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TRANSCRIPT

Dr. Morley Good afternoon. My name is John Morley. I'm the Deputy Commissioner for the Office of Primary Care and Health Systems Management. I'd like to remind folks that this is a formal meeting of a committee, and as such, the meeting is being recorded and transcribed. Welcome, everybody. Good afternoon. I'd like to begin with some opening remarks, and then I'm going to turn this over to our prestigious Chair for the committee.

Dr. Morley Good afternoon and welcome to the first meeting of the Health Planning Committee. To address the impact of emergency department crowding on the EMS emergency medical services system, and in particular, the 911 response teams. This meeting is the result of CMAC, the State Emergency Medical Advisory Committee and State EMS Council, jointly identifying a concern that delays in transfer from EMS care to hospital care is having an increasing impact on the EMS system. The Chairs approached the Chair, Mr. Jeff Kraut, and the Chair of the Planning Committee, Dr. John Rugge, indicating the delay in EMS response times is having an effect on public health. This committee is tasked with reviewing currently available data developing as close to a 360-degree assessment of the problem as possible and forwarding recommendations on potential thoughtful solutions to this critical problem. Today, you're going to hear directly from the Chair. What EMS agencies are experiencing in different parts of the state. Delays in transfer patients are increasing and patients are sometimes held in parking lots. No one wants this. I repeat, no one wants this. I know this includes the hospitals and the hospital leadership. The staffing challenges, the COVID pandemic and so many other challenges to the health system have resulted in the need to make some very difficult decisions. We're not here today to fix all of health care problems, and we are absolutely not here today to point fingers. Our goal today is to listen to EMS and leaders in the health care industry and identify potential solutions to reduce delays in response times for the 911 system whenever possible and wherever possible. I want to emphasize that the etiology of the issue is very complex and there are components that are clearly outside the control of the health care system. Any response must take into account the many challenges we face in the health care, starting with staffing shortages. Solutions must include metrics and include feedback to verify we are on the right path. To determine thoughtful solutions that can be applied in New York's diverse health care settings. From the rural hospital in the North Country, where EMS depends heavily on volunteers to a hospital in Queens where paid and volunteer ambulance services both serve the community. We must first fully investigate data surrounding emergency department visits and note regional differences in order to identify specific issues and areas for a response. Today's meeting is the beginning of this data driven conversation. As I've stated, no conversation about health care can ignore the health care staffing shortages that we face as a nation. This has substantially compounded existing issues in the health care delivery system. Our health care workers have served throughout the COVID-19 pandemic and continue to serve their patients through workforce shortages. They are tired. We use the term all the time, worked tirelessly. Eventually, you can't use that term anymore. If you're a human being, you get tired. We owe our respect and massive gratitude to these workers, and I hope that any and all solutions discussed today will be mindful and demonstrate that respect and gratitude to

all of the health care workers on the front lines. We hope we can find solutions not only to the issues of delays and transfer, but also to improve patient care and provide relief to these essential workers. I'm excited to remind you that the Governor and the legislature created a new Office of Workforce Innovation that will be located in the Department of Health, and which will address the workforce shortage issue by partnering with providers, educational organizations, labor unions and other stakeholders to expand their health care workforce and improve the health care environment. Finally, I want to thank you this committee and to Dr. Rugge for his leadership for taking on this important task. Thanks to those who have taken substantial time and effort to prepare reports, whether they're delivered in person to this committee this afternoon or sent to the committee in writing. Special thanks go to Karen Madden and Jackie Sheltry, who provided all of the support for putting this meeting together and making this meeting possible. We all look forward to the committee watching and seeing the committee's work unfold as we chart a path to these new solutions.

Dr. Morley Thank you.

Dr. Morley I want to turn this over to Dr. Rugge at this point.

Dr. Rugge Thank you, John Morley.

Dr. Rugge It's my job to call this meeting to order and also to give what I like to refer to as the Miranda warning. We are being broadcast. We are being taped. That will be available for the following month and for several months thereafter. When you do speak, be sure first to introduce yourself, say your name and try not to rustle papers or talk over others. That's it.

Dr. Rugge I need to start by thanking Dr. Morley for his opening remarks and also for referring the perceived problem of ambulance offloading trouble to the Planning Committee for consideration, input, advice, and maybe even possible guidance. We'll see. I can't help but to note that this is the first dedicated meeting of this Planning Committee for several years, actually something like six years. As I see it, we have a special role, or at least an opportunity for a special partnering relationship with the Department of Health, with our members being gubernatorial appointees confirmed by the Senate. We have been selected and organized to bring broad experience, expertise and diversity. To a council that itself is charged with the review and approval of certain certificates and also many regulations. All integral to the delivery and the reimbursement of health care services. I see this committee not as an independent advisory body, but rather as an extension of the policy thinking and development that is essential to the State Health Department and of course, to the Governor herself. In this instance, I would notice that somehow the State Emergency Services Council has been forthcoming and very clear about stresses perceived by the EMS sector with the tip of the iceberg being extended offloading time at so many of our hospitals. Likewise, Governor Hochul has identified in EMS in our 2023 State of the State Address as one of nine items requiring special attention and carefully designed responses. Having said this, we are all aware that the entire health care system across the state and really across the nation is under severe and perhaps unprecedented stress. People stress in the form of workforce shortages, financial stress with new costs added to our already super expensive costs. Patient stress in obtaining timely care in the most appropriate setting and exploring, unearthing, if you will, shortcomings in the provisions of emergency medical services. I am confident that this investigation will lead us into difficulties and sometimes deficiencies all around the health care system with cause and effect bouncing from the ambulance ramp into the emergency department itself and

then into the inpatient units and yes, into the pressures from and on the long-term care setting as well. All the while, with a variety of primary care providers looking to become engaged as well. In taking on the subject of EMS, we can expect to discover trouble and opportunity elsewhere along the continuum of care. We cannot expect to tackle global health care reform. Instead, as I see our charge, our responsibility this afternoon is to begin the process of reviewing the data and understanding the problems and issues being raised by our EMS providers. Undertaking this exercise, I suspect that we will identify the need for yet more data and more information just to properly understand the problems that need fixing. Along the way, we will surely begin to touch upon possible approaches for improvement, approaches that may well entail adjustment in reimbursement methodologies, new training opportunities, regulatory revision, and perhaps even statutory change. No way can we immerse ourselves in all these aspects of reform. This afternoon we need instead to concentrate as best we can on problem identification. Later in the meeting, as you can see from the agenda, will be an opportunity for us as committee members to discuss and clarify the role of the committee. For now, I'm pleased to say we are so fortunate to have presentations and reflections from a number of key stakeholders and leading experts in the field. Many thanks for the speakers who are here for coming forward. Equally, I'm proud and impressed by the commitment and the work already undertaken by the leadership and the staff of the Health Department. Starting today with Steve Dziura as Deputy Director of the Bureau of Emergency Medical Services and Dr. Eugene Heslin as first Deputy Commissioner who was enlisted for this particular aspect of his job by Dr. McDonald as our Commissioner. I can also not help but point out how many others in the health department have been contributing already. In one of our pre-planning sessions, I was able to count 20 health department members on the screen. With Jackie Sheltry as our Assistant Chief Health Planner for the Center of Health Care Policy and Resource Development, pulling our meeting materials together and our agenda, we are set to go.

Dr. Rugge Please, everyone, brace yourself for the offloading of data and information. It's about to start. We're adjusting the agenda a little bit, and we'll be turning to Dr. Heslin for starting our discussion.

Dr. Heslin Thanks, Dr. Rugge.

Dr. Heslin Welcome, everybody. I'm Eugene Heslin. I'm the first Deputy Commissioner and Chief Medical Officer. I'd like to start with pointing out that our Acting Commissioner, Dr. McDonald, asked if I would become involved in this because he thinks it's that important. We need to be able to have people transported to hospitals in a safe and responsible way in a timely fashion and then have that care transitioned to in the hospital. That's an easy way to say maybe scoop and run, but the system is so much more complex than that. There are a multitude of different ways of thinking about emergency care, acute care, hospital care, post care, home care. They all are integrated. Because when you push on any one part of the system, something shows up somewhere else. It is truly integrated, though dysfunctional in so many ways. As Dr. Rugge said, funding, statute, regulation, education, all are part of the issue. What we're going to try to do is define the problem, define the data sources, validate and integrate them. We're going to look at potential solutions and then a risk analysis of those solutions and the integration into the larger system.

Dr. Heslin My computer just died.

Dr. Heslin We're going to look at the intended and unintended consequences with a feedback loop to be able to define what we have started with today. What I'm going to do is present data that was originally presented to hospitals and hospital associations, emergency departments in 2020, because there was a recognition literally a month before the pandemic started that ERs were overwhelmed and it was a problem that existed. We had thought that we were bringing that planning back in 2020 as an issue. What happens is we went downstream one more level to emergency medicine is overwhelmed and EMS is overwhelmed. As you can see, it's something that has been around for a long time. We are starting to look at it in a narrow view, but a holistic way. You can't boil the ocean. You can make minimal changes incrementally because any time you change the ecosystem too fast, there's high risk for patient harm and patient failure. We have to balance the need for change with the need for safety. Both are important. Sometimes, actually they align.

Dr. Heslin Let me start with the data.

Dr. Heslin If someone could pull up the slides for me, please.

Dr. Heslin Is anybody doing the slides?

Dr. Heslin Got it.

Dr. Heslin There we go.

Dr. Heslin I'm going to go through this really very quickly because the meat of the data is being presented today. This is data going through 2021. The data is from the slide deck that was sent out to the Planning Council from the 2020 data with more up to date data.

Dr. Heslin Next slide please.

Dr. Heslin The most frequent ER visits are listed on the screen, respiratory infections, abdominal pain, viral infections, urinary system problems, wounds, back problems, back pain. Very common. The one that's not listed on the screen, which actually is fairly frequent is dental problems. It's actually a fairly high level of issues that occur. Nonspecific checks, pain, headaches. When you look at this list, there are things that actually belong in an emergency room, things that may not always need to be an emergency room and just keep that thought.

Dr. Heslin Next slide, please.

Dr. Heslin The database actually shows that from 2019 pre-pandemic to 2021, sort of mid-pandemic, but hospitals were returning to more normal behavior, not completely normal behavior because of pandemic. There was actually a decline in the number of people that were seeing per thousand visits in the state statewide. It varied up and down by region. Essentially, Capital District had a fairly significant decline and most other people were fairly flat in terms of the overall number of people that were seen in emergency departments.

Dr. Heslin Next slide, please.

Dr. Heslin What we've seen is, is that on a per capita basis, Capital District, Hudson Valley, Long Island and Buffalo, Western New York actually had per capita visits that were

lower than statewide average in their emergency departments versus the other portions of the state, which were higher than average visits.

Dr. Heslin Next slide, please.

Dr. Heslin What's very interesting is despite the change in volume, we essentially see approximately the same number of people being admitted to the hospital. Overall, 17% in 2019 and 19% in 2022. There was a decline in total patients, but a slight increase in number of admissions. That being said, that probably works out to about the same number of people being admitted despite the overall lower volume of patients in the emergency room. I'll call out Long Island, which has always had a much higher rate of admission than every other region of the state. That's actually quite interesting when you look at the EMS data.

Dr. Heslin Next slide, please.

Dr. Heslin We've always had an issue. We are 27% higher than the national median in wait times for emergency departments. That's been consistently true. That being said, we don't have a higher left them without being seen, which is the next bullet point down the national average. We're about the same as everybody else. People wait longer in New York overall. That's for a variety of reasons.

Dr. Heslin Next slide, please.

Dr. Heslin What I have highlighted here is to show that as emergency rooms are higher volume, the wait times tend to be a little bit longer than lower volume emergency rooms. Low volume emergency rooms are defined as less than 25 visits per day. Very high volume is greater than 155 visits per day or 200 visits per day for the very, very high. That's consistent for both med surge as well as for psychiatry. We expect that. People that are in very busy ERs, it takes longer to get through all the patients made worse by complicating factors such as boarding staffing issues across the board, all of which complicate ER throughput.

Dr. Heslin Next slide, please.

Dr. Heslin Again, timeliness. This goes back to data from 2021. It's about three hours to get through an emergency room. If a psychiatric patient, about five hours to get through the emergency room. That'sfrom when you're getting stream to when you're discharged.

Dr. Heslin Next slide, please.

Dr. Heslin Timeliness of care. About two hours across the board, which is why I highlighted that for both psychiatry and med surge, although huge variations in the small number of hospitals that reported data from under 10 minutes to as long as 11 hours.

Dr. Heslin Next slide, please.

Dr. Heslin The final thought I'm going to leave you with is that potentially avoidable visits. When you go back to my second slide or third slide, depending upon which deck you were looking at. It was what types of things are in emergency rooms? There was an NYU algorithm built and there are several different algorithms. We just used this one to highlight. It may not be the best one, I'll point that out. Essentially 70% of what goes to an

emergency room is non-emergent or emergent but could be treated in a primary care office. When we're looking at emergency rooms, when we're looking at crowding, when we're looking at how we can start to define drop times for ambulances, we have to take into consideration also what is happening in emergency rooms.

Dr. Heslin I'll turn it over to my colleague, Mr. Steve Dziura. Steve is the Deputy Director of the Bureau of EMS. I'll also point out he is the person that has run the surge operations center for New York State for the last two years. I can't tell you how many nights he's been up all night long with EMS, with hospitals, with diversions and moving patients from point A to point B through New York State. As a colleague, I'm tremendously privileged to be working with him. The data that he's going to present is what we have, and there are some complete parts and incomplete parts, but I think it will fully move the discussion forward.

Ms. Monroe Before you turn it over to him, I have a question.

Dr. Heslin Yes, Ma'am.

Ms. Monroe And a couple of these slides, you say that the data is incomplete for 2020 and 2021. Do you think if it were all there it would change this significantly?

