

heart disease deaths per 100,000
in Kentucky, vs 157.6 nationally
CDC WONDER via KFF, most recent
year

PCI receiving — Jewish Hospital (state Level I), Mary & Elizabeth, South, UofL Hospital

Referring EDs — Medical Center East, Medical Center Southwest, Shelbyville

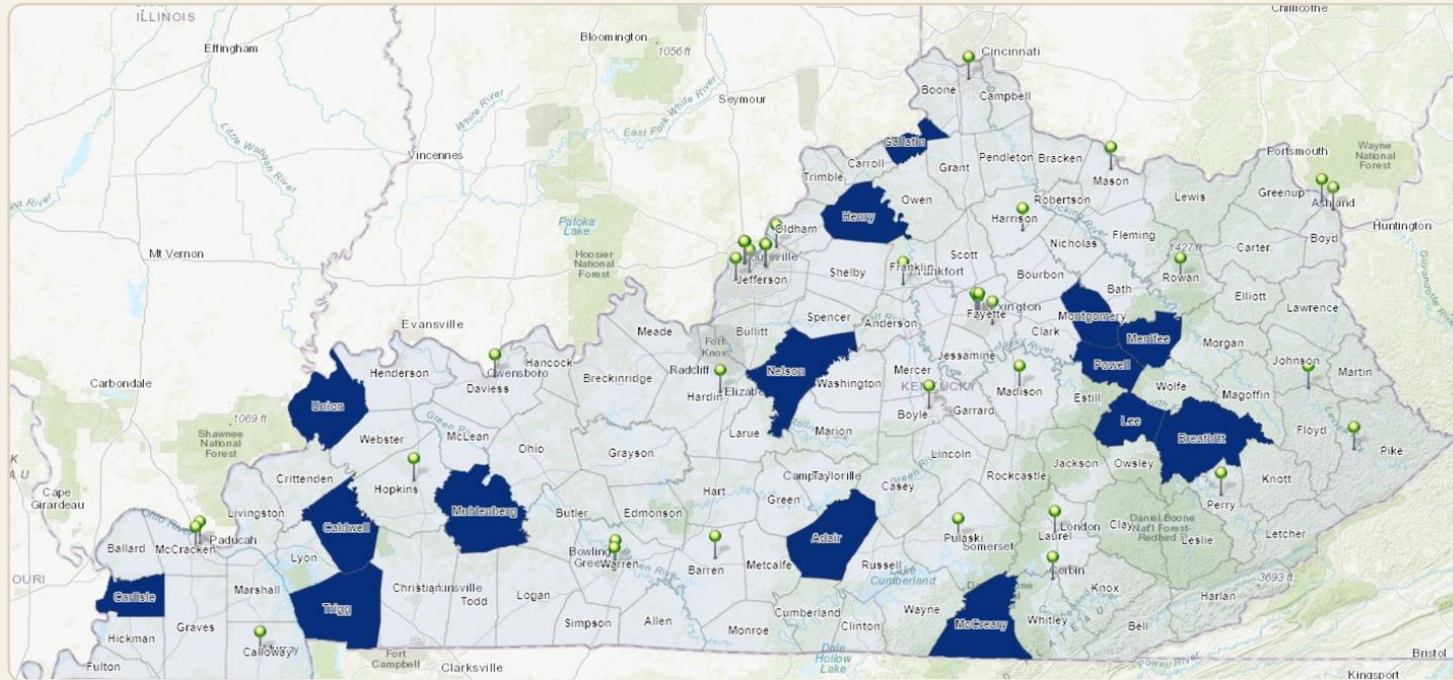
Network rules — no diversion; every STEMI referral accepted; one Transfer Center

Recognition — Jewish Hospital: ACC Chest Pain Center with Primary PCI and Resuscitation (2020); NCDR Chest Pain–MI Gold (2021)

The next gain: every owner, horse, trainer and jockey in the Commonwealth on the same clock.

KENTUCKY · THE LONGEST STRETCH OF TRACK

15 counties with the longest STEMI transport times



METRIC · 2020

Median time from unit leaving the scene to arrival at destination

■ Top 15 counties

● PCI-capable hospital

West · Carlisle, Caldwell, Trigg, Union, Muhlenberg

Central · Gallatin, Henry, Nelson, Adair, McCreary

East · Montgomery, Menifee, Powell, Lee, Breathitt

How did we do it in Michigan?

1

The coalition

- Clinicians and patient advocates committed to teamwork
- ACC and AHA working together, with other partners

2

The blueprint

- A white paper on STEMI systems of care
- State support to build on existing trauma regions and medical control authorities

3

The law

- Legislative champion: Sen. John Bizon, MD (SB 521, 2021)
- Designated appropriations
- Signed into law by the Governor

4

The rules · Nov 2023

- Written by clinicians and state staff together
- Receiving and referral centers defined
- EMS bypass and destination protocols
- Support for rural and critical access hospitals

BUILT IN

Mandatory designation tied to national accreditation · a statewide STEMI registry · regional advisory councils with performance review

TIME TO HEAD TO THE STARTING GATE

“Call to the Post”



*CAN CLINICIANS, EMS, HOSPITALS, AND
THE COMMONWEALTH COME TOGETHER
TO ADDRESS TIME-SENSITIVE CARDIAC
EMERGENCIES IN A PATIENT-CENTERED
MANNER?*

Thank you!

