#AlwaysEssential

COVID Testing for First Responders

1. Call our CCC hotline at 860-972-8100 from 7am – 7pm and select option “2”.
2. Connect live with a nurse and physician who will determine, if appropriate, next steps to be tested.

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Editor’s Note
The “New” Normal for EMS

It was just 10 weeks ago since the last edition of EMS Monitor was released. At that time, the coronavirus was spreading across a handful of foreign countries and only spoken about in small circles of healthcare in the United States. Exposure control plans were, at that time established, but arguably, most only identified surge capacity of a limited number of patients. Ten weeks later, we are being dispatched to 30 – 40% fewer 9-1-1 emergencies, but at the same time, exposed to an extreme increase in the number of patients considered highly infectious, in cardiac arrest, or with severe acute illness or injuries. EMS agencies throughout the state are being pulled in to help plan and staff mobile field hospitals, train on evolving modifications of protocols, and searching for a lifeline for staffing, PPE, and financial stability.

When we look back on the last 10 weeks, we have to consider how agile we were, or had to become; how collaborative we were with our peers or neighboring agencies, or had to become; and how resilient and strong we were, and will continue to be. We have climbed the initial mountain of infection spread, but as we know, we still have a tremendous amount of work ahead!

Our hospital and system leaders stand fast to help move EMS as it changes as a result of this current crisis. We are actively looking at the use of innovation for live connectivity with emergency room physicians, education, patient outcomes, and resource management. We are working with many of you to look at our current patient care models for areas of opportunity; strengthening ALS support systems in our most vulnerable areas; and thinking more creatively about how to assure our communities are prepared for what comes next. Most especially, we will continue to provide the appropriate EMS wellness, staff retention, and support programs you need. This includes our “Peer to Peer Support” hotline, our COVID testing hotline, and when needed, connection to our vast behavioral health network and industry experts.

We do believe the world, in general, will be changed forever – a true moment in history. The world of EMS will also continue to change, but at a much faster rate and for the better. To do so, we need to continue to work together in the coming months and years ahead and work through not only this crisis, but what will come afterwards as a result of.

In closing, we wish you all the best as we celebrate EMS Week. As much as we will miss our banquets and recognition events, know that this crisis has helped reinforce the importance of celebrating your work and efforts every week of the year.

Stay safe and stay healthy!

The Editor
System Saves!

Hartford Region
East Windsor EMS Paramedic Mike Tyburski with EMT Kevin Arzt upon arrival of a patient experiencing weakness, confusion and signs of a stroke. After an excellent on scene time and activation into a comprehensive stroke center, the patient received successful acute care treatment and discharged stable.

Time on scene: 7 minutes
Transfer of care: 25 minutes after first patient contact

Northwest Region

Congratulations to New Hartford Volunteer Ambulance EMTs Rita Wabrek and Joy Egbertson with Trinity EMS Paramedic Mary Kate McAllister who successfully delivered a healthy baby boy recently!

Mom and baby were transported to a local hospital and are doing well! Also on scene were New Hartford EMTs Dave Stankiewicz and Richard White.

Central Region

New Britain EMS Paramedic Maria DeSimone with EMT Brian Futtner, arrived on scene of an elderly patient with onset of chest pain.

Patient contact to transmit of EKG: 8 minutes
Time on scene: 12 minutes
Transfer of care: 19 minutes after first patient contact

The patient was transported to the nearest PCI center for successful clot retrieval!

Wallingford FD Paramedic Josh Barrows with Paramedic William D’Ambrose, arrived with a patient presenting with confusion and agitation. Patient was Cincinnati positive.

Time on scene: 21 minutes
Transfer of care: 30 minutes after first patient contact

Patient was ultimately transferred to a comprehensive stroke center for a successful thrombectomy.
Case Study

Hartford Region

Case 1
Crew: Aetna Paramedic Kevin Stock with partner Chris Nelson
Dispatch: Unresponsive hyperglycemic patient
Case:
- The patient had no known history of renal disease, but paramedic Stock recognized a sinusoidal 4-lead ECG pattern consistent with hyperkalemia in the setting of possible acute renal failure.
- Shortly after patient contact, the patient went into cardiac arrest.
- After proper ACLS care the patient displayed ROSC after about 25 minutes of CPR (see below)

Outcome:
- Paramedic Stock’s astute insight and appropriate treatment saved this patient’s life. After a lengthy hospital stay and rehab, the patient was discharged alert, oriented and able to independently carry out activities of daily living.

1st Contact on Scene…

Upon ED arrival...