Dr. Heslin Not materially, because by incomplete, you know, there are a handful of hospitals that haven't reported. In terms of having data, we felt that using 2019 and before probably didn't make complete sense. 2020 was disruptive, but 2021 was a little more supportive. I think the big message was that despite the fact that there is, you know, the ERs are actually seeing less people overall. What we're looking at isn't that they are necessarily seeing more people as part of the reason that the drop times are there. I think directionally it's still accurate.

Dr. Berliner This is Howard Berliner in New York.

Dr. Heslin Hey, Howard.

Dr. Berliner Quick question.

Dr. Berliner I don't know if you can answer this or one of your colleagues will. Is there anything. I mean, the data showing is basically for all patients coming to an ER. Can you look at it in terms of those patients that need immediate stroke patients, heart attack patients versus the 70% who don't really need emergency care in terms of the time to treatment?

Dr. Heslin The answer is maybe. In the time we had to prepare this, we didn't have abilities to cut the data or deeper than this. I'll take that back to see if we can do the deeper cuts. I don't know.

Dr. Berliner Thanks.

Mr. Dziura Thank you, Dr. Heslin for the wonderful introduction. I'm Steve Mr. Dziura, the Deputy Director of the Bureau of Emergency Medical Services and Trauma Systems. I'd like to start out first by thanking the committee for inviting us to speak and present this data. It's been an interesting journey over the past couple of weeks as we put this together. I think you'll find that some of the data maybe doesn't explain the entire situation but starts to provide us with the right questions to ask or identify what the right questions

are to ask. I just want to start by giving credit first to our data and informatics team in the Bureau of EMS, who took the voluminous amount of information coming in through emergency medical service patient care charts and were able to compile all the information that you see up on the screen. My goal today is to start to frame out the problem using data. I'll work through a little bit of an overview of the hospital services that are provided and capacity data from our surveys that we do daily. A little bit of background on the EMS system where we stand today licensed ambulance service providers and licensed CMS practitioners. We'll work through some of the EMS 911 trends, including demand and dispositions. We'll finally take a look at the actual offload data on both a statewide and a regional basis.

Mr. Dziura If we can get the slide back up.

Mr. Dziura Perfect.

Mr. Dziura Thank you.

Mr. Dziura I want to start off by first describing what we mean by offload time. There's a slide further along that'll give us some graphics on that. The offload time is the time measured from the arrival of the ambulance at the hospital to the time that patient care is turned over to hospital medical staff.

Mr. Dziura Yes, Sir.

Dr. Morley They arrive at the hospital meaning they walk in the door, they start to talk to somebody, or they drive into the parking lot?

Mr. Dziura Typically, it's tracked through dispatch at the time they arrive at the ambulance bay, wherever that may be, at the emergency department.

Dr. Morley They're going to report on the radio that they've arrived and that's the trigger.

Mr. Dziura Correct.

Dr. Morley Thank you.

Mr. Dziura That's where the clock starts. The clock stops when full patient care has been turned over to hospital staff and the ambulance crew is able to walk away from the patient. At that time, a full report has been given the patient's been moved from the EMS stretcher over to the hospital bed or to the waiting room.

Mr. Dziura Our first slide looks at a two-year summary. We see that 91% of our patients were offloaded to hospital staff in under 30 minutes. What we're here to focus on is the 9% of patients that were offloaded in over 30 minutes. Over two years, that was 339 plus thousand patients. 8% of those were 30 to 60 minutes. 0.9% were 1 to 2 hours. We had 4,424 patients who waited over 2 hours to be offloaded to hospitals. I think that's important to mention, because I think we can all agree in this room that should never occur. Where we can focus our attention, the most is in that 2 hour or less. That's where we should focus most of our effort. It'll make the biggest difference. What's the impact from this? The impact from these wait times leads to fewer number of ambulances available for 911 responses. While that ambulance is tied up at the emergency department, there are no other ambulances available to go to the 911 call. We're starting to see backups of 911

calls holding in different areas of the state waiting for an ambulance to become available, so that they can respond. We see an increased incidence of mutual aid requests. Having to move ambulances across county lines, across jurisdictions to come in and assist the primary ambulance service who is not available. That has a trickledown effect. It increases response times as they're coming from further distances. We start to see neighboring ambulance services leaving their primary territory uncovered to come in and cover their neighbor. Think about it like running into an accident while you're driving on the highway. That one accident can backup cars for miles and miles, miles. The same way, once we start the flow of mutual aid and the triggering of mutual aid, that can cascade for hours. Sometimes we see it takes six plus hours to recover the system back to its normal status. It definitely has some pretty big impact. We have fewer number of ambulances available for inter facility transportation. We know that hospitals are struggling to move patients around. Unfortunately, the same ambulances that are answering 911 calls are typically the ones being used to do inter facility transport work too. While they're tied up at the emergency bay waiting to offload their patient, they're also not able to go up on the floor and take a discharge patient out or move a patient in between facilities, which further complicates the problem inside the hospital. We're seeing an increased number of EMS complaints and less than ideal solutions being provided.

Mr. Dziura If we can switch to the next slide.

Mr. Dziura You'll see headlines across the news. Reputational risk and public confidence in the health care system has started to degrade. EMS agencies. And, for example, five in the Central New York region have instituted a 30-minute drop time policy, meaning that they have become so affected by this delay that they've now determined that after 30 minutes they're just going to find an open bed that's available to place a patient in and make a verbal report to a medical staff member at the hospital. They're going to leave because they can't afford to have 911 calls back up. That's what I mean by less-than-ideal solutions being developed.

Mr. Dziura The question was, where do they leave their patient? The answer is in an available space in the emergency department or waiting room. Could be a chair, could be an empty bed. I've heard of cases of moving a bed from radiology into the hallway and putting a patient in it. There's definitely some frustration in the EMS system at this issue. As I said, we're starting to see it hit the headlines more and more often across the state. We're seeing examples of long wait times in Rochester, some of the longest in the nation. Staffing crisis is in hospitals, diversion of hospitals, and it goes on and on.

Mr. Dziura Next slide, please.

Mr. Dziura Taking a look at our hospitals and expanding on the data Dr. Heslin provided. There are 192 hospitals that complete the Daily Hospital Survey Monday through Friday. That excludes holidays. This table provides a breakdown of the services provided by the hospitals within each New York forward region averaging the data over the course of 2022. During Monday through Friday without holidays, we've averaged out that data for 2022. 183 or 95% of our hospitals operate an emergency department. 180 are operating acute care beds, which includes all types of staffed inpatient beds, medical surge, ICU, psych.150 or 78% of our hospitals statewide are operating ICU beds. Just to note, the fewest number of the hospitals in the state exist in the Capital Region, Central New York Region and Finger Lakes Region, all which have less than ten hospitals.

Mr. Dziura Next slide, please.

Mr. Dziura On a statewide basis, I said 95% of our hospitals operate emergency departments. The number of staffed ED beds and patients boarding in the ED is in this chart is based on an average of all the data reported in 2022. For clarification, boarding patients are those who have been determined to be admitted to the hospital but are still in the emergency department waiting for an available bed on a floor. When we talk about staff beds, I want to clarify that staff beds include only those beds that are operational, meaning there's the correct staff and equipment to be able to manage a patient in that bed. I mention this because you'll see in many cases we have beds, we have space in facilities, but there's not the equipment or the staffing to go along with them. When I talk about being able to put a patient in an empty bed in the ED, it's because that bed wasn't designated as a staff bed and that bed isn't being used.

Mr. Dziura Some highlights out of this slide. Four regions have fewer staffed ED beds per capita than statewide average. You'll see those in red under the third column. The last column on the right represents the adjusted number of available staffed either ED beds per capita. When the average number of ED beds occupied by boarding patients is removed from the total number of staffed beds. When we do that, we see still four regions that have fewer staffed ED beds per capita, but there are different set of regions. They happen to be starting to align with the regions where we see a higher level of complaints throughout the state.

Mr. Dziura Next slide, please.

Ms. Monroe What is a boarding patient?

Mr. Dziura Boarding patient is a patient that has been determined to be admitted to the hospital, but is currently in the emergency department waiting for a bed on a floor somewhere.

Mr. Dziura We talked about trickle effect in EMS. There's also a trickle effect in the hospital. The trickle effect tends to land in the ED. The reason we start to see many boarding patients in the emergency department is because there's not enough available beds in the facility to move that patient to. This slide looks at acute care beds available in the hospital. 94% of the hospitals reporting operate acute care beds. The number of staffed acute care beds and the number of occupied acute care beds is again based on the average of all data reported in 2022.

Mr. Dziura In this slide, seven regions had fewer staffed acute care beds per capita than the statewide average. Four regions have a higher percentage of occupied beds than the statewide average.

Mr. Dziura Next slide.

Dr. Heslin I just want to interrupt for one second.

Dr. Heslin What we were not able to gather in this data, which is actually fairly important, is a slide that would talk about how many patients are in the hospital ready for discharge that don't have a place to be discharged to. What we have presented is people that are in the emergency room, people that are on the floors and the hospitals are functioning at as high capacity as they can do. What we don't have and didn't have the ability to put together quickly was the data on how many people are in the hospital that are actually

medically ready for discharge and have no place to go. We have anecdotal information, but we felt that was not appropriate to present anecdotal information.

Mr. Thomas This is Hugh Thomas in New York City.

Mr. Thomas If I could just make a quick comment on that. You can imagine, because you've heard from us on this. We're tracking that data daily now and starting to share it with Albany. It just shows you I think it's important in the confines of your comments on the EMS comments. If you look at the Finger Lakes Region and you all know this. There are reasons for that, but I won't bore you with. That has resulted in significant pressure on the ED. Unfortunately, there's resistance on the outflow from regions here where in terms of long-term care. Give you the data today just for the group's perspective. In two hospitals in Monroe County today, we have 175 medically ready for discharge patients and we've got 160 borders. You can see the numbers on both sides. I know it's not official data, but it gives you a little context, at least in the Finger Lakes Region.

Dr. Heslin Can you back up one slide, Jackie?

Dr. Heslin Just to put a pin in that, looking at the Finger Lakes Region, you said there were 175 in one of the hospitals and 160 in the other?

Mr. Thomas We have medically ready for discharge 102 in general and 64 unity and ED borders of 90 and 50. What is that? 170 total. That's just our system, our two facilities in Monroe County.

Dr. Heslin What I wanted to point out, there was 210 patients boarding on average in the Finger Lakes Rochester Region. I think you made a good point, because I understand that your sister hospitals out there have an equal number of patients, they.

Mr. Thomas Our colleagues are dealing with the same thing.

Dr. Heslin Correct.

Mr. Dziura In our ICUs, we have 78% of hospitals operating ICU beds. On this slide, we noticed that six regions have fewer staffed ICU beds per capita than the statewide average. Seven regions have a higher percentage of occupied beds than the statewide average. I'll also note in running the surge operation center over years, the past two years, and this when we're looking to help transfer patients, tends to be the most frequent request is to help a facility find an ICU bed for a patient somewhere in the state. This also tends to relate to the distances that we're moving patients. It's very difficult to find ICU beds. We tend to have to move them very long distances to get one.

Mr. Dziura Next slide.

Mr. Dziura The next slide starts to talk about the background of our ambulance services in the EMS system. First look is there's 982 licensed ambulance services statewide. 20% of those are fully career services. 48% are fully volunteer services. 32% are hybrid, meaning they have both volunteers and career providers operating in their system. 78.5% of all the 91 responses in 2022 were handled by career ambulance services. Another way of saying that 20% of services handling 78% of the 911 responses in the state.

Mr. Dziura Next slide.

Mr. Dziura This is more just informational. A further breakdown of the ownership structure of ambulance services statewide. 54% are not for profit. 37% are government or municipally run. 9% are for profit.

Mr. Dziura Next slide.

Mr. Dziura We've seen a steady decline in the number of ambulance services over the past ten years. In fact, 9% of the ambulance services, we've lost 9% of our total in the past ten years. We had 1,078 in 2012. Today we have 982. It's a net loss of 96 ambulance services. You'll also notice, though, that there's a high turnover of ambulances. 110 new ambulance services were created at the same time 218 were transferred or closed. Over the past four years just to keep our data consistent as we start to look through the slides, we're looking at 2019 through 2022. Over the past four years, we've seen a loss of 43 ambulances or 4% of our ambulance services.

Mr. Dziura Next slide.

Dr. Heslin I'll just point out that an ambulance service is an ambulance service of one. FDNY, which is the New York City Ambulance Service, would be counted as one. The ambulance service that's in a small community of one ambulance would be considered an ambulance service of one. When you're looking at this data, you're looking at the number of services, not the absolute number of ambulances.

Mr. Dziura It's also important to point out and thank you for that, Dr. Heslin, that that is one of the limitations of our data, is we don't have the ability to see how many actual ambulances, operational ambulances were affected by any of that movement.

Mr. Thomas Quick question.

Ms. Monroe I assume that FDNY is the largest ambulance service in the state.

Mr. Dziura That is correct.

Ms. Monroe How many ambulances do they operate?

Mr. Dziura Over 600.

Ms. Monroe The range is from 600 to 1.

Mr. Dziura Yes.

Ms. Monroe Thank you.

Ms. Burke Are you taking questions right now on that chart?

Ms. Burke It's Alison Burke from Greater New York Hospital Association. On the ambulance, the decline in the number of ambulance services. I wonder if there has been any looking into the consolidation. We've had a significant amount of it, at least in the Downstate region. I don't know how that equates to loss of ambulances, but there have certainly been a number of entities services that have consolidated.

Mr. Dziura In the loss number, that does include, as I pointed out, transferred services. In the EMS world, an operating certificate can be transferred to another ambulance service. In some cases that fully eliminates the previous service. In some cases, they roll that into the new operation. Unfortunately, with the limitations of our data, we don't have any way of knowing that absolute value.

Mr. Lawrence Harvey Lawrence, a member of council.

Mr. Lawrence I'm really not familiar with the ambulances and ERs, but just looking and listening to some of the statistics. Are you do you at all measure fatalities? Have you seen an increase in fatalities in transportation? Is that a metrics or an indicator that is used at all?