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TRANSFORMING CARDIOVASCULAR CARE FOR ALL

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MISSION

To transform
cardiovascular care
and improve
heart health for all

VISION

A world where
science, knowledge and
innovation optimize
cardiovascular care
and outcomes

CORE VALUES

Patient-Centered;
Teamwork and
Collaboration;
Professionalism,
Excellence
and Equity



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ACC STRATEGIC PLAN (2024-2028)

STRATEGIC PILLARS



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ACC leadership in Kentucky



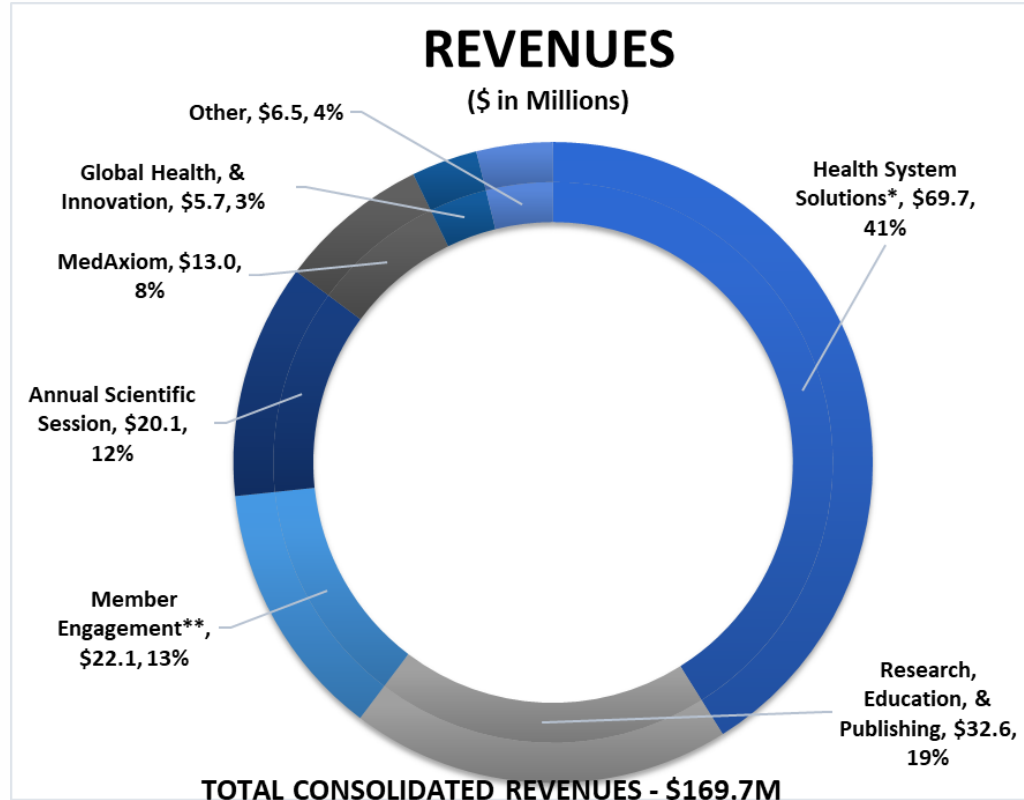
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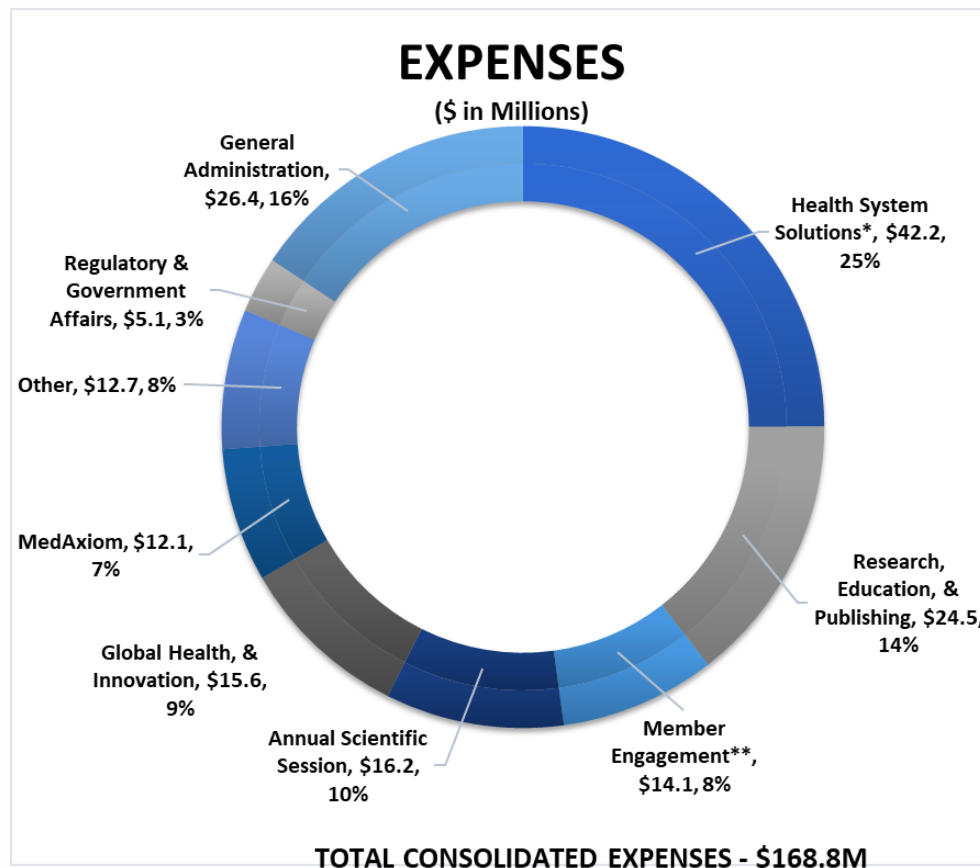
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ACC FINANCES AND MEMBERSHIP VALUE