Case 2
Crew: Middlesex Health EMS Paramedic Stephen Legere, Paramedic student Jeremy Maddox, Hunters Ambulance Paramedic Aaron Rigono and EMT Elissa Maillet
Dispatch: Sudden onset 10/10 substernal chest pain with difficulty breathing, diaphoresis and pallor
Case:
- Identified a STEMI and initiated appropriate clinical care, rapid transport and pre-notification.
- The team took the precaution of placing defibrillator pads en route.
- During transition into the emergency department and still on the EMS stretcher, the patient sustained a v-fib cardiac arrest. Because of the preplaced defib pads, Paramedic Rigono was able to successfully defibrillate within about 30 seconds.

Outcome:
- Due to the proactive treatment resulting in immediate intervention, the patient was able to undergo successful PCI to a 99% stenosis of the RCA and was discharged home after four days.

Upon ED arrival…

Upon successful PCI…
COVID-19 has really changed many of our standards of operation, regardless of your role in EMS or healthcare. How we respond to calls or facility transfers sometimes requires us to slow things down to ensure we maintain a safe environment.

Background
Acute Respiratory Distress Syndrome (ARDS) is a condition characterized by bilateral pulmonary infiltrates with refractory hypoxemia that is non-cardiogenic in origin. These patients can be extremely tenuous and create a number of challenges for a transport team. Transport ventilators do not always behave the same way as in hospital ventilators which sometimes also have more advanced modes of ventilation such as airway pressure release ventilation (APRV). A PaO2/FiO2 ratio (P/F Ratio) provides guidance to the severity of ARDS. Mild cases of ARDS have numeric ranges between 200-300 mmHg; as the number drops the mortality increases. Values less than 100 mmHg indicate severe respiratory distress syndrome.

Dispatch
Recently, we received a request for a middle aged COVID-19 positive patient, weighing more than three hundred twenty pounds, requiring transport to a tertiary care center. The sending physician requested that the patient had to be transported in the prone position due to the severity of the ARDS.

How were we going to transport this critically ill patient safely?

We elected to conference the crew with our medical director and the sending physician, to discuss the reasoning for this unique request. Our suspicions about the severity of this patient’s illness were confirmed with a reported P/F ratio of 87 mmHg in the prone position indicating severe ARDS.

The Case
The provider stated the ventilator settings were pretty maxed out on a conventional low volume, high respiratory rate & high PEEP settings. The patient’s FiO2 was set to 60% which may have given us a small sigh of relieve before departing on this transport.

So, can we just turn the patient onto their back and complete the transport? There are many potential risks to transporting a patient in this position, such as how we will manage the endotracheal tube if it were to become dislodged and what if the patient required CPR? How would we safely be able to move the patient into a supine position in the small airframe of our helicopter?

The sending physician was insistent on the prone positioning, indicating that the P/F ratio was even worse in the supine position, further exacerbating the severe hypoxia. Further, prone positioning may help improve exhaled tidal volumes, decrease shunting and allow recruitment of dorsal aspects of lung segments which were subject to atelectasis while the patient was lying on their back. I could certainly appreciate this physician’s stance on not changing course until new therapies could be implemented at the tertiary center.
The decision to transport this patient by ground was made after a lengthy discussion about risk and benefit, specifically if the reduced out of hospital time was worth the risk. We worried about cardiopulmonary arrest during the flight, even if we were able to transport this patient in a larger helicopter.

With the endotracheal tube in a downward position and the issue of patient size, what if unplanned extubation occurred? We would not likely have the time to replace the endotracheal tube before rapid deterioration into cardiopulmonary arrest.

Upon Arrival
Arriving at the bedside, we found the patient well sedated on continuous neuromuscular blockade. FiO2 was increased to 100% as we transferred the patient prone from the bed to the transport stretcher which went flawlessly.

Next, we transitioned to our Revel® transport ventilator and again no issues. FiO2 requirements were higher on our ventilator, but the patient did just fine on 85%. Plateau pressures were around 34 cmH2O, indicating they certainly had some compliance issues with not much room to move on any of their other settings.

The suction Ballard was left in place knowing we had a COVID-19 positive patient and wanting to minimize the risk of aerosolization, as well as understanding the challenges of suctioning a prone patient during a transport. This proved to be a lifesaver as the patient had acute desaturation as we approached our destination. The DOPE (Dislodged, Obstructed, Pneumothorax, Equipment Failure) acronym worked perfectly as my partner rapidly cleared the obstruction before our patient’s SpO2 dropped below 80%. This was a huge win as we arrived and transferred our patient safely.