Dr. Rugge Can you speak very close to the microphone?

Mr. Lawrence I'm looking at transportation metrics and time, delays and drops, and I'm asking whether there are any metrics related to fatalities associated with the transportation, EMS transportation.

Dr. Heslin I believe the question is, have there been fatalities associated with transportation delays? I don't think we have that data.

Mr. Dziura I won't say absolutely no. I don't have knowledge of any of those reports. I don't believe, unlike where that information is specifically collected, we don't have a similar system.

Dr. Heslin Let me just say, we'd like to try to go through all of the data because it's dense and then try to entertain questions at the end so that we can have a cohesive discussion.

Mr. Dziura A recent survey of the EMS system that was conducted by the State Emergency Medical Services Council sustainability tag found that the number one factor affecting ambulance services or negatively impacting ambulance services is staffing and personnel issues. The number two issue being funding.

Mr. Dziura This slide has an awful lot of information to unpack, so bear with me. Overall, there are just over 78,000 EMS practitioners licensed in New York State. The data in the table represents the number of active EMS practitioners, meaning those the unique license numbers of individuals that appeared on the EMS medical charts for that year. Only 42% of the licensed EMS practitioners were active in 2022. Over the past four years, we've seen a 17.5% decrease in the number of active EMS practitioners, so over roughly 7,000 practitioners. We have to keep in mind, too, that EMS practitioner licenses as a result of the pandemic emergency declaration were extended for one year in 2020 and for one year in 2021. They typically have a three-year recertification period. Many were extended at this point to a five-year recertification period. Over the course of the next two years, those certifications will be expiring. We anticipate there may be a further drop in the number of active providers out there. I've also provided the breakdown of certification levels. 23% Paramedic. 2% Critical care technicians. 4%. Advanced emergency medical technicians. 71% basic emergency medical technicians.

Mr. Dziura Next slide.

Mr. Dziura This slide starts to look at the 911 responses versus patient transports. In all the data sets that you're going to look at from this point forward, we've limited it to just 911 emergency response transports. Our data team has scrubbed out any of the inter facility transports or discharge transports. We are strictly looking at those calls that originate or those requests or ambulance service responses that originate from a 911 request and move to the hospital. Over the course of four years, 11 million 911 responses occurred and 7.5 million of those patients were transported to hospitals throughout the state. During that time, that four-year period, 47,000 EMS practitioners were active. We saw 911 ambulance responses. Again, meaning the number of times a person called 911 and asked for an ambulance to come. Grew by 4.5% or 123,000 requests. The number of transports, so the times that resulted in the patient being transported to the hospital grew by 1.3% or about 24,000 more transports. Statewide, our transportation ratio stayed flat, plus or -2%. When you look at it on a region-by-region basis, you start to see a much more dramatic shift.

Mr. Dziura Next slide.

Mr. Dziura This slide looks at those requests first. The people that requested an ambulance via 911. We saw a 4% increase. We start to see big shifts in a region by region look. 11% in Capital Region, 19% in Finger Lakes, 23% in Mid-Hudson. When we remove New York City, so when we look at the rest of state view, we saw a 11% increase or 144,000 more requests for ambulances while New York City saw a 1.6% decrease in responses.

Mr. Dziura Next slide.

Mr. Dziura This slide again is looking at transports. These are the people that were transported to the hospital as a result of those responses. Statewide, we saw a 1.2% increase. In the New York City Region, we saw a 6.6% decrease in responses. 67,000 fewer calls across the rest of the state. Outside of New York City, we saw a 10% increase or 91,000 calls. Some of the highest impacts were Capital Region, Finger Lakes, Mid-Hudson, Mohawk Valley and North Country saw the largest number of increase transports.

Mr. Dziura Next slide.

Mr. Dziura I promised you a graphic and some explanation on response times. EMC captures a lot of timestamped information during their patient transport. Some definitions. The response time is the time that the ambulance was dispatched to the time it arrived at the patient's home. The patient offload time, as we've discussed, is the time between arrival at the destination or the hospital where they're going to until the patient care is transferred to hospital medical staff. For the purposes of this presentation, when we talk about total call time, we're looking at the elapsed time between the initial dispatch of the ambulance and the transfer of patient care at the destination or hospital to medical staff.

Mr. Dziura Yes, ma'am.

Ms. Monroe Do we have to be concerned at all about the time between that 911 call and the dispatch? I mean, is that pretty automatic or might there be more delays even between the calling and the ambulance being dispatched?

Mr. Dziura There could be delays, but not that would affect anything we're looking at. There could be shifts. Some 911 centers in the state do what's called emergency medical

dispatch screening. They ask a predetermined set of questions. Based on the responses, it works them through a workflow to determine what types of resources need to be sent to that patient's house. Their target time is 90 seconds from the time the call arrives to the time the dispatch happens, but obviously there's some outliers that can make that shift. In other parts of the state, including the region Mr. Philippi is from there implementing nurse navigation programs, which may create additional time on the front end from time 911 call is made to the time the dispatch happens. For low acuity patients, where they're attempting to find other places to disposition that patient to as opposed to sending an ambulance to them. We removed that part of the time because there's too many variables.

Mr. Dziura Some disclaimers on the data in the following slides.

Mr. Dziura We looked at the total number of patients transported by year 2019 to 2022. We looked at the total number and percentage of transports by offload time and broke that down 0 to 30 minutes, 31 to 60 minutes, 61 to 120 minutes and those greater than 120 minutes. We eliminated some data out of the drop times. I'll explain that in a second. The other things you'll see on the slide is the average annual response time. That's response time averaged for that region over the course of the year 2019 through 22 and the average annual total call time. Again, average time for the entire region. Hospital offload data for 2019 through 2020 was removed first because they contained an incomplete dataset and it Dr. Heslin and I noticed it definitely impacted the analysis on the data. The reason it had an incomplete dataset is the numbers with the national EMS information. I know I'm screwing up that name. Information System Data elements required for patient care charting changed in that period. In 2020 through 2022 the new data was in place, but that leads to our second point. We saw a lot of data issues in the 2019 data set, the 2020 data set, rather because of the COVID response. It was really throwing off our data.

Dr. Heslin It's safe to say that in 2019 in offload data, we only had less than 5% of state data. In 2020 through the COVID year, we had less than 50%. It was unclear as to presenting data with such a small data set. The 2021 and 2022 data sets are much more complete. That being said, there are still some gaps that need to be worked on, but we felt comfortable presenting data in 2021 and 2022 on off load times based upon the volume of data available to us.

Mr. Dziura With that, we'd like to present a bigger data set, more years of data to start to be able to determine where the trends are headed. Unfortunately, we couldn't do that. We'll look at this data from a directional standpoint as opposed to an absolute trend standpoint.

Mr. Dziura Moving to our next slide.

Mr. Lawrence Before you go, I've been sitting here sort of trying to muddle through my earlier question. I just wanted to get some clarification. You do or do not collect data related to transportation fatalities from the point of pick up to the point of drop off? If a fatality occurs during transportation, is that data collected? Is it not? I mean, I'm just trying to that seems to be the worst possible outcome for transportation. Throw away the amount of time, whatever. If there's a fatal that occurs between those two points, that seems to be the worst case. Is that information collected and reviewed? Has it never happened?

Mr. Dziura The information is collected, the emergency medical services patient care report or the PCR contains every event that happened, much like a hospital charting system in sequence throughout that call. So, for example, if we went to somebody's home

for a fall and they identified a hip injury that would be recorded. The treatments they provided for that hip injury would be recorded throughout. If at some point that patient went into cardiac arrest, that too would be recorded. All the data that went along with that, including any EKG strips, any medications that were provided, any interventions that were done. Unfortunately, what I can't do is it would be very difficult to try and suss through that data to determine what fatalities or changes, drastic changes in patient condition can be directly attributed to a delayed offload time versus something that happens in the normal course of illness and treatment.

Dr. Heslin Let me take another shot at it a little differently. Most times when a person is transported to a hospital, Mr. Lawrence, they're not usually declared in an ambulance. They're brought into the emergency room. They are treated in the emergency room. If they have a fatality, they would have passed in the emergency room. It would show up as a fatality in the emergency room, not necessarily in EMS status. It's a fairly complex data point that you're asking for.

Mr. Lawrence I don't know. Maybe I'm looking at it too simplistically. If someone dies on the on the way to the hospital that seems to be a data point. In that time of death or whatever occurred, and we don't have to necessarily attribute it to the delay in transportation, but just that it was an event that occurred.

Mr. Dziura A simple reporting of patients that arrived at the time of arrival at destination were in cardiac arrest or respiratory arrest can definitely be provided. What the difficult part is, is trying to determine did they originally find a patient in cardiac arrest or respiratory arrest, or did that change throughout the time of the call? That would literally take a call-by-call analysis to determine.

Mr. Lawrence I don't know. Again, you guys' study this. I don't. It seems to me that that would be an important metric to include to really, even if you can attribute it to the transportation release, know where it occurred and if you at some point be able to look at it in large numbers to see if there's a correlation between delays in transportation and in fatalities, that would seem to be natural.

Dr. Rugge Not one we can answer currently, Mr. Lawrence.

Dr. Heslin What I would suggest we do is we take that back to our EMS colleagues and see if they have a thought on how we might be able to capture that data. That they have their council that they work with all of EMS, and that might be a way to capture that thought as a thought.

Dr. Heslin Let's go through the rest of the data, because I think what you'll see is some interesting findings as to the thing. One of the things I will point out is we're looking at four, really five data points. The percentage of people that are within goal, the percentage of patients that transport and change in transports over four years, the response time on average over four years, the total call time on average over four years. Because of the limited data set, the offload time that exists over two years and these are percentage change in off load times. The important thing to think about is how many people are making it to goal in 2022. If you look at the slide and you see that really small number that is under the blue before you get to the comparing section. 2022 is 1.648473. That's the number of people that made it to the ER in drop times in less than 30 minutes or 89.7% of the patients. That's the metric to start with that then you balance all the rest of the information.

Dr. Rugge Just fair warning, Steve, we're running a little behind.

Mr. Dziura Just some quick basic layout of the slide. The blue bars on the top of the chart represent the total number of patient transports for each year, 2019 through 2022. Directly below that, the yellow, orange and red. That is the percentage of offload time for calls or offloads of patients greater than 30 minutes. We scrubbed out a 0 to 30 minutes from that data and are just displaying 30 minutes and above. The table to the right of that gives you the breakdown numerically of the number of patients and also a percentage of the patients for each category. Directly below that in the purple is a response times over four years bar chart. To the right is the total call time over four years. The blue box on the right does the comparison. As we move through quickly. I just want to highlight a few different regions where we saw some interesting things. Statewide, our offload time increased over 30 minutes, increased by 1.9%. The largest jump, 1.8% of that occurred in the 30-to-60-minute range. We saw a average response time that was that decreased by 1.2 minutes and a total call time, slight increase by 0.0 6 minutes. That's important to note, especially on the response time. We want to look at how this impacts the 1.2 minutes doesn't sound like an awful lot of time. You have to remember that, for example, in cardiac arrest, there is nobody there with that patient yet. That's an extra 1.2 minutes of brain death that's occurring during that cardiac arrest period.

Dr. Heslin Fortunately, I'll point out that it was a decrease of 1.2 minutes. Statewide we actually did a little better. We want to go through region by region to show those changes.

Dr. Morley To make the point you were just talking about a cardiac case. There are more and more things being added to the list. Cardiac is one, stroke is another. We've known about the golden hour for trauma for quite some time. While it may not make a difference to this particular patient here, statistically when you've got hundreds and thousands of patients being affected, it's affecting somebody. Somebody is having a delay for a heart attack. Somebody is having a delay in treatment for a stroke. Somebody is having delay in treatment for trauma.

Mr. Dziura Capital Region, we saw a 10% overall increase in the number of patient transports or an extra 12,000 calls. Our offload time increased by 1.4%. This is one of the highest regions. This is in the top five of regions that saw or experienced a higher offload time. Response time increased by half a minute and the total call time increased by 4 minutes.

Dr. Heslin Yet they had a overall positive response of less than 30 minutes and off load time of almost 94%. 94% of the time they met the goal of less than 30 minutes.

Ms. Monroe Could you clarify one other thing before we go to the other regions?

Ms. Monroe I have this picture in my mind where the ambulances are lined up to drop people off with no real triage so that the heart attack or the stroke moves ahead of the upset stomach that shouldn't have been there in the first place. Is it like take a number and when your number comes? Is there triaging among the ambulances that are waiting?

Mr. Dziura Well, it's a great question. The answer is yes. There literally are ambulances stacked up at the emergency department. I routinely get sent pictures to the surge operation center email of twenty ambulances stacked up at an emergency department waiting. I've personally been inside hospitals where I've looked and seen fifteen to twenty

ambulance crews with patients on their stretchers right inside the door in front of the nursing station waiting for an assignment or bed. There is a bit of triage that does occur. The EMS providers obviously do their care and assessment of the patient in route to the hospital, and that's typically reported to the hospital prior to arrival. The hospital does have a heads up of what's coming. Once they arrive in the hospital most facilities will take an immediate quick report from EMS to try and get a sense of the acuity of the patient and how fast they need to work to try and find a bed. They also have to balance that against all the patients waiting in the waiting room as well. That's a place where I talked earlier about Syracuse, where they just have five agencies that just find a bed and put them in. What's also occurring there is you may be throwing a lower acuity patient into a bed that was going to be used for a higher acuity patient out in the waiting room. That's why I said there's less than ideal solutions being implemented arbitrarily by certain places. Central New York was another area where we saw a overall increase in offload time of 2.4%. They decreased from an 80% offload time of under 30 minutes to a 77% of the time in under 30 minutes. The largest, again, the largest group increase in offload delay was in the 31-to-60-minute range. This is also an area where we saw an increase in response times. In fact, this was increased by 1.1 minute and total call time by 8.7 minutes. This region was ranked first in a total call time increase when you compare it against the other ten.