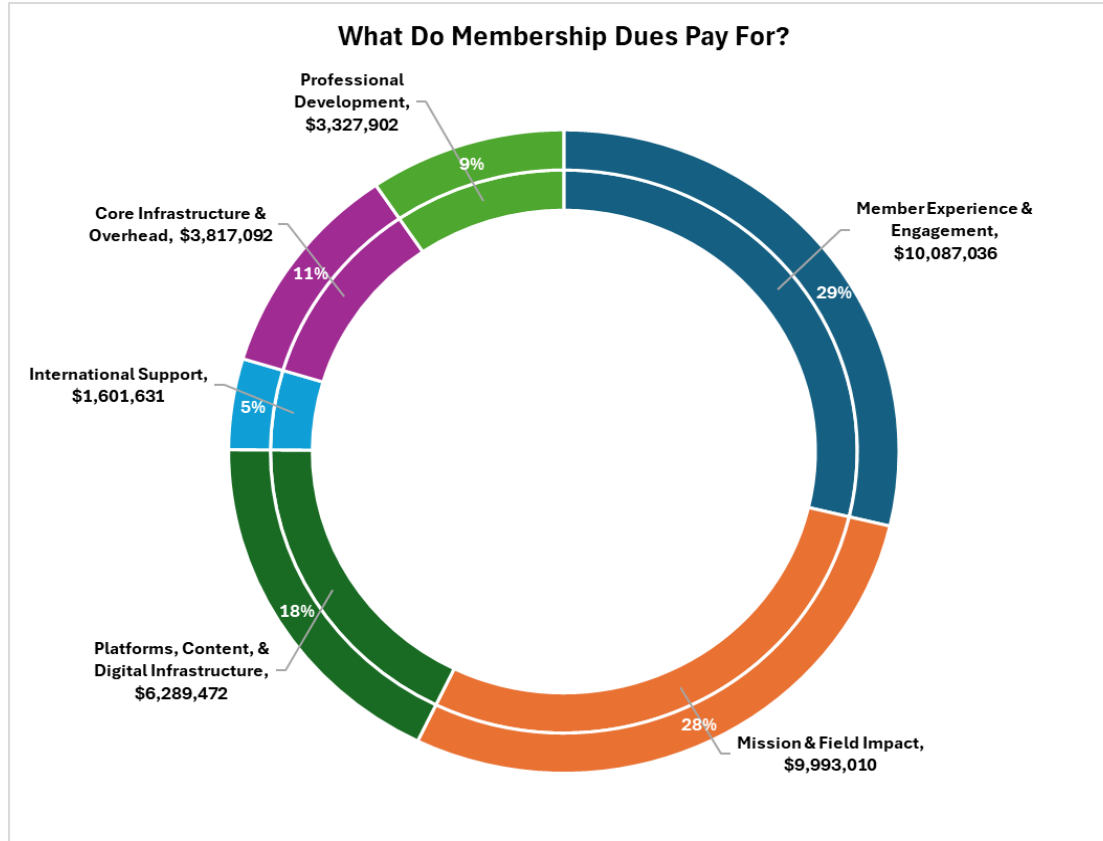
2025 ACC Consolidated Revenues



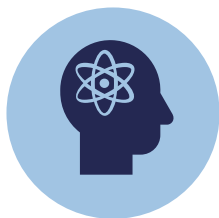
2025 ACC Consolidated Expenses



What do Membership Dues Pay For?



