NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
HEALTH PLANNING COMMITTEE
ED OVERCROWDING: EMS LEVERS WORKGROUP
AUGUST 23, 2023
10:15AM – 1:15PM
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY/ZOOM

Dr. Rugge Just by way of starters, welcome to this workgroup meeting of the Planning Committee of PHHPC, Public Health and Health Planning Council. This is a little different than having a committee meeting. This is an educational session. We have the benefit of some real experts to guide us and let us know what's going on in the world of EMS. I thought we might do some introductions. I am John Rugge. Just with a line or two about experience. I started practicing family medicine in rural Adirondack Country in 1974, and then came to develop a system of community health centers called Hudson Waters Health Network. One of my distinct memories is having the local ambulances stop at our health center on the way to the hospital of a patient look like he or she might be in trouble because there was no one else. The training of the EMS squads was variable. They were all volunteers. Of course, there was no such thing as cell phones. We had no idea what that was. Things have changed remarkably in that period of time. As we've heard already in the pre discussion, continue to evolve and hopefully we can be helpful in making that progress.

Dr. Rugge With that, Ann Monroe.

Ms. Monroe Good morning, everyone. I'm Ann Monroe. I'm Vice Chair of the Planning committee and been a member of PHHPC for about five years.

Dr. Rugge Who wants to go next?

Dr. Rugge Dr. Lim, you were the first.

Dr. Lim Good morning. Sabina Lim, PHHPC member from Mt. Sinai. Thank you.

Dr. Watkins I guess I'll go next. Kevin Watkins. I am a member of the PHHPC council. By training, I am a primary care physician from Chicago and currently I'm working as a Public Health Director at Cattaraugus Going Health Department.

Dr. Rugge Dr. Soffel.

Dr. Soffel Denise Soffel, a long-time consumer advocate, especially on Medicaid issues and access to care. PHHPC member and former staffer to the New York State Senate Health Committee. I've been thinking about these issues for a while from a number of different perspectives.

Dr. Rugge One more to go.

Dr. Torres Good morning. I'm Dr. Torres, member of the PHHPC council and Vice Chair of the committee on Public Health.

Dr. Rugge Thank you.

Dr. Rugge Just by way of describing our activities, this is a workgroup meeting rather than a formal committee meeting. That designation allows us to have Zoom participation, which otherwise is not allowable. What this implies or dictates is this is an educational session for us to do learning rather than the time for us to make former resolutions or decision making. It's a wonderful group. Questions to them about the content of their presentations are terrific and will be important to have. If ideas come along, we've reserved time at the end of this meeting for a discussion about where to go next by way of recommendations and all the rest. We could hold those comments to the end. It'll be fine. As a quick reminder we are being taped. If it's possible to say your name when you first start it would be helpful. Also, to avoid rustling papers and all the rest. Nobody does that anymore. We're okay. Prior to this meeting, Ann Monroe and I work together to draft a new statement of roles and responsibilities for the Planning committee. This is a draft subject to improvement and edits, but I thought it would be helpful for Ann to just describe how we're understanding what our role to be, because the previous statements were of another era like a decade ago and didn't really pertain as closely to our current agenda.

Ms. Monroe With that, Ms. Monroe.

Ms. Monroe Thanks, John.

Ms. Monroe This is a draft. Because this is a working session, we can't adopt this. We will do that at the next formal Health Planning meeting that is scheduled and then it will go to PHHPC for adoption and be posted on the website. We don't need to go through it today, but I would like you to look at it and be prepared at the next scheduled Health Planning committee to finalize it and make a recommendation to PHHPC that it be how the Health Planning committee is described on the website and in other promotional materials. Legal has looked at this and has signed off. Marta has signed off. It is ready whenever we have a formal way of adopting it. The second document that you have we'll talk about at the end, which is just more about informative for PHHPC of what activities we're looking at. Next year it might look different. It is a separate document that would not need as much adoption as it would just information for the larger PHHPC and anyone else who is interested in what we're working on this year. I think that's sufficient for today, John. We'll look at these formally at the next Health Planning committee.

