Date: November 11, 2008

To: REMSCO

Re: STEMI Project

Thank you for your inquiries concerning this joint effort to bring pre-hospital patients who meet physician (FDNY-OLMC) approved STEMI criteria directly to a NYS certified PCI center for emergent cath with the goal of open artery within 90 minutes of the 911 call. We are pleased to continue to work with REMSCO you towards this important public health initiative.

Phase 1 of this initiative has been progressing well. After meeting with each of the 22 hospitals individually, all hospitals with NYS approved PCI centers are sharing outcomes data. We have assigned a point person in-charge of this program for FDNY (Dr. Bradley Kaufman) and each hospital has done the same. A one page form for data collection has been developed and approved by each of the participating centers. Communication of data, both frequency and medium (phone, fax, email, etc.) is according to the individual center’s preference. Our internal data collection processes have also been strengthened and we now have a fully functional computerized database. Initial errors in design and implementation of the FDNY database programming have been corrected. Initial data entry is done during the call by OLMC and follow up outcomes data is done when received by OMA. Pre-hospital data and hospital outcomes are then matched and individual patient data is then returned to the treating hospital and aggregate data for the city is shared with all hospitals.

Although false positive transport rates need to be improved, let us not neglect 3 important results: data sharing process is now a success, life-saving urgent cardiac catheterization c/w standard of care has been provided to over 274 STEMI patients since the program began in 11/07 and shortly we will have ECG transmission to reduce false positive.

Now that the data is flowing regularly, we will be sending this aggregate data to REMSCO for regular distribution on at least a quarterly basis.

In each of the months of July and August 2008, we achieved a 64% return rate for outcomes data. It is too early to report September or October data but we expect similar return rates or better.

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As we are receiving nearly 100% of the data outcomes for patients going to cath, the only way to improve data collection further is either with greater ED participation or by sending all patients directly to the cath lab. This latter possibility will be discussed with all of the participating PCI centers (ED and cath labs) but only after false positives are dramatically reduced by ECG transmission for real-time physician interpretation. We are hoping to beginning prehospital 12-lead ECG’s transmission to FDNY OLMC facility for real-time physician interpretation in early 2009 (Jan or Feb) and shortly thereafter forwarding that ECG by fax or email directly to the PCI center.

The following specific questions were asked of FDNY:

1) What percentage of patients brought to STEMI Centers meet EKG criteria under REMAC Protocol?

A review of prehospital 12-lead ECG’s with a paramedic interpretation of STEMI (from Jan and Feb 2008) revealed a positive predictive value of 0.38 when evaluated against physician review. However, this data is flawed because the denominator included not just OLMC approved STEMI patients. In August we did a citywide drill to re-educate FDNY paramedics on 12-lead interpretation and identification of common STEMI mimics. This drill was shared with REMSCO. When we begin transmission of ECG to OLMC this will not only reduce interpretation error but will also provide for real-time teaching.

2) For patients with proven STEMI, what percentage receive primary treatment with a thrombolytic agent versus PCI?

Our data reveals that approximately 23% of those patients transported as part of this program are brought emergently to catheterization. We do not collect data regarding those patients that are thrombolysed, only that they were not emergently cathed. We will begin collecting this data when we start ECG transmission.

3) For proven STEMI cases receiving primary treatment with a thrombolytic agent, what percentage later go to have emergent or non-emergent PCI?

We require participating centers to tell us whether patients were brought emergency to cath or not, as this program is designed to enable rapid catheterization of STEMI patients. We will begin collecting this data when we start ECG transmission.

4) What percentage of STEMI centers have a 24/7 capability as defined by having on-site staff (as opposed to on-call) for the operation of their cardiac catheterization labs?

There are 22 participating hospitals who have all agreed to provide 24/7 catheterization to appropriate patients transported to them as part of this program. We do not (and would not) mandate on-call vs on-site requirements. Hospitals must have mechanisms in place to allow for emergent catheterization as part of this program.

5) At what point would STEMI Centers be allowed to continue their participation in the absence of sharing data that was a precondition for designation? How might a STEMI Center’s unwillingness to share data effect their participation in future projects (i.e.; Hypothermia Project)?

The hospitals participating in this program have all agreed to provide outcomes data. At this point, if a hospital is unwilling to provide that data to us, they will no longer be considered a participating center. This is no longer a problem.

We look forward to discussing this further with the REMAC and the REMSCO.

Thank you

FDNY-EMS-OMA