MORE THAN JUST MEMBERSHIP



Leading the Way in CV Science and Education

- Live courses, roundtables and educational products
- Cutting-edge Annual Scientific Session
- *JACC Journals*
- Robust clinical guidelines and other guidance



Optimizing Patient Care and Outcomes

- NCDR suite of clinical registries
- ACC Accreditation Services
- Quality programs, clinical apps & toolkits
- Advocacy
- CardioSmart patient education



Trusted Source of News and Information

- *ACC.org* & *JACC.org*
- *Cardiology Magazine*
- Market Intelligence
- Podcasts and webinars
- Focused member-facing newsletters



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BEYOND CLINICAL COMPETENCIES

- Fuster Prevention Forum
 - [ACC.org/FusterPreventionForum](https://acc.org/FusterPreventionForum)
- Practice Made Perfect and Other Podcasts
 - [ACC.org/Podcasts](https://acc.org/Podcasts)
- ACC Leadership and Career Development Programs
 - [ACC.org/LeadershipDevelopment](https://acc.org/LeadershipDevelopment)
- ACC Leadership Forum
 - [ACC.org/LeadershipForum](https://acc.org/LeadershipForum)
- CV Business and Management Essentials Program (Wharton and MedAxiom)
 - [MedAxiom.com/Wharton](https://medaxiom.com/Wharton)

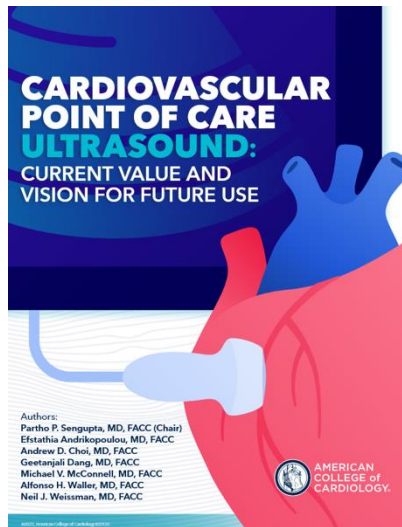
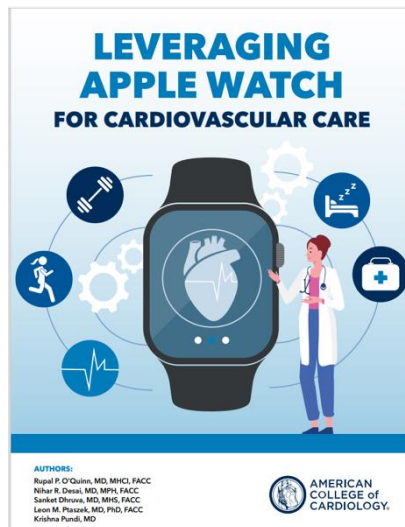
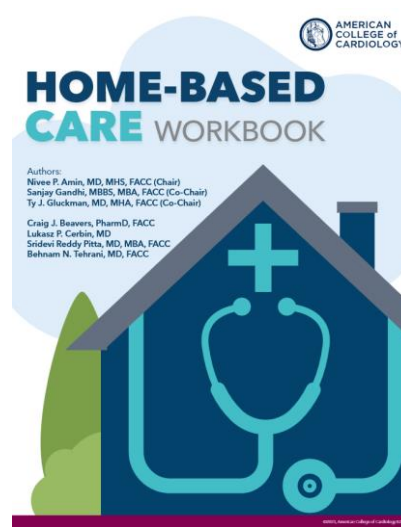




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CARE TRANSFORMATION

INNOVATION PROGRAM RESOURCES



Download these workbooks and other resources at
[ACC.org/InnovationProgram](https://acc.org/InnovationProgram)

AI RESOURCE CENTER

Access the Following Resources:

- AI-Enabled Clinician Podcast
- Curated AI Resource Library
- AI In Practice Resources
 - AI Prompt Generation Guide
 - AI Capabilities and Clinical Scenarios
 - AI System Assessment Criteria



Find out more and access more resources at
ACC.org/AI

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is now available in **OpenEvidence.**



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CLINICAL GUIDANCE

New in 2026: Dyslipidemia Guideline

CENTRAL ILLUSTRATION: 2026 Dyslipidemia Guideline-at-a-Glance

Lipid Lowering to Reduce ASCVD Risk

Screen
EARLIER

Check
REGULARLY

Aim for
LOWER LDL-C

Treat
LONGER



- Screen at **age ≥2y** if family history of premature ASCVD, severe hypercholesterolemia, or FH
- Screen at **ages 9–11y** to identify FH and other lipid disorders



- Screen lipids again at age **19y**
- Recheck at least every **5y** and use PREVENT-ASCVD to identify risk



- LDL-C goal:
- **<100 mg/dL** for PREVENT-ASCVD <10%
 - **<70 mg/dL** for PREVENT-ASCVD ≥10%, FH, DM with risk factors, CAC ≥100 AU
 - **<55 mg/dL** for clinical ASCVD at very high risk*



- Check lipids **4–12wk** after start or dose change of lipid-lowering therapy, then **every 6–12mo** thereafter
- Benefits increase with longer therapy; tailor duration to individual risk

Promote lifelong healthy lifestyle behaviors

Wiggins BS, et al. JACC. 2026;10.1016/j.jacc.2026.02.4872



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New in 2026: Acute PE Guideline