Dr. Heslin When you look at the data will highlight that 78% of the time, they were less than 30 minutes. That means compared to many other regions, you know, almost a quarter of the patients don't meet the goal of being timely in the emergency room versus other regions.

Mr. Dziura It's also worth noting, if we go back to the beginning where I talked about number of hospitals, this region in particular is a region with one of the fewest hospitals in it as well. The reason I bring those points up is Dr. Heslin and I spent hours looking at what could possible causes be, and one of the ones we came up with was maybe it's just the number of doors the patients come through or the number of resources based on the number of hospitals within that region. There are so many factors that can play into this. In Finger Lakes region, we saw an increase of 10% in the number of patient transports. Offload time increase of 1.4%. Response time increase of 1.3 minutes in a total call time increase of 3.8 minutes. They're running in the 80% range for patients offloaded in under 30 minutes. Long Island is one of these interesting regions that we looked at in that kind of rose to the top as we were looking at the data. They saw an 8% increase in the number of patient transports. They saw a 4% increase in the amount of offload time, but they actually transported when we go back a few slides. They transported more patients as compared to the rest of the state. The percentage of patient transports on a region by region view I believe 11% where the rest of the state went down.

Dr. Heslin Long Island is unique. It's going to require a deeper dive. They had no increase in the number of ambulances that went out. They actually decreased. They increased their transports well above state average. State average for transports is about 68%. They're at 80% in total transports. What's also interesting, they did not increase their ER volume, but what they did do is they have the highest number of patients that are admitted. Something's going on on Long Island that is, you know, with a stable population, there's a pretty large increase in admissions compared to others. What's the difference? Is it primary care engagement? Is it large networks? Something is happening different out there. 93% of the time they make their goal in terms of less than 30 minutes.

Mr. Dziura So, Mid-Hudson, what I want to point out is they saw a pretty significant increase in the number of patient transports, 24% increase, yet they saw a decrease in

response times and total call times. Their offload time stayed about flat. Mohawk Valley also saw a pretty significant increase in the number of patient transports. They saw a 1.1-minute increase in response time and a 3 minute overall in total call time.

Dr. Heslin 97.6% of the time they met the 30-minute goal.

Mr. Dziura I can specifically speak to this region. It's a region where I live and it's where I used to work. It was the gold standard to be offloaded to the ED staff within 20 minutes. I'm not surprised. I think the only thing that surprised me is that they were able to maintain that with all the extra factors added in over the past couple of years. New York City actually saw a decrease in the number of patient transports. That's going to need a deeper dive. It was 67,000 fewer patients were transported over the course of the four years. We're going to need to deeper dive that one and figure out why. Is there a screening happening? Is there a triage happening somewhere? Is there more medical direction being utilized that's reducing the number of transports? North Country. North Country ranked number one in the number of responses and number of transports. They were the highest number of increased 911 request and the highest number of increases in transports throughout the state. 36.6% increase. They saw an additional 10,646 calls. You got to remember this region is a.... If we looked back to the table of the service types that operate in this region, it's primarily volunteer or hybrid services operating. I believe there's only a couple commercial services or fully career services working up there. Southern Tier was another interesting area where we noticed the patient transport went up 5.5 to 4.7%. We actually saw a decrease in the offload time. This may be a good group to talk to figure out what they're doing differently to reduce outflow times despite higher number of transports coming into the emergency department. Finally, Western New York saw a 1%, 1.8% increase in number of patient transports. The increased patient offload time, 1.4%. They saw the highest call time increase at 6.1 minute. That was a lot of data.

Dr. Heslin As a quick summary, some of the points. Is there a problem? Yes. We have shown that there is a problem. Is it everywhere? The answer is no. It is in many places, but not everywhere. There are probably some best practices that do exist. We need to suss them out still. We know that hospital boarding plays a role and back up the system plays a role. Interestingly, 20% of emergency service, it's EMS provides 80% of the visits. There was a significant decrease in the number of active EMS from 40,000 to 33,000. We saw a significant increase in the number of calls outside of New York City and the number of transports, except for Long Island, which we have to suss out best practices. The overall number of people that are seen in emergency rooms has remained stable or gone down marginally. The number of people that have been admitted is stable or has gone up marginally. Yet the amount of work that EMS is doing has gone up by 10% in rest of state. Why is that? Why are people using ambulances more to go to the hospital when they used to get to the hospital in a different way? We still see 81% of people discharged from the hospital. How many of them never needed to be there to start with? We know that 70% of work that's done in an emergency room could be potentially avoidable. We need to look at education. We need to look at staff. We need to look at alternate care sites. We need to look at telehealth. We need to consider engaging more hybrid squads, possibly to work in other areas. We need to look at borders and understand more about that and all the things that Dr. Rugge opened up with in terms of funding, workforce and otherwise. We're happy to entertain some questions. I would like to point out that we have subject matter experts from EMS, as well as the hospital and associations to provide further data. Happy to take a couple questions on what we've presented and then move forward.

Dr. Rugge Just a second. We do have time at the end of following these presentations for significant committee discussion. If the questions could be very concrete and specific to the presentations that would be helpful.

Dr. Torres This is more of a comment.

Dr. Rugge Go ahead.

Dr. Torres Running a not for profit in the South Bronx, one of the things that I hear from the members of the organization and from others is that if they were to go to the hospital without the ambulance, they lose their cue or priority and that would most likely guarantee them a bed in the hospital once they get there via ambulance despite having access to family members that would take them via car.

Dr. Rugge Excellent point.

Mr. Dziura We hear that over and over that there's this belief in the world that if you come in by ambulance you're going to be seen faster in the emergency department. When the reality is when you come in by ambulance, you're going to get triaged and cued in the same manner that the people in the waiting room are being triaged. It really doesn't make a difference. The only reason people seem to think it's faster is because there's probably a higher acuity, higher number of high acuity patients coming in by ambulance, which would be seen faster, but the lower acuity is still waiting.

Dr. Torres I appreciate that comment. To that, what I am hearing and what I am experiencing, unfortunately, is that delay of appointments to see the primary doctor or a specialist with people waiting seriously up to two to three months in order to be seen. The reality or the experience of that individual in a very vulnerable community is that then if I have to wait three months or two months, let me do it this way and that's the script.

Dr. Morley Can I just remind folks to identify yourself for the purposes of the transcription whenever you speak?

Dr. Morley Thank you.

Dr. Torres Dr. Torres, Co-Chair of the Health Committee.

Dr. Berliner Howard Berliner, member of the council. Where did the 30 minute of boarding time come from? I mean, is that a national standard?

Mr. Dziura That's a good question. Based on the research we were able to do throughout the nation, most reports focus on 30 minutes or less. I can't give you a concrete, solid answer that 30 minutes or less is the right time. Maybe it should be 20. Maybe it should be 10. I don't know the answer to that. What I can tell you is data reports throughout the nation and in fact, the world tends to focus on 30 minutes or less, and that occurs after that. I can also tell you that when we look at historical data, we didn't see as much stress in the EMS system until it started exceeding 30 minutes routinely and more frequently.

Dr. Heslin One of the things to consider was drop load times, Dr. Berliner, is that there has to be an adequate transfer of the patient, which means that you have to be able to do. Let's think of it in terms of an inpatient in a hospital. By a time, a nurse does a report, actually move the patient from one floor to another, change the patient over, changes out

the equipment, it takes probably close to 25 to 30 minutes. We'd like it to be faster. We also have to remember it has to be a satisfactory transfer of that patient. I think that some squads and many try to do it in 15 minutes as their standard. It seems to be the standard that he was able to find.

Dr. Rugge I think it's been a nice point out that offloading problems is really a reflection or a consequence of system problems along the way. We're going to have to decide what to address and how to do that. In the meantime, we expect lots of help in understanding the issues at hand.

Dr. Rugge Thank you.

Dr. Philippy Thank you, Dr. Rugge and Dr. Morley, Dr. Heslin, Deputy Director and the committee members. Thank you for having us here today. I do want to take just a ten second little bit, if I may, to talk a little bit about this concept of what we've referred to as drop time, because I think it's important to set a bit of context here. A lot of what the Deputy Director has been talking about in terms of the statistics is probably more correctly door to bedtime, right? It's the time that it takes for that ambulance to arrive to the time that patient is offloaded onto a hospital stretcher. As my colleague Dr. Cushman pointed out, generally speaking, unless it's a complex patient, we're going into a critical care situation. That transfer is not going to take much time. Once we get a bed someplace for that patient to be if it's a chair, that transfer is going to be fairly quick. The time that we're holding the wall, so to speak, is the time that we're waiting from the moment we reach the door. Often, we're triaged fairly quickly in the ED. In many cases we're triaged within 5 or 10 minutes in some circumstances, but then we're waiting for that open bed. More to the EMS side of things in the business world of EMS, we refer to drop times as the entire time from the time we arrive at the hospital until the time that we go back in service, which adds a little bit of nuance to it, because then there's, as was pointed out, the time to collect your equipment, clean up your ambulance, get ready for the next call. Not even taking into account doing the actual patient care chart. This is literally just how quickly can I get my ambulance back in a suitable fashion to get in service and go to the next call? When we talk about this, one of the things that's very interesting is did the data that the bureau is able to derive from the ambulance services and what we report, we're depending on a number that is really not all that reliable and that is the actual time of transfer of care. That number is dependent entirely on the EMS practitioner making a Oh, wait, hang on. What time is it? Let me check my watch. I got to remember that time or write it down somewhere because I'm not going to hit my actual electronic patient care chart for some time. I have to remember that after the last six or seven calls that I had. To be fair to the voluminous data and the excellent work that the Bureau has done to derive this information, it is in its very basis, a little bit flawed. As we talk about the future of how we approach this problem, one of the things that we really want to look at is how we are going to get better data. How do we increase the ability to rely on that data? And then more importantly, defining some of that stuff. As Deputy Director pointed out, the national EMS information System helped us to identify that a little bit better in 2020 when we started working on Data Dictionary to perform our crews and how to better give information. In the end, it is tough. I'll read a little bit of my statements here. I'd like to talk a little bit more about the idea of where we're coming from in terms of these times, because I think it's important to understand that. Allow me to start off with by saying ambulance wait times have ranged from 20 minutes, as was mentioned a moment ago to 6 hours in emergency departments across New York State. These things have downstream effects, as we've just heard, on ambulance response to emergency calls, because the turnaround of getting that ambulance back in service is affected by our ability to get the patient we have, the person that is immediately in our care to the definitive

care to get ready for the next patient. These delays can result in increasing otherwise preventable morbidity and mortality. They stress an already short, staffed EMS system, leading EMS practitioners potentially to seek employment elsewhere and forcing EMS crews to provide care to patients inside and outside the walls of hospitals without offering appropriate resources. I acknowledge that the staffing issues and capacity constraints which now face hospitals are severe. This is a us problem. We need to work together. We need to find collaborative means by which we can identify pinch points, strategize solutions and engage in decision and policy makers in crafting change. We are on the brink of a failure of the EMS and hospital health care system. I am not exaggerating. Only in partnership will we be able to avert the consequent loss of life that can occur. Let me talk just a little bit about the idea of drop times. Dr. Heslin mentioned this. I wrote it down. I think it was a absolutely dynamite thing to say. This is a very complex etiology. There are many factors that affect this particular issue. There is not one solution. There's no silver bullet to this. We have to approach this from a multifactorial approach. It has to include prehospital approaches, in-hospital approaches and post hospital approaches. As we mentioned and has been mentioned a couple of times, the ability to move patients out of the hospital, which in many cases may require an ambulance or other alternative means, is absolutely key to maintaining that throughput because this is a tunnel that we have to work all the way through it. Regional differences are key as well. One of the things that I say by noting this is the Deputy Director pointed out so, so eloquently in the statistical analysis, but this is absolutely true in almost agency to agency relationship. For example, a colleague of mine who works in the Central Capital region points out that in his agency in 2022, 2,500 transports less than 20 minute, rather, 18.8%. This is one agency, mind you, but this is his experience. less than 45 minutes, 79.8% and greater than 45 minutes, 20%. 20% of his total transports were greater in 45 minutes of wait time door to bed. 60 minutes OR longer, 9.1%. time exceeds 90 minutes 50 times in the year of 2021, which is the last time he had data for that. it's 50 patients who waited more than an hour and a half to get a bed on an ambulance stretcher, which I don't know if any of you ever been on one is unfortunately not the most comfortable place to be. We sympathize with our patients. We want to get them to definitive care. We want to get them in a more comfortable setting. We also want to see that that process is started because there's not an opportunity for a provider to see that patient generally while they're sitting on our stretcher. The process of starting that begins with that transfer of care. Our average drop time for a larger agency such as in my region, were actually seeing a change of 5 minutes in average drop time. That it doesn't seem like a lot of time, except when you start to look at that in aggregate of many thousands of calls. For example, 70,000 calls a year that my particular agency handles. That's a lot of minutes. We were actually looking at just the month of January 2022. Over the course of that month, we would need to add one full 12-hour ambulance every day to accommodate just the changes in drop time in the month of January 2022. I'm going to add that to another piece of context. In our analysis of drop times over the entirety of 2022 and I'm sorry, that was January 2023. I apologize. In the entirety of 2022, we would need to add 4 to 5 ambulances daily per shift, and we run 12 hour shifts to meet the demands of our current system in all aspects. We have actually increased the time on task from an average of 55% to 58%. 58% of our time on task is just sitting on the wall waiting at the hospital. That is a considerable amount of our time. That equates to, as I mentioned, another ambulance raising 32 ambulances for the month of January 23 alone. These are some real numbers. 5 minutes change in drop time equates to a considerable weight in the system, and that is because we're averaging that out. I think more important than the average is, is to actually look at the outliers. We spent a lot of time talking about averages, but I can tell you, quite frankly, that the outliers of 2 hours, 3 hours, 4 hours for any number of patients is unacceptable. When those circumstances happen, we need to try and find out what those pinch points are. We need to work together to figure out who, as Dr. Heslin