Dr. Rugge Yes.

Dr. Rugge As that summary discusses, our first job is to identify opportunities for improvement. We were helped enormously which brought to us the issue of long delays and offloading at the ambulance ramp too many times and for too long. With that, the next task is to do an analysis of how this is going. That's what we're doing today. Coming next would be recommendations for reform and improvement, which is likely to be both regulatory and reimbursement related.

Ms. Monroe I'd just like to add that we're happy that those of you who are involved with the EMS are here. We see this as a collaborative and cooperative opportunity to look at our joint issues together and not in any way an opportunity for PHHPC to assume control over EMS or in any other way disrupt your lives. It's a collaborative effort and we're really glad you're here.

Dr. Rugge All true.

Mr. Dziura Dr. Rugge, if I may. I'd also like to acknowledge Steve Kroll, who is a member of the State Emergency Medical Services Council. He'll also be presenting today.

Dr. Rugge Yes.

Mr. Dziura He is also the representative from the SEMSCO on behalf of the Chair of the SEMSCO today.

Dr. Rugge We really do appreciate the input and the perspectives and the knowledge you bring to us. Thank you very much.

Dr. Rugge With that, we may go right off to Steve to help us understand the system of EMS and the regulatory overview that we're dealing with.

Dr. Rugge Steve.

Mr. Dziura Good morning. I think it's still morning. Today we're going to talk a little bit about... Make sure this is up on the screen. The purpose of this first part is to... The committee members have asked for a bit of an overview on the emergency medical services system, regulatory structure, and such. We put together a deck. We're going to talk a little bit about the roles, the statutory and regulatory roles of the different councils that are connected to or work with emergency medical services, a little bit about the system, the EMS system itself operationally, and we're going to touch the treetops on some funding mechanisms that are in place for emergency medical services. EMS is governed by, you know, our governing laws are Article 30 of the Public Health Law. Article 30A, which is. Article 30 is emergency medical services. Article 30A is Emergency Medical Services, Personnel Training Act. Article 30B is the Emergency Medical Trauma and Disaster Care. Article 30C is Emergency Medical Services for children. Article 30 creates the SEMSCO, the State Emergency Medical Services Council, the SEMAC, the State Emergency Medical Advisory Committee. I'm going to go in more depth on these first in a minute, but I wanted to introduce the terms to you. The State Emergency Medical Advisory Committee, the Regional Emergency Medical Advisory Councils. There are eighteen of those and the Regional Emergency Medical Advisory Committees, which there are sixteen at this point. Article 30B creates the State Trauma Advisory Committee and Article 30C creates the Emergency Medical Services for Children Advisory Committee. A little bit on the structure. All these councils that I mentioned are underneath the Department of Health, their Commissioners Councils, the State Emergency Medical Services Council and Emergency Medical Advisory Committee. What's the difference between the two? The Emergency Medical Services Council is primarily made up of operators and EMS service providers from each region throughout the state. Each of the eighteen regions. Their primary function is rules, development, regulatory from more of an operational perspective. The State Emergency Medical Advisory Committee is a committee of the SEMSCO that is made up of physician's representative of each region within the state with the primary role of creating medical based guidelines and protocols and policies that are then adopted by the SEMSCO. The Regional Emergency Medical Services Councils. There are eighteen of those. There are eighteen regions throughout the state. They do not match any other regions we have in the state. We just wanted to add that one layer of confusion. Each regional council's primary purpose is developing policies and procedures specific to the locality that they're representing as well as processing at a regional level the ambulance service public needs certificate of need applications. Unlike this council, where public need comes direct to the PHHPC, in the EMS world public need is determined by the regional councils and can be appealed to the State Council. Each regional council also has a group