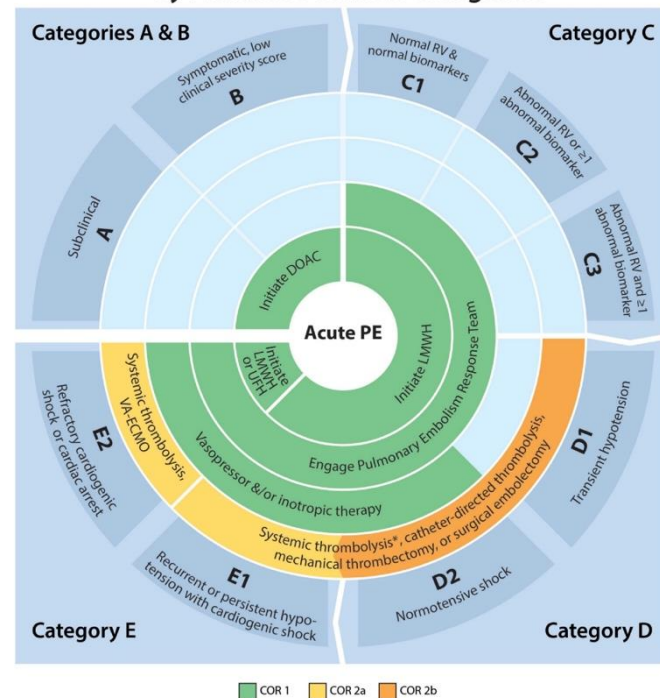
AHA/ACC Acute PE Clinical Categories

A	B	C	D	E
Subclinical Incidental and asymptomatic	Symptomatic Low clinical severity score*	Symptomatic Elevated clinical severity score†	Incipient Cardiopulmonary Failure	Cardiopulmonary Failure
Lowest risk → Highest risk				
	B1 Subsegmental (Single/multiple)	C1 Normal RV and normal biomarkers	D1 Transient hypotension‡	E1 Recurrent or persistent hypotension with cardiogenic shock
	B2 Non-subsegmental	C2 Abnormal RV or ≥1 abnormal biomarker	D2 Normotensive shock§	E2 Refractory cardiogenic shock or cardiac arrest
		C3 Abnormal RV and ≥1 abnormal biomarker		
		+/-	+/-	+/-
		R Respiratory Modifier (O ₂ <90%, RR ≥30, need supplemental O ₂)	R Respiratory Modifier (≥6 L nasal cannula or use of an NRB mask)	R Respiratory Modifier (Hypoxemic respiratory failure or ventilatory failure)

2026 Adults With Acute Pulmonary Embolism
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CENTRAL ILLUSTRATION: 2026 Acute PE Guideline-at-a-Glance

Selected Management for Acute PE Patients by AHA/ACC Clinical Categories



Dudzinski DM, et al. JACC. 2026;10.1016/j.jacc.2025.12.023

SCIENTIFIC STATEMENTS

2026 Gene Editing
Therapy in
Cardiovascular Disease

New in 2026:

EXPERT CONSENSUS SYSTEMS OF CARE

2026 Operator and
Institutional
Recommendations and
Requirements for
Tricuspid Interventions

OTHER

2026 Masters Athletes
With Abnormal
Cardiovascular Findings

OTHER

2026 Opposing
Legislative Mandates For
ECG Screening in
Competitive Athletes

CONCISE CLINICAL GUIDANCE

2026 Outpatient
Management of Isolated
Left-to-Right Shunt
Lesions in Pediatric
Patients



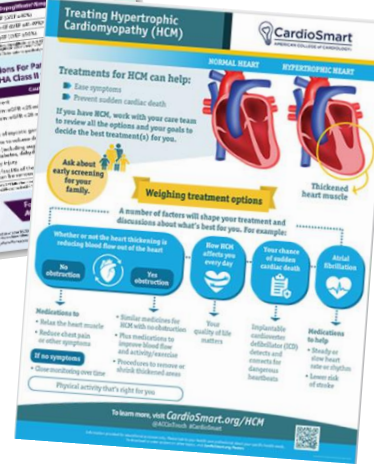
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CLINICAL TOOLS & RESOURCES

Guideline Clinical
App

CVD Risk Estimator
Plus App

CardioSmart Patient
Education



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Find Patient Education at: [CardioSmart.org](https://www.cardiosmart.org)