mentioned a moment ago, who has the best methods of doing things? What are the best practices? If Jamestown has a solution, I'm all for it. Let's talk to them. If the two hospital systems in my region, one of them may have a better way of doing things than another. Let's find that out. I think that's where the partnership between the EMS field providers and the hospital folks that you represent is absolutely critical. To be able to sit down and have those conversations. What are you doing well? What's not working? What can we do to help? When we start talking about things that we can do to help...Let's talk about some of the things that we are doing. Deputy Director mentioned the nurse navigation program. We are in Rochester, Syracuse and Buffalo right now, engaged with our regional 911 centers to intercept calls that are low acuity. These are calls that are defined by the medical priority dispatch system as having a low probability of any sort of life-threatening outcome. Our Medical Director reviews those MPDS codes, determines which are most appropriate, and then these calls are shunted from the very 911 call without any contact with the EMS system to a nurse who then has a pre-set standardized method of assessment. The nurses then can divert those patients potentially to telehealth, give the advice themselves, refer them to poison control, refer them to mental health, behavioral health or substance abuse services in the community. If the call is someone who actually turns out to need an ambulance, the nurse sends it right back to the 911 system with a relative delay from our statistics about 5 minutes. Not someone who would be coming immediately apparent that they needed emergent lifesaving procedures, but the nurse recognized through further interview that maybe something the 911 communicator missed, sends it back to the system and would go back into the 911 process. We're only talking about 1% of calls right now that are being called in that manner, but it's a start. It's nipping away at the edges. Add to that thing like treat in place an alternative destination which have been authorized through federal grant systems, through the Centers for Medicaid, Medicare Services. They're only available to a few of our services in New York State. I know that folks from the Office of Health Insurance Programs are working to find ways that we can utilize our in-state services as well to pay for those. To the point again, we're nibbling away at the edges of the problem by offering alternatives. Those alternatives, a physician could see that patient by telehealth or that person could be transported to an alternative destination other than an ED. Again, if we try to keep those front-end issues low, we might be able to affect the long term, the back-end issues as well. Dr. Heslin mentioned ways that we can, and I think actually Dr. Rugge mentioned this as well, ways at which we can look at changing statutory regulation. This is things that we can discuss further is how are we in the EMS system can work together to identify those potential changes. Many ambulances don't have surge capacity. As was mentioned, if you are the sole ambulance service for your region and you're going to a hospital and you are now on the wall for an hour or 45 minutes, that is an hour and 45 minutes that that region may not have an ambulance available or that the nearest ambulance is going to be some further distance away. Someone mentioned earlier about response to the call. I can tell you that at least in certain areas that I am familiar with, response to calls is being delayed. Whereas as many as five years ago, it would be reasonable to expect if you call 911, it would be dispatched within 2 minutes and that you would receive a response from that ambulance in a relatively timely fashion, depending on the type of call it was. We are seeing across the state delays in ambulance response of upwards of 30 minutes to 45 minutes. That's before the calls even dispatched. That is because there are simply not the resources to send. There's no one making a decision that we don't want to send ambulances. We want to help. It's just that we don't have the people to send. Anything that we can do to keep those critical acute care assets in service is absolutely critical to do. That's why, again, we're here talking about some of these things. Optimizing inter facility transport is another thing as we look at how do we help the hospitals move those patients. There are ways in which working with the EMS providers in those hospital areas, we can better manage the throughput. We can

have conversations with our EMS providers and not look at a phone and say whose numbers on top of whom, but actually have real life conversations. For example, a 1 to 1 situation where a hospital system has a regularly scheduled call every day with a communication center for ambulance provider. They chart out and plan their discharges for the following day. That has resulted in a considerably more reliable process and has also helped to relieve that stress in the hospital system. Again, I could talk a lot more about some of these issues than I have in some of the materials that I've handed out to you. I think what I really want to stress here is that we have an opportunity between our two respective councils to advise the Commissioner and yourselves to advise the Governor's office and how we can address this problem systemically and collaboratively. I could go on. Believe me, Dr. Morley knows that I have a pension to go off script, but I think the important thing here is the statistics are valuable. They may not tell the whole story. I can tell you what the biggest issue throughout the entire system the availability of 911 assets is and how are we going to keep that process going so that we can help the hospitals move patients in and out.

Dr. Rugge Thank you very much, Mark.

Dr. Rugge I think we're beginning to appreciate how complex and lengthy this problem is, but just ask our speakers coming up to try to keep their presentations to the three- or four-minute mark that is at least no longer than the Gettysburg Address.

Dr. Cushman Thank you, Dr. Rugge. Thank you, Dr. Morley, Dr. Heslin, members of the committee. Really do appreciate being here. I'm Jeremy Cushman. I'm an emergency physician. I'm also an emergency medical services physician overseeing an EMS system. I'm actually a paramedic. I still work on an ambulance, bringing in patients, standing in lines occasionally. Everything that we're talking about resonates very strongly with the emergency physicians, our staff that work in emergency departments, treating a little over 7 million New Yorkers every year. It's been mentioned multiple times, but really, a lot of this comes down to hospital crowding. When the invitation came out, it was really examined some of the root causes. Well, one of those primary root causes is hospital crowding. It's manifested and borne disproportionately in the emergency department through that common practice of boarding that you've heard about, which is basically holding admitted patients in the emergency department. This is not a new issue. Dr. Rugge, Dr. Heslin have identified. New York highlighted this as a significant public safety concern 35 years ago in 1988. We recognize that we're not going to fix this in the next couple of months. It's extremely complex. Unfortunately, the health care system has normalized the practice of boarding. We're all responsible, even us ER docs, despite repeated calls for change and the public health effects that it has on patient outcomes, unique capacity, capability. Fundamentally, the root cause of these prolonged wait times and the practical effect on EMS colleagues that we have is hospital crowding. We also recognize that much of that is misaligned health system financing, which effectively concentrates that impact on patients arriving in or to the emergency department and directly contributes to health care inequity. EDs are actually not filled with people who should go elsewhere. We do take a little issue with 70% don't need to be there. Sure, that's after we figure out that they didn't need to be there. If that were the case, then 70% of the visits would have global five visits indicating that they had no reason to be there to begin with. The reality is that there definitely are some that we can direct to better sources of care. I'll speak to that in just a few minutes. It's actually the people that need to be there the most, the patients that are seen and admitted into the hospital that are kept as boarders awaiting inpatient beds who are primarily responsible for the fact that we don't have beds. To that end, let me just provide you some context. Let's just take 100 patients

that arrived at an emergency department of a course of a day and try to see them in a 20-bed emergency department. It's pretty easy. Try to see them in the same ED when you're holding 25 admitted patients. The crowd starts to build. It starts to back up. They start to queue. Patients wait for hours to be seen because there's no place to see them. We use chairs, hallways, closets, anything and anywhere. I provide care in a tent, actually. That is one of our primary treatment areas. Our waiting room sees more patients, more undifferentiated patients into our tent than the rest of the emergency department. That's the reality that we work in every day. Now, the physician might be available, but our nurses, God bless them and staff, are busy with the admitted patients. Truly, again, the physical bed has been taken away. I know where some of these beds are because I work in these facilities, so I go find them in other hallways and other areas and closets. Now, despite emergency departments, physicians, nursing, staff providing care in these crowded and suboptimal conditions, literally for decades. We have been increasingly unable to limit the impact to our EMS partners. What we're seeing now is, quite frankly, our failure in the emergency department to be that buffer. We just can't do it anymore. There's just literally no space to be able to do that. We know that these offload delays negatively impact patient care by tying up ambulances for other 911 calls for service. Mark, I'm glad that you mentioned the issues of inner facility transports are profound, particularly for many of our underserved rural communities and quite frankly, even some of our urban centers where people cannot get to the specialty care that they come to. They come into a critical access emergency department with an acute stroke. They get stabilized. They get thrombolytic. We're starting to do, there's no way that they can be admitted there. They have to be subsequently transported an hour or 3 hours. Trying to figure out a place for them. We don't have the resources or the personnel to transport those individuals. Now, both causes, and solutions are complex, and they are not unique to New York at all. Some factors contributing to this crisis line solutions at the federal level, which is why our parent organization, the American College of Emergency Physicians and 30 other health care organizations, wrote a letter to President Biden this past November calling for a summit of stakeholders across health care to identify immediate and longer-term solutions to the nation's urgent boarding crisis. Now, with that said, there's still time for action. There are still actions that we in the short term can start to formulate by looking at these data. Thank you so much for simply having this conversation in this meeting today to start addressing the issue that we can navigate the state and local level. Written testimony will delve into that stuff. I'm not going to take that time. I'll summarize them as follows. One, admitted patients should not be boarded in emergency departments. The simple fact is that this morning in my emergency department we had 106 borders and 78 beds. My partner emergency department had 84 borders and 65 beds. My other partner emergency department had 41 borders and 34 beds. That was his night as of 9:00 this morning in my community. Ambulance diversion should be utilized as a last resort and be managed in partnership with EMS leaders at the local level. The process of ambulance diversion is where a hospital says we're just not going to take any ambulances right now. That's another issue that we have the ability to address and make sure that it's collaborative with EMS leaders. It can be useful if it's done carefully. Pre-Hospital programs that Mark mentioned, pre-hospital programs, ET3, community peer medicine, nurse navigation, reimbursement for medical care, and not just transport, so that we can treat them in place should be and can be enabled to provide the right patient the right health care at the right time, help to remove some of those insurance, bureaucratic and other barriers to timely patient care and transfer. Mr. Thomas mentioned, I think, 95 ALC patients. I had 110 ALC patients. That's patients in the hospital looking for an alternative level of care that have no medical need. Pretty interesting, right? I just told you that I had 71 borders. Sorry, a little higher than that. I have 110 patients in the hospital that didn't need to be there. It's amazing that the number of transfers in something that I would encourage that we look

forward to that, which gets to my last ask, if you will. I look forward to working with everybody to understand the limitations of the existing data, identify some more accurate measures of crowding, inefficiency to be able to discharge, the effects on the EMS system and importantly, its access to emergency health care. Now, the impact on inpatient boarding and subsequent crowding on morbidity, mortality, medical errors, staff burnout in excessive cost. We can pull all the literature. It's there. We don't have to reinvent. We don't need that data. It already exists. It's already published in the medical literature, but unfortunately, it remains largely underappreciated and unaddressed. There is absolutely no question. I'll say it even more bluntly. The issue is complex and it's thorny. To that end, I know we, the American College of Emergency Physicians, very much appreciate the Public Health and Health Planning councils recognizing the very tangible effects on our ability to provide health care for the millions of New Yorkers that utilize our EMS system in our emergency departments every year. I certainly very much look forward to being a part of these conversations, as Mr. Philippi identified and identifying some solutions to make sure that we are providing that right care to the right patient at the right time and not having, heaven forbid, people dying in the back of my ambulance because I'm delayed on the way to the hospital.

Dr. Cushman Thank you very much.

Dr. Rugge Thank you.

Dr. Rugge We'll be moving right along to Karen Roach. We have HANYS Health Care Association of New York State.

Ms. Roach Well, you handled my intro by introducing me and my organization. Thank you, Dr. Rugge and your colleagues for convening the conversation today and for all the presenters who have gone before. This is very interesting. It's not new. Obviously, preceded COVID, a lot of these workforce stresses, but COVID really kind of blew it up. I just wanted to touch on emphasize some of the points that have already been made and then talk about a couple of projects that my colleagues are working on to try and chip away at some of these issues that have been identified. Within hospitals, the workforce crisis affecting many sectors of our economy is complicated by factors unique to their role. There are not only providers of critically needed care, but a safety net for their communities when other systems fail, are exhausted or in the event of a natural disaster or other emergency. Emergency departments are at the front door of the hospital. The first point of contact for many patients. The last resort for many who have nowhere else to go. These workforce pressures, as was stated the same with EMS, is the same as hospital personnel and finances. The workforce pressures are contributing to fiscal challenges, leading to four out of five hospitals in New York reporting negative or unsustainable operating margins, according to a survey HANYS and our associations did last fall. According to the survey, 49% of New York's hospitals report having to reduce or eliminate services to mitigate the staffing challenges. 100% of the hospitals reported nursing shortages they cannot fill. I wanted to talk about some of the data that has been touched on in terms of the people in the hospital that don't need to be there. HANYS says embarked on a complex case discharge delay project. These are there are hundreds, if not thousands of New Yorkers with complex care needs unnecessarily languishing in EDs and hospital beds, often for months or years. Hospitals are serving as long term destination rather than a waystation for those who, once their acute care needs are met, would be better served in a non-hospital setting. HANYS 2021 White Paper provided an overview of this long-standing challenge and offered suggested actions including bringing forward better data to call attention to the issue and forming complex case discharge response teams in every

hospital. In addition, the report recommends obviously for forging stronger relationships and partnerships with community resources to assist with prevention and response. To learn more about the scope of this project HANYS conducted a three-month data collection pilot last year with 52 hospitals. The project found that the discharged delays were only overwhelmingly due to an absence of care options, followed by a lack of insurance coverage or means to pay for discharge care and extended administrative processes such as state and local agency referral and eligibility for services and benefits. Just a quick snapshot, and this data has not been published yet, but it will be in a couple of weeks. Just some of the findings. The universe of patients that were collected. The data was collected for those with greater than four avoidable days in the ED or 14 inpatient days where they didn't need inpatient care. The average ED discharge delay was two weeks. This was a universe of 115 patients selected over this three-month pilot period. The inpatient discharge delay of two months, children and older adults living with medically complex and or behavioral health conditions experienced the most frequent and longest delays. I know I'm speaking to experts here, so this probably isn't news to you, but I just think having the data is going to help us move along to start identifying some options of how to tackle the issue. Another project I just wanted to highlight is a collaborative that HANYS is doing with Iroquois and the Home Care Association, the statewide Hospital Home Care collaborative for COVID. This is a project funded by the Mother Cabrini Foundation to highlight best practices that were developed during COVID to manage the surge of patients and have people avoid hospital stays that don't need them. We recently published a compendium of those projects. We'll be sharing that with this committee, too, to help in your deliberations. Let me just jump ahead to some of our overall recommendations. We are advocating for codification of a lot of the workforce flexibilities that were in the Governor's executive order including the flexibilities for EMT to treat in place, take people to alternate locations and get paid for it. We also obviously support the different models of community medicine and would advocate for flexibility should the state decide to regulate or formally recognize these projects. There are a lot of these that are already working and successfully caring for patients with good outcomes. We would like them to be able to continue what they're doing. We support New York joining the interstate licensure compacts for nurses and doctors. Also, we support the investments and training of the recruitment of EMS personnel proposed in the Governor's budget. We will be advocating for greater support in the Medicaid program to hospitals where they only now are getting paid $0.61 on the dollar for the cost of the care they're delivering. We'll give you more complete recommendations in our official comments that we will submit later. I just wanted to say that we are here as partners. I like the comment that it's a us problem. It's not finger pointing. We're in it with you all. We're ready to work together to try and solve these issues.