of physicians known as the Regional Emergency Medical Advisory Committee that work on the medical side at the regional level. The Emergency Medical Services for Children's Council is created by grant funds. It establishes a program both in the Bureau of Emergency Medical Services and this council to really focus on the needs of pediatric patients in emergencies and disaster situations. The State Trauma Advisory Council Committee, rather, their primary function is injury prevention, quality assurance and trauma center designation standards and regulations for the state. There's a lot of words on this page. We'll get this out to the members afterwards to follow up on. I wanted to touch a little bit on each of the council's primary roles and responsibilities. The SEMSCO, as I said, the State Council that is the EMS equivalent to the PHHPC is primarily tasked with assisting the Commissioner on developing rules, regulations, guidelines related to emergency medical service, specialty care, designated facility care and disaster medical care, including the application and recommendation and revisions of rules and regulations. They're also tasked with providing information, as requested, to the SUNY trustees, so that for the evaluation of college course credit for Emergency Medical Technician and Advanced Emergency Medical Technician courses. They're responsible for working with the department on the development of minimum standards set for continuing medical education, recertification of emergency medical service personnel. As I said before, they also here are responsible to hear any appeals regarding public need or certificate of need from the regional councils, and then they provide a funding estimate to the department and to the Senate Assembly and Governor's office and division of budget on an annual basis for the funding needed to provide adequate care, adequate training, rather for emergency medical services personnel. The SEMAC, as I said, their primary role and responsibility; treatment, transportation and triage protocols, including development of protocols for invasive procedures and infectious control and the use of regulated medical devices by EMS personnel. They also advise the SEMSCO on quality assurance, quality improvement standards and then review any medical protocols developed at a regional level to ensure that they are consistent with statewide standards. As we said, their major function is to hear and make determinations on applications for new ambulance services. Additionally, they assist the department in carrying out coordination of emergency medical services, specialty care, designated facility care, and so on. They can conduct surveys, analysis studies to make recommendations to the department on training needs within their region. They develop an annual training plan and so on. The Regional Medical Advisory Committee. They approve physicians that provide online medical control, coordinate the development of medical control systems at each region, are actively involved in quality improvement activities in the region, addressing systemwide concerns. And then, as I said, they nominate one physician from each of the regions to sit on the State Emergency Medical Advisory Committee. We have regional representation on the State Council. EMS for children. Their primary role is to advise the department and the Commissioner as well as the SEMSCO/SEMAC and in some cases the PHHPC on all aspects of emergency medical services for children, including pediatric emergency, medical trauma, and disaster care. Last but not least, the State Trauma Advisory Committee, whose primary role is to develop rules and regulations for recommendation either to the SEMSCO or to the PHHPC for appropriateness review standards and quality improvement guidelines for trauma and disaster care trauma systems, trauma centers and trauma stations, which is anybody that's not a designated trauma center. The Regional Trauma Advisory committees pretty much carry out the same duties on a regional level and make their recommendations to the State Trauma Advisory Council. Finally, the department's roles and responsibilities. In addition to all the regulatory oversight surveillance investigations, so on that you would expect these are some of the nuanced responsibilities of the bureau of EMS and Trauma systems. Revise appropriate review standards for emergency departments and services and trauma centers and stations. Really, EDs, trauma centers, and trauma stations under Article 28 for

adoption by the PHHPC. This is where we start to cross back and forth a little bit where they're looking at the trauma side, but you guys have the regulatory responsibility for hospitals. There's recommendations to you. In fact, I believe at your next meeting, there's a recommendation coming up on the agenda from the State Trauma Advisory Council. Departments also responsible for the categorization of general hospitals and the designation of facilities as emergency department or emergency services, as well as designation of facilities as trauma centers or trauma stations, which includes burn care. The Department maintains a regional quality improvement program for trauma and burn disaster care. We maintain the repository for all trauma data throughout the state. Develop and revise a comprehensive emergency medical and trauma care plan for the state. Develop and revise operational guidelines for a fully integrated statewide transportation system, which is partially what brings us here, is we're trying to integrate that transportation system across both sides and facilitate and coordinate the implementation of regional emergency medical systems. I'm going to pause there for a second. That's a good pause point to see if there's any questions on the structure, roles, and responsibility of the councils.