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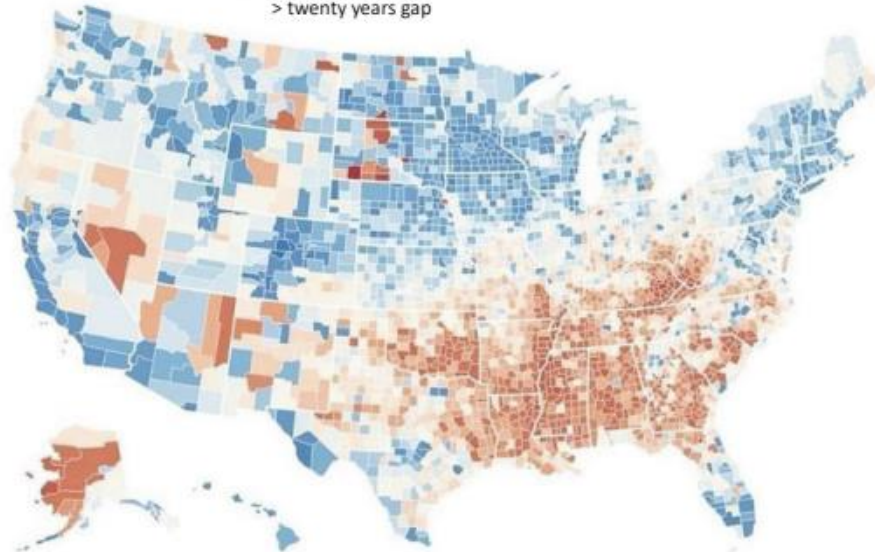
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ADDRESSING HEALTH EQUITY IN CV CARE

America is experiencing the greatest gap in life expectancy across regions in the last 40 years

Life Expectancy in America (2023) → 77.5 years

Average age at death
66.8 86.8
Summit County, Colorado **86.83** years.
Oglala Lakota County, South Dakota **66.81** years.
> twenty years gap



Source: Jeremy Ney, author of [American Inequality](#)

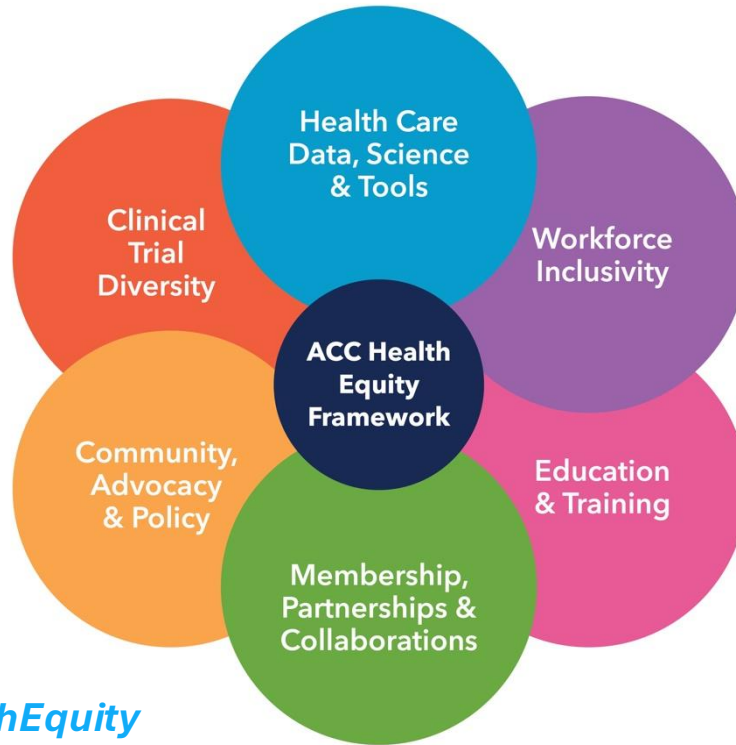
If you don't like life expectancy as a measure

How does the U.S. ranks among 30 OECD countries?

Obesity	30
Infant Mortality	27
Heart Attack	22
Respiratory Diseases	21
Diabetes	20
Cancer	14
Stroke	8

MRI machines per population	1 🏆
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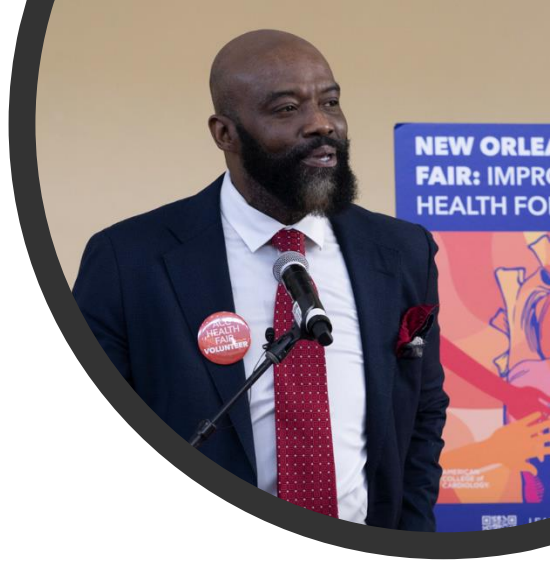
ACC HEALTH EQUITY STRATEGY



Explore more: [ACC.org/HealthEquity](https://www.acc.org/HealthEquity)