Ms. Roach Thank you again.

Dr. Rugge Very important to know that we have a collaborative approach and then we're partnering with them towards solutions together, even though the problems may be insolvable.

Dr. Rugge Thank you.

Dr. Rugge Next up, we have Greater New York Hospital Association Dr Aaron Dupree and Allison Burke.

Ms. Dupree Thank you, everyone, for the opportunity to speak on the delivery of care in emergency departments. My name is Aaron Dupree, Senior Vice President and Physician

Executive of Body and Clinical Initiatives. I'm here with my colleague, Allison Burk, Vice President of Regulatory and Professional Affairs from the Greater New York Hospital Association, which represents over 200 health systems and hospitals, both not for profit and public throughout New York, New Jersey, Connecticut and Rhode Island. Emergency departments are designed to treat patients with acute emergent life-threatening medical conditions. The most acutely ill, those with trauma, heart attacks are fast tracked, stabilized and escalated to the necessary specialty care. ED care is regulated in part by the act, which requires that all patients presenting to an ED be given a medical screening examination and stabilized regardless of their ability to pay. Hospital EDs are often the de facto primary care provider for uninsured individuals who are less likely to seek routine preventive and primary care. Due to gaps in community services and resources, it is also routinely provided behavioral health care and serve as a stopgap for social determinants of health issues such as food and housing instability. EDs are called upon to serve many needs besides strict emergency care. This is an additional burden on EDs that have limited access to community resources that don't operate 24/7 365. Hospitals are taking steps to improve patient access to non-emergency community-based care and have implemented strategies to mitigate any wait times. For years, hospitals have invested significant resources.

Dr. Rugge We've lost your sound. A technical problem here.

Dr. Rugge We'll be right back with you.

Ms. Dupree The hospitals are also building urgent care clinics alongside or close to EDs, which enable patients with non-emergent symptoms to get care more quickly and cut down on ED overcrowding. Hospitals do report rigid regulatory requirements and delays associated with a certificate of need approval process, which then delays the ambulatory growth and access. Policymakers and providers must also ensure, though, that ED physical plants and operations function well and are ready for actual emergencies. Hospitals constantly seek to renovate, improve and expand as necessary their AEDs, which can be difficult for financially struggling hospitals with limited access to capital. The Greater New York Hospital Association has advocated for funding that hospitals can use for this purpose and has helped to secure billions of dollars through the statewide Health Care Facilities Transformation Program, including hundreds of millions of dollars specifically for ED modernization projects. Greater New York Hospitals Association supports the Governor's budget proposal that seeks to reduce delays associated with the CON process and has been a long time partner of the Department of Health on various CON streamlining projects. Hospitals have also adopted successful pilot models of care such as mobile integrated care, which can utilize EMS personnel to deliver care and services to patients in an out of hospital environment in coordination with health care facilities or other providers. The Governor's proposed budget seeks to permit this model and also establish alternative delivery models for routine non-emergent care. Both of these strategies can contribute to reducing the non-urgent ambulance transport to EDs and wait times. Greater New York strongly supports modifications to scope of practice rules that are commensurate with professional training and education. A promising area is expanding the use of non-patient specific standing orders in the ED, which would enable nurses to perform tasks without waiting for a doctor's order. One example is giving nurses the discretion to perform noninvasive tests such as an EKG when a patient presents with chest pain. Many hospitals have implemented a national best practice split flow model that allows a provider to triage the patient soon after their arrival and puts the individual on one of two tracks or streams of care, depending on the severity of the injury or illness. Hospitals have also invested in care coordinators and navigators and peers with lived

experience for patients with behavioral health issues. These investments improve care transitions and engagement in routine care and monitoring. The social determinants of health significantly impact ED utilization. We together almost improve access to critical services such as transportation, healthy food, education. EDs cannot fulfill their mission to serve those with acute, emergent and life-threatening medical conditions, while also serving as a primary care provider for the uninsured. Providers have a role to play in addressing these problems but can't solve them alone. New York's health care system must be built to ensure access to routine preventive and primary care to the under and uninsured. It is, by their nature, are stressful, hectic places. While improving ED throughput is critical, it would be shortsighted to ignore the root causes of crowding. Hospitals are committed to finding collaborative, innovative solutions to improve care, with the goal of helping every person get the care they need when they need it in the most appropriate care setting.

Ms. Dupree Thank you.

Ms. Burke I'm sort of here just to tag along and add on a little bit. I just want to say that Mark and others have really mentioned a lot of what goes on. Given whichever region I've been living in at that time in my life and my employment at Greater New York. There certainly is a lot in the data. I will say we have a number of hospitals, particularly in the Downstate region. You have all pointed out some of the uniqueness in the data of Long Island, but we have a lot of members that actually operate their own ambulance services. We in New York City have a unique public private partnership with the fire department that operates. We work at their pleasure in the 911 system. There are many guardrails and different protocols and strategies. A lot were mentioned today called triaging. Throughout the COVID pandemic, we worked with our New York City partners in the fire department on implementing operationalizing the ET3 pilot model that seems you're going to hear a little bit later from a colleague from Mount Sinai about their success in that regard. There are strategies, but we really do view this as a partnership on both sides. Our hospitals are intricate participants in the EMS system. We just aren't the emergency department receiving it. We are also the providers of that care. We're very happy to be at the table and look forward to working with you all.

Dr. Rugge Thank you very much.

Mr. Thomas Hugh Thomas, member of the council.

Mr. Thomas You want us to hold questions for the whole panel?

Dr. Rugge Please.

Dr. Rugge We are running quite short of time, and questions will be very welcome, but at the right time.

Mr. Thomas Will do.

Dr. Rugge Thank you.

Dr. Rugge I'm trying to look in the right direction to Gary Fitzgerald.

Mr. Fitzgerald Iroquois Health Care Alliance represents about 50 hospital systems across upstate New York. We have the smallest hospital in the state and Albany Med and SUNY

Upstate as well. We've been working for years on the staffing shortage in Upstate New York. We have a great data that we've supplied with the Department of Health. Just quickly, because we're running out of time here, we have about a 20% vacancy rate in our hospitals for our RNs that attributes directly to the wait time and to the ER overcrowding. Our beds are not full. We have beds available, actually physical beds that are not able to be staffed, as I said earlier. The nursing home population, as Mr. Thomas said earlier, is just exploding in our hospitals. Usually, traditionally our nursing homes would be at about 90% occupancy. Right now, they're at 60% because of lack of staff. Quite frankly, staffing ratio legislation that was passed a couple of years ago. Those patients stay in the hospital beds, take up space in the hospitals, which could be used for patients in the ER. The ER backs up and the ambulance is backup as well. Everything's connected, as Dr. Heslin said earlier. I'm going to spend five minutes or less on three things that we think are a solution to the problem. We have a community paramedics and program pilot program being run in three counties in our region, Jefferson County, Columbia County and Broome County. This is being funded by Mother Cabrini Funds. This is the second year we're in. We have a three-year grant. This program has been amazingly well-received with the communities that we put it in place. Jefferson County is way ahead, quite frankly, of the other two counties, because they've been trying to do this over the years, working with the EMS community, the county public health department and the hospitals in that region. For one example, one frequent flier. They have about twenty patients. This just started in October of 2022. Twenty patients. One frequent flier into the ER. Used to go three times a month by ambulance to the local ER. Since this program has taking place, October of 2022 excuse me, she's not called 911 once. It's people going into the home, making sure they're taking their medication, making sure they're eating well and doing all those things. This program has the potential to have a real positive impact in the ER, overcrowding in our membership. I'd love to spend more time with you on that. I think it's a positive solution. Quite frankly, we've run into some opposition and scope of practice issues over the years. We hope we can overcome them this year. The Governor's budget does include some scope of practice flexibility. We're hoping that survives the budget process. There are solutions out there. Glad to hear the cooperation of the EMS community as well. Where it's working now in those three communities, it's an amazing result. We'll share data with you when we have it, when we get back at the end of this year and next year. Thank you for the opportunity. I appreciate it.

Dr. Rugge Thank you.

Dr. Rugge Moving Back Downstate to the Suburban Hospital Alliance and Wendy Darwell.

Ms. Darwell I am here.

Ms. Darwell Thank you.

Ms. Darwell Thank you so much for the partnership. We look forward to working with you on this. I did submit written comments, so I just want to highlight a few things here in the interest of time. I also took a look at the data. A little bit different results than Dr. Heslin, probably just a matter of timing, but at our Long Island branch, we've been collecting hospital volume data for a couple of decades. As part of this exercise, I did go and take a look at where our ED volume is with respect to pre-COVID and post-COVID data, essentially flat on emergency room visits. Our inpatient volume was down by 11%. That being said, inpatient occupancy was only down about 1%, which says to me that the patients who are getting admitted are staying longer. They're more complex patients who consume more staff resources. We've got occupancy rate that is actually pretty low. I think

the same turned out to be true on Dr. Heslin's charts. All of that to just say, I don't think we have a capacity problem, at least in the regions that I represent. It's the size of the workforce. As you've heard my colleagues say from other parts of the state, that that's true everywhere. I know that you know that. It's the single biggest factor that we have an backups to the emergency room. There's been a lot of discussion about this being a nursing problem, but it's not just that. We've got backups in patient transport. We don't have enough lab techs. We don't have enough imaging techs. We certainly don't have enough nurses. We're reliant very heavily at this moment on the use of contract labor. When you're bringing in folks from somewhere else, they're just not going to be as efficient. They don't know where the supplies are. They don't know how to use the systems. You're further stressing the system in that way. From end to end, you've got this backup happening in the hospital and then we're having problems on the back end. I think a couple of other people have touched on that. A lot of my member hospitals struggle with non-emergent post-discharge transportation. I had one hospital CEO tell me the other day that they routinely can't get patients picked up to be transported back to nursing homes until eight, nine, ten at night. That's certainly not great for the patient. It's disruptive for their family members. That also means that's an entire bed day that's been lost. If the patient doesn't leave till 10:00 at night and then you're flipping the room, that's a patient that didn't progress through the system all day long. At this time, roughly last year when the National Guard were being used to supplement EMS resources. What we asked for in the Hudson Valley was help on that back end. We weren't having trouble getting patients to the hospital. We were having trouble getting them out. That's not just a matter of capacity. There are issues here that can be better resolved through policy changes. One of the contributing factors to patients that are taking up beds in the hospital who shouldn't be there is that insurance companies won't do authorizations over the weekends and on holidays. If you don't call by noon on Thursday to get authorization for a patient to discharge to some post-acute setting, that patient staying in your hospital bed until Monday or maybe Tuesday. Again, there's that trickledown effect from all of those backups. Certainly, inappropriate utilization of emergency rooms is a huge part of the problem here. We do need better models of care for patients who don't have primary care providers, who don't have insurance coverage that's accepted at urgent care centers. We've got a great proliferation in my region of urgent care centers, but they are not emergency rooms. They don't have to take everybody who comes through the door. There are those for whom there just simply aren't better transportation options. I had a CEO tell me that they've had patients come in by ambulance because they had no other way to get to an MRI appointment. That's just a terrible use of resources. We really, really I hope as part of this conversation, we'll consider how we need to improve the non-emergent transportation systems. That said, we do have some models that we're innovating and are showing some promise. Community medicine. I know everybody's talking about it here. Can't say how strongly we support this being coming part of the permanent regulatory structure. We've also got members that are hiring paramedics to work in emergency departments, so that they can facilitate that handoff between, and I'm sure participate in the triage process when you've got multiple ambulances that are stacking up. Those paramedics are there only under the emergency executive orders. That's one of these areas where we need a policy change to be able to make that permanent. There has also been some redesign of triage processes, really just to create a little bit of extra white space in the emergency room or adjacent to the emergency room so that you can bring more folks in beyond the ambulance. Usually, that just buys you time until more ambulances come when you do actually have that much of a backup. Certainly, there are technology solutions as well to try to facilitate throughput, although those are generally very expensive enterprise wide. A difficult thing, I think, for any hospital to consider taking on at this moment in time. I hope that we can also focus on the post-discharge uses of community

paramedics and frankly, the reimbursement models to support that. As my colleague Gary just said, there are a lot of patients who aren't getting support in the home who need it. We can keep people out of the hospital if we actually incentivize health plans to cover that kind of service in the home and we get the right resources to patients there so that they're not continually circulating back through the emergency room. Use of proactive home visits, telehealth check ins for those high-risk patients and having the ability to utilize alternate care sites. I loved hearing about the Rochester model where you're intercepting patients at the beginning of the process because I think we really need to look at that entire spectrum of care from that 911 call till the time we actually get patients settled back at home from a hospital or in a post-acute care setting, if that's appropriate. Last thing I'll say is, and I don't think I need to say it because I think it was very, very clear in the data that you presented, Dr. Heslin I don't think there's any one size fits all solution here. It seems like we have very different issues in different regions of the state. As you look at recommendations going forward, I hope that there is that flexibility for regional differences and, you know, a recognition that we might need different solutions in different parts of the state.