Dr. Rugge Just from me just one observation or question. That is this is a complex, multilayered system that would seem to offer plenty of opportunity for local input and local variation, but also raises a question about are the problems with consistency and coordination? How was that all worked out?

Mr. Dziura Yep.

Mr. Dziura The State Council, the SEMSCO... I've got so many councils in my head now. I'm even struggling to come up with the names. The SEMSCO and the SEMAC are responsible to set the standard, the minimum standards. What you see at the regional levels are regional variations based on regional conditions. For example, further transport times. In certain parts of the state, we have areas that don't have a plethora of paramedics. They have what's called emergency medical technician critical care. Just variations on different protocols. The state council is responsible to oversee and manage that anything done at the regional level is consistent with the state standard.

Dr. Rugge All very well coordinated, I take it.

Dr. Rugge Yes, Denise.

Dr. Soffel Thank you.

Dr. Soffel Two questions. One is a point of information. When you were talking you mentioned something about regional medical control or something like that. Can you explain what that means?

Mr. Dziura Sure.

Dr. Soffel Because that's a totally new concept to me. I have another question.

Mr. Dziura Sure.

Mr. Dziura I'll take the first question. EMS providers in the field operate in a specific scope. They have a scope of practice that's governed by standing protocols. So, for example, when to deliver certain drugs, what treatment procedures and algorithms they should

follow when they're permitted to or should do certain invasive procedures. That's all established under standard operating medical protocols. We have both a basic life support protocol and advanced life support protocol. Throughout those protocols and if a provider runs into a situation not covered under the protocols, they need to have the ability to contact a medical control physician, somebody that is authorized by the region to give a direction and orders to the EMS provider out in the field. The reason that they have this responsibility is because it's important that the physician understands the scope and equipment and capabilities of the field EMS provider. Charged with approving those physicians. Part of that approval process is making sure they have that level of understanding.

Dr. Soffel That's really helpful. Thank you. It's a new revenue phrase that I've never heard before. My second question is, how active are all of these regional councils? How many people are on them? How often do they meet? To what extent is there a sort of active engagement and participation? How often do they put out new standards or new regulations or new policy or new ideas? You understand the gist of my question is sort of how much of an interactive. I mean, Dr. Rugge pointed out, I think correctly, this is a very complicated system. I'm curious about how much is there actual give and take?

Mr. Dziura Yep.

Mr. Dziura All of these councils minimally meet quarterly. Together, all combined, I think we've done the numbers before. It's about 150 members that serve on all these councils combined. Remember, there's some overlap. Some council members that serve on the REMSCO are appointed by the Commissioner to the SEMSCO. Some of the REMAC physicians are appointed to the SEMAC by the Commissioner. There's a bit of overlap in regional representation, but all of them are very active. Minimally quarterly they're meeting. Many of them meet more frequently than that throughout the year. In regard to the policies and protocols, I would say that on the SEMSCO/SEMAC/REMSCO/REMAC side, they are very active in developing regional solutions to issues they're encountering. On the state side, you know, developing those protocol standards. There's actually a committee of the SEMAC called the Medical Standards Committee, who is very active throughout the year evaluating protocol recommendations from throughout the state. What we've been trying to implement is an annual update to any protocols. We're almost there. We've been trying to do that for the past couple of years. It was a little sporadic for a while, but we've got it to where the committee is reviewing these throughout the year and then comes out with a recommendation once a year, which allows agencies the time to train and implement and do what needs to be done to get those protocols live.

Dr. Soffel Sorry. One more quick, quick question. How does behavioral health overlay with the system? Is behavioral health one of the issues that you guys deal with on a regular basis?

Mr. Dziura I'd say it's a topic that comes up. Additionally, there is a... Do we currently have a behavioral health specialist?