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HEALTH EQUITY IN ACTION



THAD & GERRY WAITES RURAL CARDIOVASCULAR RESEARCH FELLOWSHIP



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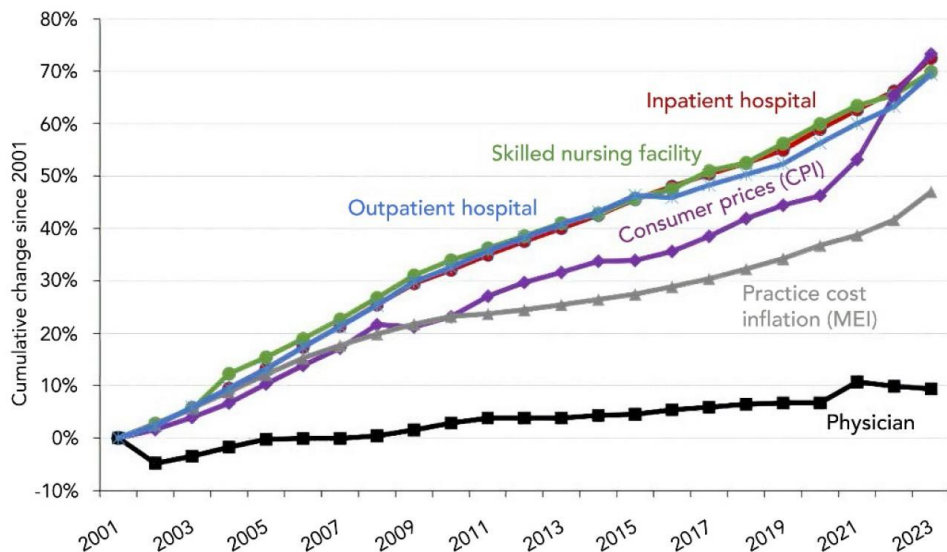


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ADVOCACY

The Medicare Reimbursement Gap: 20 Years of Divergence

Medicare Updates Compared to Inflation (2001-2023)



~+65–80%

Hospital Medicare payments increase via OPPS, DRG
2001 → 2024 (cumulative)

~-26%

Physician Medicare payments decline
2001 → 2024 (inflation-adjusted)

2–3×

Site-of-service premium paid
for same service in HOPD vs.
physician office

MACRA / MIPS

2015 quality reform replaced SGR but did not restore
historical losses

Key Payment Reform Initiatives

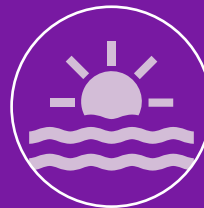
Impacting Cardiovascular Practice (2027 - beyond)