Dr. Rugge Thank you very much.

Dr. Rugge It seems that stresses on any part of the health system lead to stresses on other parts of the health system, and trying to find special solutions for special problems may be beyond us, but we will try.

Dr. Rugge We have a few minutes for questions to our presenters.

Dr. Rugge Dr. Ortiz, do you want to pipe in at this point?

Dr. Rugge You had a question before that we delayed. I'm coming back to you.

Dr. Ortiz I didn't have a question, but I can always jump in. I think it's quite interesting from all of the data that has been presented and in a lot of the discussions is that, so we have this idea of practice in systems. That's been very clear. I do want to note that the not so bubbling up any more about the work force shortage because now it's sort of waves of it. I know at Binghamton we have Harpers Ferry, so it's a student run EMS system. It's been around for 40 years. They take in about fifteen students every semester. We actually offer the courses through the School of Nursing, but we partner with Broome County Health Department to offer the EMT courses. I do wonder once again, are we missing the opportunity to partner with universities even if they don't offer a program like that yet? There's no reason why they cannot offer something like that. Even simply within SUNY, a SUNY could offer a course at another SUNY and that can transfer back to something. I can easily offer that course at 64 other campuses across the state. You see how we're like missing a good target group of students to become educated as EMTs while they're in college. They can also sit for the EMT advance. We offer those courses. By the time they're already integrated and they're graduating, they’re already being servicing in that group. I keep thinking and I keep coming back to we're missing some connections between practice in academia where we don't have to create such distinct lines anymore. So, I mean, I'm not sure if that's helpful, but I think there are possibilities within it.

Dr. Philippy Dr. Ortiz, I am a product of that very system. 1983, University of Rochester ran EMT courses. I took it as a collective. Here I am 30, almost 40 years later. There are a number of models that that do exactly what you suggest. In fact, when we met at the Vital Science Conference two years ago, there were a number of college emergency services and affiliated services that were utilizing that very model. In my area, one of the agencies

that I work with, Dr. Cushman, is the Medical Director for actively recruits from the university system to bring students in and realizing that they have special scheduling criteria, but you're absolutely right. The more that we can expand on that and the more that we can bring that in, high school BOCES programs such as an early learning programs, there are a lot of opportunities there.

Dr. Rugge Innovative solutions.

Dr. Rugge Ann Monroe, go ahead.

Ms. Monroe Is it time for questions?

Dr. Rugge If you have a question for one of the presenters, this is the time, but we will have further discussions later.

Ms. Monroe I'll hold.

Dr. Rugge Okay.

Dr. Rugge Anyway, by way of innovations, we have Dr. Nicholas Gavin from Mount Sinai describing a unique and special program.

Dr. Rugge Dr. Gavin.

Dr. Gavin Thank you for having me.

Dr. Gavin To Dr. Morley, Dr. Rugge, thanks for putting this group together. I'm Nick Gavin. I'm a practicing Emergency Physician, Associate Professor and Assistant Vice Chair for Population Health and Clinical Innovation at Mount Sinai Health System. The crisis of hospital crowding is a result of the incentive structure of our predominantly fee for service system. Hospitals are incentivized to maintain maximal occupancy at all times and short of regulatory measures to mandate excess capacity. This crisis can be mitigated in three overarching ways. First, you can stem the tide of new arrivals. Second, you can maximize efficiency while patients are in the ED. Third, you can bolster inpatient capacity. Innovation within Mount Sinai Health System is occurring across all three domains. Specifically, today, I'd like to talk to you about what we're doing in digital health. In regard to preventing ED visits for ambulatory sensitive conditions we've moved to a digital first strategy. We have a virtual urgent care that exists within my Mount Sinai, our digital application for patients. The virtual urgent care program enables access to a provider with a few quick clicks. The program is accessible to patients with all forms of insurance. Similarly, we've surfaced video visit capabilities with primary care providers, often with same day availability. The purpose of this digital first strategy is to enable frictionless access to the care option with the lowest possible cost. In addition to existing Mount Sinai patients who access virtual urgent care, one channel into that same provider platform is our ET3 program, which has been mentioned a few times today. I just want to point out the thread there. It's led by Dr. Kevin Chason, our EMS Medical Director. EMS is emergency triage, treat and transport model ET3 is a voluntary five-year payment model that Mount Sinai has now implemented in New York City. The stated goal of ET3 is to provide flexibility to ambulance crews to address emergency health care needs for Medicare patients who call 911. Essentially ET3 enables EMS providers to be compensated not just for transporting patients to an ED, but for one, facilitating a telehealth visit or two, transporting patients to an alternate destination. Our implementation of ET3 has been initially focused on

telehealth treatment in the home and was launched in August of 2022 with two units in Manhattan. We've subsequently expanded to both Brooklyn and Queens. With approximately 27,000 patient encounters across our 911 service since August, we've found 1,452 patients that met our region's criteria for ET3. Given the limitation of only certain EMS crews having access to ET3 services, we've offered those services to 159 patients. Of those 27 patients, or 17% have accepted a telehealth visit as an alternative to transport. 74% of those we were able to treat in the home and avoid transport to the hospital. As a case example, I was staffing our virtual platform several weeks ago and our EMS team enrolled a patient in ET3. She was someone I'd never met specifically before, but a patient profile I'd seen many times as a practicing ER Doc for the last decade. She was morbidly obese, had multiple medical problems, was primarily wheelchair bound. She was having severe leg pain. It was the evening, so she couldn't get in to see her doctor. She was having pretty severe pain, couldn't really get around her place. I did an assessment with the help of a paramedic, convinced myself that she didn't have a DVT or an arterial occlusion and decided to treat her at home. I sent a prescription to her pharmacy and ensured that she could see her primary care doctor the next day who was able to see her the next day and make sure there was nothing wrong. The most important aspect of this story is what did not happen. I did not ask for her to be transported to an ED where she'd be yet another patient for our nurses to care for. I didn't order an ultrasound, an X-ray or bloodwork that undoubtedly would have been normal. I also was not tempted to admit this patient due to her inability to walk or any concern for her safety at home. In collaboration with the patient and her family, importantly, we were able to find another way. The enablers were telehealth and the ET3 reimbursement model. We have a lot of areas for opportunity in improving this program and getting it up to scale, most important of which is patient acceptance. I think as much as we can push telehealth broadly, this will become more readily accepted in our communities. Separately, but in a similar fashion for established patients we have a community medicine program. I think you heard the word community medicine seven times today. Another thread to point out to you all. If there are things that the experts that you've gathered here have said, CP is one of them repeatedly said today. Our Mount Sinai providers or our external contracted partners become aware of a high-risk patient who has an acute unscheduled problem. Just an interesting part of this. Those providers can activate our CP program. The model is basically two paramedics go into the home, they do an assessment and connect with an online medical control trained physician. The connection with the physician enables treatment with IV fluids, analgesics, antiemetics, and so on with the goal of facilitating care in the home. Since Mount Sinai's program began in 2017, we've evaluated over 5,000 patients and our overall treatment place rate has been 63%. Of the 37% who were transported to the hospital, over 80% were ultimately admitted. Essentially, the practice is enabling the ED to operate at top of license. It's really cutting down on that funnel coming into the ED. As our community paramedic program matures, we're looking to expand capabilities in the home, including the ability to perform point of care testing. We're also working on evaluating longstanding programs that have had partners in the community with the goal of advocating for reimbursement reform. In particular, I want to highlight the opportunity in caring for patients who depend on the services of New York State's Office for People with Developmental Disabilities. We have a partnership with a group of residential facilities, twenty plus residential facilities across Downstate New York. We're able to care for patients who are... These are our most vulnerable patients across New York State. We're able to care for them in place, keep them in place, not have them be transported to a hospital where their behavior will escalate. It's really incredibly successful. In summary, at Mount Sinai Health System, we built one platform for acute unscheduled care with one goal provide the right care in the most convenient setting possible. We're working on seamless transitions between our digital programs and our brick-and-mortar facilities. All of this is rooted in high

quality, high value care. Regulatory support for these programs, including Medicaid reimbursement reform, enablement of point of care testing outside of Article 28 facilities and expansion of paramedic scope of practice are some ways that New York State can continue to support transformation in this space.

Dr. Gavin Thank you.

Dr. Rugge Thank you very much.

Dr. Rugge I remember the very first digital advance in my professional life, and that was the hospital dispensing me with a beeper. When the beeper went off, I had to look for the nearest payphone, call the hospital, find out what was wrong, and did I have to come back? This represents an advance. The challenge here at this table is to keep the regulatory response up to date with all those changes because they're only increasing.

Dr. Rugge Next on the agenda is a discussion about committees' role. I think I can rely on people reading the agenda rather than my having to repeat it. We're going to look for more data. We're going to try to identify models and case examples that will be useful. What is not indicated is we will also look for solutions, recommendations to address the ER offloading problem, but knowing that addressing that problem, maybe going into the ER or going elsewhere. Along the way, we will need to give periodic reports, of course, to the council because the full council is responsible for any final actions. This starts as early as tomorrow. Tomorrow's presentation regarding this committee will be extremely brief, simply mentioning the topics we are trying to address, letting Health Department leaders and staff help us to assimilate and work through this both for our next meeting. We have a challenge with the next meeting and that currently the Health Department is very wrapped up in the annual state budget. It may be difficult or impossible for us to meet before the April 18 meeting of the council, but we will have a more extended report for that meeting and then shortly thereafter have a meeting of this committee and to also have a work plan with a schedule of those meetings. Looking forward to the participation of all the people here in this room today.

Dr. Philippy One of my mission tasks from our council was to convey our thanks, first of all, for being invited, but also ask that the council consider AA bidirectional exchange of personnel perhaps. Perhaps at some point the council, each of us could consider having our partner seat at the table so that a representative would sit and potentially a representative sit to establish that ongoing collaboration and cooperation.

Dr. Rugge Duly noted.

Dr. Rugge Thank you.

Dr. Rugge Open the floor for discussions just as another word. We have been keeping a whiteboard. Jackie has been keeping a whiteboard. I'm not sure if we're going to be able to flash it up on the screen, which includes items that have been mentioned that need further discussion and investigation. Looking for the limited time we have for our committee members now to make observations and then looking to conclude with a summary list that he's been maintaining of projects that he will be further investigating on our behalf.

Dr. Rugge Anyway, next is for us as committee members.

Dr. Rugge Ann Monroe, I think you were next.

Ms. Monroe Well, first of all, I'll think twice before I call an ambulance after I heard this presentation today. There's a store in Buffalo called We Never Close Inc. When I think about our response to crises in our community. It's only the emergency room that never closes. Although my colleague talked about you may have to wait two months for a primary care appointment if it's five after five in the afternoon, you may have no other option but to go to an Emergency Room. It brings to my mind the issue of what is the expectation of community-based providers to meet the needs of patients? Does the regulatory system and the financial system support a broader availability and response capacity to deal with people who need their care? I'm not surprised that people go to the Emergency Room that they call an ambulance for it. They don't have any other options. Weekends, evenings. What it raised for me was a question about the data, which is, is there any way of knowing what time of day these calls are and whether or not it would give any weight to this issue of evening and weekend availability. Also, what the question of age of the person who's calling. I just think some of that finer data would help us look at how we might approach some of these innovative projects and where to implement them if we had a better sense of what this problem was about.

Dr. Philippy I know Deputy Director is probably chomping at the bit on this one.

Dr. Berliner I can answer one of your questions, which is the biggest day of the year is going to be Sunday.

Dr. Berliner First of all, visits after the Super Bowl or during the Super Bowl are always.

Dr. Philippy If you're calling the ambulance for an acute emergency, rest assured you're going to get an ambulance. I want to make that clear. We're talking about the low acuity calls and the calls that it may be otherwise even EMD coded. More importantly, yes and no. The reason I say that is because one of the things that we've realized in data analysis over the last two years is that COVID broke our data analysis. And before that, we could track with fair specificity and sensitivity the time of day and the types of calls we would receive over probably five- or six-years' worth of data. I don't know what changed with COVID, but in 2021 and 2022 that paradigm has completely changed. It is not impossible. We can still try to track that. I will tell you that we will get just as many shootings and stabbings at 10:00 in the morning as we once got at 10:00 at night. Just as many heart attacks at 2:00 in the morning as we used to get at 5:00. It's very odd. More to your point about the demographic, that's absolutely something we can get. I'm sure the Deputy Director can speak to that more than I can.

Dr. Rugge Some time ago, this council did propose establishment regulatory establishing the recognition of urgent care facilities. The executive was in full support. The legislature in the Senate did not. This may be something that will come up again, but in the meantime, Dr. Heslin has some responses to it, and then we'll get to Dr. Boufford.

Dr. Heslin Just speaking about primary care. I'm a primary care physician. I practiced for thirty years in a practice. I still go back and see an occasional patient. Part of every contract that my office ever assigned. There's a clause that for twenty-four hours, seven days a week, we are responsible for our patient and have availability to care for that patient. Now, we can provision that you need to go to the Emergency Room, or you need to go to urgent care, but one of the issues that we have here is really education, which is that patients don't know that they can call their primary care office. Now, for people that don't have primary care, that's a bigger issue. It is actually a clause in virtually every

contract for every insurance that exists. We need to be able to suss out what actually already exists versus what we need to educate people about.

Dr. Gavin If I could respond to that.

Dr. Gavin The patients who even are calling, the huge, consolidated practices that now exist as opposed to possibly when you were practicing the likelihood of you actually getting your primary care doctor who knows something about you and providing guidance that won't lead you to an ER is minuscule. Patients are voting with their feet because they're not getting a response. Respectfully, I don't know that educating to call a doctor who doesn't know them is going to lead to fewer visits.