Mr. Greenberg Ryan Greenberg, Director of the Bureau of EMS and Trauma Systems. We have a space for a psychiatrist on our state council. It hasn't been filled in a number of years, not due to a lack of desire, but a lack of finding someone who's able to commit to some of the time. Although, we do think from some recent interactions that we might have a candidate. We're looking forward to that. Your question related to behavioral health, though, we see about, depending on the system, 10% to 15% of the call volume in EMS is

related to behavioral health in some shape or form. Mental health emergencies or different things that come from that. We deal with it on a daily basis in different capacities. I think you're seeing different systems handle that differently. If we look down at the New York City system, they're trying a new program now called Be Heard, which is their Behavioral Emergency Response Unit. It's a partnership between their Office of Mental Health and the city and the FDNY, where they're putting a paramedic as well as either a paramedic or EMT on an ambulance with a social worker and responding to calls and again, trying to work with that in different ways. In regard to that same thing, we have a new program that's coming up that will be interacting with, which is the crisis centers around the state. They'll be presenting at our state council meeting in September to explain to us about the twenty-two crisis centers that will be opening up most likely during 2024 and 2025,and looking to be able to take our mental health patients that we see on a regular basis to one of those crisis centers rather than to an ER, obviously, permitting it's the appropriate place for them to go. There is a lot of work that we're doing with that and a lot of challenges that I think you'll hear today from that relate to it.

Dr. Rugge Thank you.

Dr. Rugge Dr. Torres.

Dr. Torres You gave me food for thought. What's the setup of the trauma station to the burn unit? I just needed to understand that a little bit better.

Mr. Dziura Sure.

Dr. Torres There was reference made.

Mr. Dziura Yup.

Mr. Dziura We designate both pediatric and adult trauma centers. Level one through three or three through one, depending on how you want to look at it, with one being the highest-level trauma center at the adult and pediatric level. The way the law currently reads is, any emergency department that is not designated as a official trauma center is covered as a trauma station. It's a term in statute that essentially means that every ED has to be somewhat ready for a trauma patient. As far as burn centers, burn one time. Not to dig too deep, but I got to give a tiny bit of background. When it comes to designation of trauma centers, the department partners with the American College of Surgeons who conducts the verification reviews for trauma centers. Based on their recommendation, the department does a survey at the facility as well or participates in the ACS verification survey and then issues the designation. At one time, the ACS did handle burn center designations as well. That's been since removed out of the American College of Surgeons. It is now handled by the American Burn Association. When we talk trauma centers, it's either a trauma center designation as a one, two or three or a burn center designation under ABA standards.

Dr. Torres Thank you.

Dr. Torres And then the next question is, is there for a prominent clinical trend that's being observed and the establishment of the crisis centers following that or its independent?

Mr. Greenberg Sorry I missed the first part of that. Something about the crisis.

Dr. Torres Are you seeing a prominent of clinical trends in certain areas? Are you seeing more burn, car accidents? Cardiac? I was just wondering the clinical trends that are being experienced in this model in the EMS response.

Mr. Greenberg One of the things that we look at is like the trauma report that comes out, which is actually due to come out next couple of months by the end of the year. That looks at a lot of trends around the state and stuff like that. We're looking to model one of those, similarly with the data that we're collecting for EMS. So, you know, to kind of take that and be able to see where we're seeing trending different types of things. As we went through the pandemic and even post kind of pandemic or the secondary waves, we would monitor for specific types of call types that were coming in. We'd be able to watch where pockets were popping up of COVID like symptoms or things like that, particularly because of the rate that we get the data. Normally it's within four to six hours we receive in the EMS report. The data is live. When we do have a specific thing that's going on, maybe a respiratory illness or something else that's going on, we do have the capability of doing it, but it's not something that we do on a regular basis, just doing bio surveillance.