Ambulatory
Specialty Model for
Heart Failure



Site-Neutral
Payments for Non-
contrast Imaging



ASC Expansion,
Sunset of Inpatient-
Only List, Impact on
Office, HOPD, ASC



One Big Beautiful
Bill Act – Medicaid
Funding

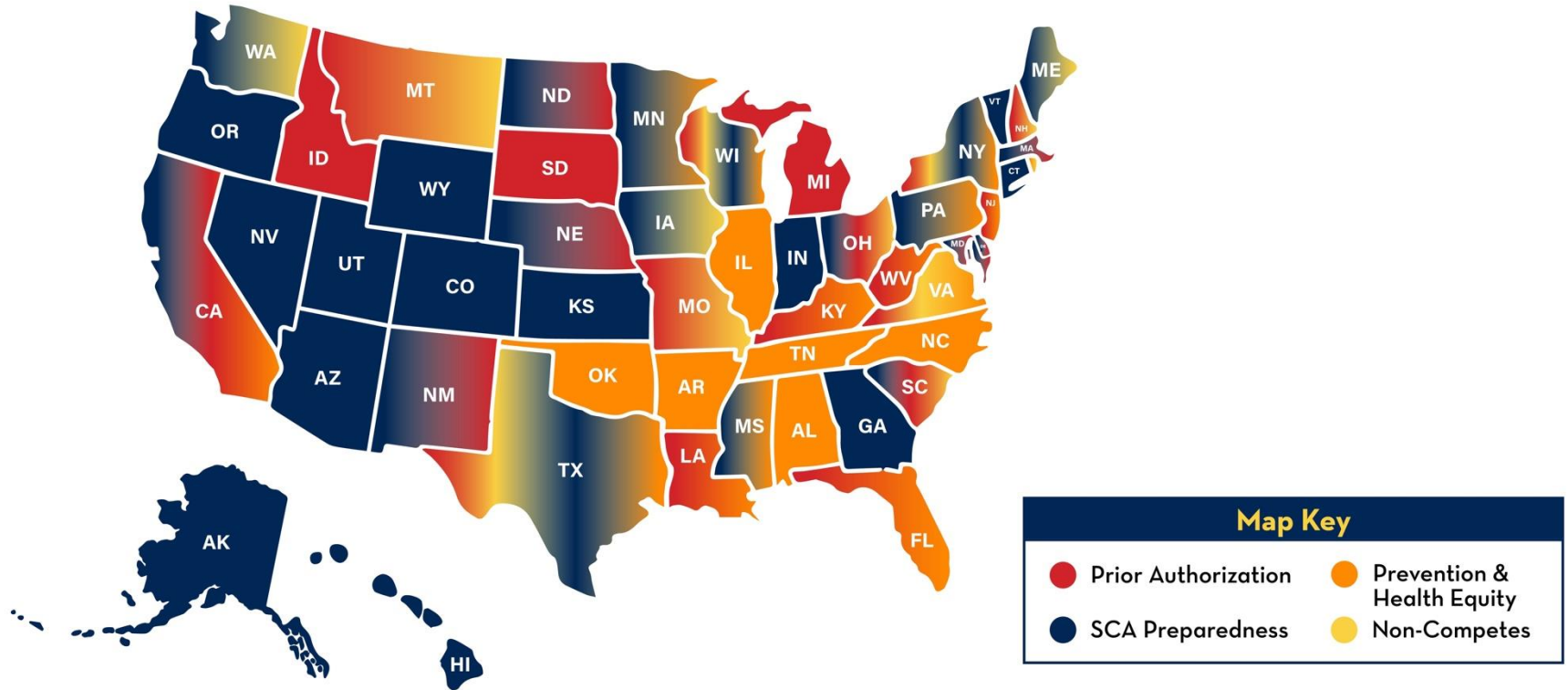


ACC ADVOCACY PRIORITIES



- Establish Sustainable Medicare Payment Practices
- Support Clinicians in Providing Equitable Value-Based Care
- Bolster the Clinician Workforce Now and For the Future
- Champion Access to Care For All
- Foster Care Transformation and Optimization

TRENDING ISSUES IN THE STATES



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RECENT ADVOCACY SUCCESSES



Secured a two-year extension of Medicare telehealth flexibilities and restored access to in-home CV rehab delivered virtually through 2027.



Eliminated the 15% cap on indirect costs for facilities and administrative expenses.



Achieved support for state-based maternal mortality review committees through 2030.



Drove passage of AED access legislation in several states, made possible by Chapter engagement and ACC's involvement in the Smart Heart Sports Coalition.



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LEGISLATIVE CONFERENCE

OCT. 4 - 6, 2026

#ACCLegConf





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JOIN THE CARDIOLOGY PARTY

HeartPAC® is the Cardiology Party advocating for you on Capitol Hill by:

- ✓ Investing in Congressional Champions
- ✓ Acting on Cardiology Issues
- ✓ Supporting the Future of CV Care

Learn more and get involved at ***HeartPAC.org***.



HeartPAC™

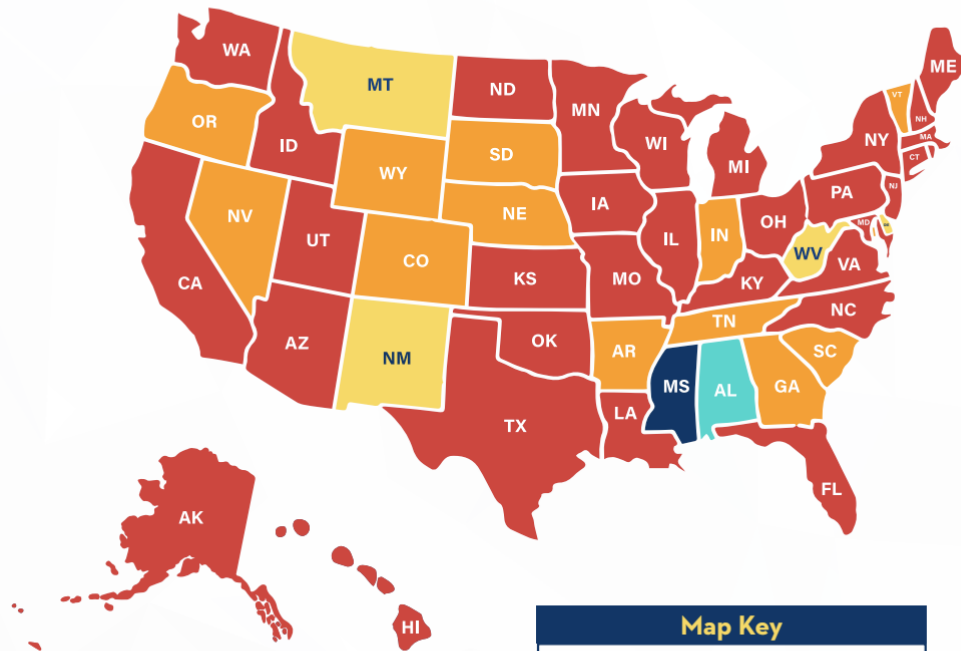
ACC POLITICAL ACTION COMMITTEE

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HeartPAC Participation Rates 2023-2024

This map shows the HeartPAC participation rates in each state for the current election cycle.



Map Key

- 0.5-2%
- 2-4%
- 4-6%
- 6-8%
- >8%



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MORE WAYS TO GET INVOLVED



Action Alerts

Contact your lawmakers about health policy issues.



Advocate Checklist

Learn what goes into a successful advocacy strategy.



Practice Visits

Host a lawmaker at your practice.

Visit [**ACC.org/Advocacy**](https://acc.org/advocacy) to learn more.



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