Dr. Heslin Respectfully, I practiced last Thursday, so I guess I'm not that far off. I think it also depends on large practice versus small practice and the culture of the practice that exists. There are practices that actually still do see patients. There are many practices that get to 4:00. They want to be done at 5:00, so they simply send people on. What I'm pointing out is there are a variety of different things that are out there. One size does not fit all at this point in time. I also want to comment about Dr. Gavin, who pointed out the virtual urgent care. I'm going to take an executive privilege here of New York State runs a virtual urgent care in partnership with Health and Hospitals Corporation for the treatment of COVID. There is an 888 Treat New York number where any New York State resident can call up 24/7 and receive a virtual urgent care visit to be able to care for them to be evaluated. Virtual urgent care is 100% great. I think it's something we offer. The state pays for those people that are uninsured. Your insurance gets billed, but state does cover the uninsured patient. We encourage people to use it.

Dr. Rugge I would also observe it's another digital advance. We have electronic medical records. In a practice, primary care practice, these days one could expect that with a push of a button and a glance, the receiving provider would have all the information about the patient's background, medical conditions and medications in a way that the ER physician will not have available. Moving forward with the regulatory and reimbursement recognition of those capabilities may help to de-stress the EMS.

Dr. Rugge Dr. Boufford.

Dr. Boufford I just want to thank everybody for their presentations. They're really interesting. I guess I sort of have two observations, maybe three. One is Ann's right on which is when are things available? Denise and I have been sort of thinking to ourselves still after thirty-five years we have this solution space here. That's a real issue. To me, the second observation is that whether we like it or not, all roads lead back to inadequate primary care services. I mean, this is a great meeting and really interesting. I appreciate there's not an organization around primary care like where we can bring in like you all are organized like emergency rooms or Haney's or Greater New York. It's a big problem. It's a big problem for this council. I think we care a lot. I mean, just having come out of a public health meeting all morning, primary care is fundamental in the prevention space and fundamental to the whether you say 50% of the patients that don't need to be in the emergency room. Part of it is we don't have regulatory authority over it. As John said, we tried to do something in the urgent care space four or five years ago. It didn't work. I mean, I think we have to kind of roll out some of that thinking about ambulatory care. Again, that kind of hit a wall because it's part and parcel of this solution space. The third thing I want to say is I think you all know the solutions. I think the issue would be maybe the challenge for Dr. Morley's office and maybe Dr. Heslin is to convene you all with hopefully some folks

from primary care. I I love the way you said 911 assets. I think it's a really important framing of the issue because so much of the conversation was about pre-hospital triage. How do we get people to the right place at the right time, so they don't have to come to the hospital? It was a nice effort. I would say I think as a council we are deeply concerned about this issue and the broader sort of weaknesses, I guess, in the overall health care system in New York. Now is the time to take a look at it. Perhaps, as John said, I know people are very busy, but perhaps this group could be convened with some of the folks that are involved with ambulatory care prevention or others. The local health departments, actually, I've talked to Kevin about this from time to time. Very often through county executives and others have resources that could be into this discussion and come back with. What I'm hearing, as usual, regulatory reform and finances. It seems to me that if we could perhaps to John, with due respect, you know, have some more meetings outside at the staff level. With these great colleagues and stakeholders, we could ferret out the solutions and bring them back for the council to consider. I think that would be really, really useful.

Dr. Rugge Absolutely. I think working together with the Health Department to decide on the appropriate scope of this investigation and these solutions. We will certainly be looking to bring in the experts to help us craft those responses.

Dr. Rugge Dr. Soffel.

Dr. Soffel I was waiting for you to finish John.

Dr. Soffel It's interesting, having been inundated with an incredible amount of information that's really fascinating, I have all these questions that didn't get answered. I want to start with the observation that I used to hear Jim Towns say all the time, which is the system that we have is designed perfectly to respond to the incentives that we have. I am wondering what are the incentives that are driving this dysfunction? Who is benefiting from it? Because if no one was benefiting from it, then it wouldn't look like this. That's a question out there for the ether. Second observation is I have to assume consumers are behaving rationally because we all behave rationally. There are rational reasons that we don't fully understand are calling 911 when they feel that they have a crisis. I think that understanding that and I think Ann is absolutely 100% correct that one of the main reasons that people call 911 is because they don't have other points of access and entry. That's been true, as Joe points out, for thirty-five years. This is not news. Then from work that I did in when I was working on the community health needs assessment in Long Island. The district community health needs assessments. They were so much fun. One of the issues that came up often around emergency departments was transitions and rehospitalization, particularly from nursing homes. That people would be discharged to nursing homes without adequate transition planning and handoff and would end up bouncing back to the emergency department. I'm wondering how many of these emergency ambulance calls are due to that other problem. My last question is, the other thing that I heard a lot on Long Island was people end up in the emergency department because of a lack of behavioral health crisis care. Especially schools have a kid who is out of control. They don't know what to do. They take them to the emergency department. A parent has a child that they feel that they can't control. They take them to the emergency department. I'm wondering how much of that is also a contributing factor to what you have accurately described as a major dysfunction in our emergency department emergency system.

Dr. Cushman I'm sensitive to the time if it's inappropriate for me to give.

Dr. Soffel I didn't for everybody to give the answers to all those questions. Those are just the things that are percolating in my mind.

Dr. Cushman Truly, you hit on a couple of really, really important things that actually dovetail very well to what we heard from the Sinai folks and what we're hearing in a couple of different areas of this space. We haven't even touched the behavioral health issue, which is another profound crisis that affects our EMS systems, it affects our hospitals, it affects our emergency departments, etc. Yes, it's huge. In most cases, an emergency department that is a twenty bed ED with eighty patients in it is not the best place for someone having a behavioral health emergency. The issues of patients coming from a skilled nursing facility, for example, in many cases we are still a bit in the you call we hall mentality of the skilled nursing facility calls 911, because they've seen a change in patient condition and according to current regulations someone has to evaluate them given that change in their condition. Currently, EMS cannot provide that evaluation. It's debatable whether or not you could even have a telephone consult with someone because the be all and end all of that is that we have had a lot of folks that are in this alternative level of care that absolutely should not come to the emergency department because we know exactly what will happen in the emergency department. They will become acutely delirious. My colleague, wherever she went, will then be in the hospital for anywhere between fourteen and twenty-two days. At least those are our numbers. There are some great opportunities to leverage a lot of the solutions that have been offered here to look at, again, both regulatory and operational reform of how do we provide almost on demand care for individuals that are at facilities that don't have the level of evaluation necessary or the equipment necessary to evaluate their sudden changing condition so that we could potentially prevent them from coming to the ED, which has a whole trickle down, as you heard.

Dr. Soffel Particularly on evenings and weekends.

Dr. Cushman We can tell you; I know that those are still reliable. I know exactly what facilities I'm going to get calls from around 3:00 to 4:00 on a Friday afternoon.

Dr. Rugge We are doing quite a nice job of filling our whiteboard. Dr. Heslin has a little bit of a whiteboard of his own. I'm going to turn to Gene for some comments regarding possible agenda items going forward and we will then have to decide about reconvening, which we'll be doing.

Dr. Rugge Good question.

Dr. Rugge It's hard to see our New Yorkers.

Dr. Rugge How are we doing there?

Dr. Rugge Dr. Berliner are you still there?

Dr. Rugge Harvey Lawrence?

Dr. Rugge Any others?

Mr. Thomas Howard took off.

Mr. Thomas This is Hugh Thomas.

Mr. Thomas I had raised my hand earlier, but that's okay. I think a number of the speakers have covered it. I certainly will share whatever thoughts are with Dr. Heslin and Dr. Morley.

Dr. Rugge Thank you all for joining us.

Dr. Rugge One more question from Ann Monroe.

Dr. Rugge Yes, indeed.

Ms. Monroe I've heard about these community paramedicines. What the licensure or barrier to licensure do EMT's have to meet in order to be able to conduct a parent medicine program? Are they reimbursed differently by the health system? Is it reimbursement through paramedics? I don't know how it works. Are they able to qualify to do that work? Is it difficult to do so?

Mr. Dziura I'll take that one.

Mr. Dziura Current statute does not permit community paramedicine in New York State. The only way it's being allowed is through Executive Order 4, which allowed for the creation and department approval of community paramedic programs. As you've heard, they've been implemented in various ways. The exception and it's interesting, the example we heard from Mount Sinai where he said he specifically called out unscheduled visits were the ones they were using community paramedicine for. The way the statute currently reads is that emergency medical services scope only involves those patients experiencing emergency conditions. Therefore, what they're doing is when somebody calls and has an acute onset of a condition, they can use their community paramedicine program, but they can't take those same providers and schedule them to go see the patient two days from now. It has to be the use immediately. It's the gray space we're operating in. The Governor's executive budget did include a provision to hopefully bring community paramedicine in into the EMS realm permanently. Otherwise, when the Executive Order expires, so too does community paramedicine.

Dr. Morley Could you say a word about the reimbursement?

Mr. Dziura Thanks, Dr. Morley, for that prompt.

Mr. Dziura Currently, the only services that are being reimbursed through Medicare/Medicaid are the ET3 programs, so that emergency triage and transport, which is a pilot program being run throughout the country. Only twenty agencies in New York State are part of that. They have access to funding mechanisms. It was mentioned earlier what is the incentive? I will tell you; EMS is not incentivized at this point to not transport a patient to a hospital because the only time they can get paid is when they do transport a patient to the hospital. There's no incentive for alternative destinations or alternative methods of treatment. We have seen some unique situations. In the case of Mount Sinai program, they have ambulances. We've seen Northwell with their own ambulances. We've also seen even locally here in Albany, a consortium of primary care providers who are using or have developed a payment structure working with their local EMS system in a similar fashion as Mount Sinai does on acute onset type conditions that don't warrant or necessitate the need to go directly to an ED they will send out a community paramedic unit to evaluate that patient and do a telemed visit to determine if they do need to go. There is

no direct payment method. There are no billing codes directly for community paramedicine.

Dr. Rugge There are so many gray areas I only hope this council can print in black and white.

Dr. Rugge Dr. Heslin.

Dr. Heslin I want to thank everybody, first of all. What I want to say is it's an extremely long day, very data dense and lots of problems, some solutions. We have to remember that we are dealing with a federated system of some regulated entities, some unregulated entities, big hospitals, small hospitals, network systems, home health care. We brought up home health, but we didn't talk about home health care integrated with this. I'm so glad Jo brought up primary care near and dear. In terms of outcomes, I wrote down a list of maybe eleven things that might be things we want to focus on. First is pre care discussions. Clearly, one of the most important issues. Primary care, EMS, hospitals all need to be involved because they are all integrated with possibly telehealth solutions. The second is enter facility transfers. Are there alternate models? Ambulances are paid for. One of the reasons why hospitals use ambulances as they don't have to ask the patient to pay for the ambulance. The ambulance, which could do some of those transfers, have to be paid for by the patient. Hospitals use ambulances. Ambulance is a lower acuity. Then next is, how do we engage a greater number of squads that are out there? I mean, 80% of the transports are being done by 20% of the squads that are currently operating. Although we don't like people to go to other regions and otherwise, we have traveling nurses, we have all sorts of things happening in the system. Is there an acute way to decompress the system through relationships with these hybrid squads and others to be able to decompress the areas where we see more stress immediately? How do we get more people licensed? The number of people getting licensed has gone up. The difference is that the number of people that are EMS licensed that are engaged has gone down. It's not that they aren't bringing people into the system. How do we keep people engaged? How do we re-engage those people that are in the system that dramatically left the system between 2019 and 2022? We need to get better data sets across the board. Our data is incomplete and, as pointed out, can be inaccurate in aggregate form. We have to also be mindful of, you know, the 9010 rule because, again, doing things anecdotally is very difficult to operate as a state. The next discussion should be about boarding partnership. What's the partnership that's going to work on the discussion of boarding and hospital overcrowding? The next discussion we attempted to take on number of years ago is alternate sites. Urgent Care. While it's interesting, as pointed out, urgent care does not accept many insurances. Oftentimes people pay out of pocket for that. It's an access issue. It is an unregulated industry. Frankly, the business model, if it was pushed into regulation might be something that we'd see a drop off in urgent care because they're serving a subsector of the population that is wealthy, frankly, just put it out there. The next one, community paramedicine medicine with home care integration. How do we start to look at that? We have a full homecare set and long-term care and aging. There's a whole set of regulations that they have to follow. As we look at community paramedicine medicine, we have to figure out how that integrates in. How does it fit with the current regulatory status that exists? How do we fill that gap? The next one, behavioral health. I'm not going to say more about that today. Just saying. The next one is one size does not fit all. That was a great comment because we are such a big and diverse state. New York City, we have many people. We have a county that has literally 4,000 people in it. If you just as an example, New York City has about 2,000, almost 3,000 pharmacies. If you took New York City, you could put twenty New York cities in a county that has zero pharmacies.

Just in terms of access and how we look at the state, we have to understand that. The final one maybe is a deeper dive on Long Island, because by at least anecdotal data, they did not have an increase in the number of calls that went out, but they did increase the number of patient transports. Every other region had an increase in the number of calls versus the number of transports. Are they doing something that is a secret sauce that could help to improve the amount of people that are calling EMS? Finally, how do we inform, educate and be able to continue this in a tactical way that it just doesn't die on the vine?

Dr. Heslin Thank you.

Dr. Rugge I think it's pretty clear we have more work to do. It is just about 4:30. I think our heritage is when the way that we make a motion to adjourn is people stand up and walk to the door.

Dr. Rugge Any final comment?

Dr. Rugge We hope to reconvene with an expanded group, new ideas, and eventually have a compact set of reforms to suggest to the Health Department, to the Governor, and most likely to the legislature.

Dr. Rugge Thank you very much for bringing us together.

Dr. Morley I just want to add that you will hear from the department in terms of next steps. There will be information coming back to the people that met here today and New York City, all of the group. We may actually potentially get a smaller group together in the interim before we get this group back together again, but we'll see what happens.

Dr. Morley Thank you.