Feedback
This may not sound as exciting as some of the scene responses many of you have been involved in during your EMS career, but take an opportunity to recognize all the challenges in such a call. This transfer was a mental exercise for all that were involved, with us laying all the cards on the table to come up with the best solution. After discussion with other air medical programs, we have adopted a uniform approach to caring for a prone patient during air medical transport. Who would have thought there was consideration of posterior CPR if there was an arrest during the transport?

It’s a different world out there right now and when you are asked to do something out of the ordinary, slow down, use your resources and always think safety first.

Sean Trainor, RN, BSN, CCRN, NR-P, started his healthcare career in EMS, working as a paramedic for over 18 years. Becoming a registered nurse during his tenure with Boston MedFlight, Sean was most recently at Connecticut Children’s Medical Center prior to joining the LIFE STAR team in 2018.
Dr. Charles Johndro named new System EMS Medical Director

As we further evolve our systemwide EMS initiatives, the work that we are doing in Hartford HealthCare is essential to helping our sponsored agencies provide the best care possible. The current COVID crisis has also shed light on the importance for streamlined communication and clinical guidance across our state.

To continue the work he has done representing EMS with the COVID crisis, we are pleased to announce that Dr. Charles Johndro has been named the new system medical director of EMS for Hartford HealthCare. In his expanded role, Dr. Johndro will begin working alongside our system EMS leaders and administrators to develop system wide strategies that affect our pre-hospital providers.

Collaborating with each of our regional EMS Medical Directors, Dr. Johndro will be responsible for the clinical innovation and growth of EMS across our system. During the current COVID crisis, Dr. Johndro has been integral in supporting our regional EMS directors to disseminate key clinical initiatives to our sponsored services.

In addition to this role, Dr. Johndro will still maintain his current positions as the EMS Ground Medical Director at Hartford Hospital, Medical Director of the CESI – sponsored Paramedic program, assistant professor in the department of Emergency Medicine and Traumatology at the University Of Connecticut School Of Medicine, and attending physician in the Hartford Hospital Emergency Department.

Peer to Peer Support for EMS Providers

Long before we confronted our current healthcare situation, we understood the importance to support the mental wellbeing of EMS practitioners. Long workdays add to balancing personal, professional and patient needs, as well as the stress of the environment in which we encounter each day. Hartford HealthCare has launched our “Peer to Peer Support” hotline – where a dedicated EMS professional will answer your call and talk through your current situation. If needed, your peer will connect you with a behavioral health specialist to provide greater support and guidance when it matters most.

Peer to Peer Support Hotline

📞 860-696-6811
📧 HHCEMS@hhchealth.org
The Proof is in the Numbers

Prior to the start of the coronavirus, the team at St. Vincent’s Medical Center began implementing best practices for stroke care similar to their counterparts system wide. This included a "Direct to CT" for patients arriving by EMS.....the results thus far are astounding:

22% improvement
Door to Neurologist

22% improvement
Door to CT Scan

48% improvement
Door to CT Scan read

39% improvement
Door to Needle

This is a 32 minute improvement

Continued process improvement!
Congratulations to the ED and Neuro team for their initial results.

The relationships and friendships that are developed in EMS extend for years! Recently Charlotte Hungerford Paramedic Tom Latosek posted: “All 3 of us haven’t been in the same place for about 10 years. Great to see these guys!” — with AMR Paramedic Adam Trujillo and Aetna Paramedic Joe Kosswig.

Windham Hospital Paramedic Bree Eichler practices with a new “Weather Pod”, which will provide adequate protection to the paramedic to properly perform intubation.

KEEP AN EYE OUT...

Hartford HealthCare Emergency Medical Services
EMS Conference
Late September 2020

More information to follow – we are excited to offer what will be a fantastic lineup of providers and speakers with both small group and hands-on opportunities.
Thank you to our agencies and partners who celebrated National Nurses Week!
Upcoming Calendar of Events

Please keep an eye out for all virtual CME opportunities throughout the spring/summer.

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Have a question or suggestion? Email us at First Name.Last Name@hhchealth.org

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HHC EMS Coordinator: East: Jeffrey Way (Backus)
HHC EMS Coordinator: East: Paul Pedchenko (Windham)
HHC EMS Coordinator: Fairfield: Terence Sheehan
HHC EMS Coordinator: Hartford: David Bailey
HHC EMS Coordinator: Northwest: Trisha Wain
HHC EMS Operations Mgr: Northwest: Fred Rosa
CESI EMS Operations Manager: Dawn Filippa
LIFE STAR Program Director: Patricia Margarido
LIFE STAR Nurse Director: Heather Standish

Join our Facebook group for the latest statewide news and recognition!