Mr. Dziura And just to add on to that, I would also say a lot of the syndromic surveillance quality improvement initiatives trending is still a work in process at the bureau. Up until, I believe it was 2021, a quarter of the EMS agencies being both first responders and ambulances were still reporting on paper-based charts that would normally tak upwards of a year or two to get that data keyed into to our repository. In 2021, we required the submission of patient care data completed by EMS providers to be submitted electronically, which is now building quite a dataset that's very responsive and has the ability to do real time monitoring of the system. That's still a work in progress by us to build that out.

Ms. Monroe Quickly, just, you know, PHHPC is required by law to be open to the public when we hold our meetings. Is that true for all of these councils as well? Do you have much community participation at any of these levels? What seems to be the primary interest of the public when they do participate with you?

Mr. Dziura Yes.

Mr. Dziura Taking them in order, the council meetings are all subject to Open Meeting Laws, just like PHHPC. They're typically held right here at Albany, although right now we're doing them at Troy, but they are open to the public. We do have at the state level, typically around fifty to one-hundred people that attend the quarterly meetings. Many folks are involved in the committees of the SEMSCO. The bylaws of the SEMSCO allow for 50% of committee membership does not have to be a member of the council. We're getting participation from community, from EMS operators, EMS providers that are actually out in the field doing the work. If there's a specific topic that comes up, we'll see more of a community presence. Specifically, if there's a public need assessment being done or an appeal on a public need determination being done. We'll see community members from that area participating.

Ms. Monroe Thank you.

Dr. Rugge Just as one observation, we're running a little over time. I think there is some flexibility because we can keep our comment period at the end a bit on the short side, but need to get through all these presentations, keeping in mind that we need to know how the EMS system is working. We also need to study and understand the opportunities for

diverting people from one location, an emergency department to another that may be more clinically effective and more cost effective. Keeping that lens in place, I think will be important.

Dr. Rugge Back to you, Steve.

Mr. Dziura Yep.

Mr. Dziura The second piece I was asked to talk a little bit about on is the system pieces, the actual operational pieces in the system. There's primarily three that we look at. It's the 911 or what's referred to as piece public safety answering points that are operated most at a county level, but we do see it go down to either a town, village or department level, depending on where you are in the state. What I wanted to talk about is two functions that we see. One that we're seeing more and more. One that is an emerging service or operation that's being integrated into 911, one of which is emergency medical dispatch. If you ever remember watching the Rescue 911 episodes where, you know, you're listening to the tape recording and the dispatcher is asking a whole bunch of questions and then teaching somebody how to do CPR or stop bleeding or, you know, something along those lines that was an early version of emergency medical dispatch. The system's evolved quite extensively into a protocol-based card system that dispatchers are trained and certified to use that are responsive to the type of complaint that a person is calling about. So, for example, if somebody calls for a CPR emergency or a cardiac arrest or unconscious person, the emergency medical dispatch protocol would lead them to eventually giving CPR instructions after confirming a whole bunch of stuff. That's the front end that the caller sees. The back end is a tiered algorithm based on the type of call that's been presented to the dispatcher. What that tiered algorithm proposes is that each 911 or piece that's operating an system can determine what types of resources need to be sent to that call based on the type of call that is happening. I equate this to, you know, if you have a cat stuck in a tree, we don't send the entire fire department garage to that cat stuck in the tree. We send one truck. Whereas if the house is on fire, we hope everything shows up. EMS is based in a similar fashion where if somebody needs help getting up off the floor, we send the right resource for that. If somebody is in cardiac arrest, we send a stronger response with maybe a bigger focus on time. Closest available unit or closest available resource, something along those lines. It's an interesting system. It is not required by law. However, it is a piece of the... I'm going to mess up the name. The Dispatch Accreditation program run by Department of Homeland Security and Emergency Services. That's one program that we see in place. The other that we'll talk a little bit more about shortly is the integration of Nurse Navigation, which integrates really well with an emergency medical dispatch program that identifies lower acuity patients that may not need an ambulance or lights and sirens or uniform response and rather can be shunted to a different type of service somewhere else. Sean's going to talk a little more on that in a bit. One of the questions that did come up is, who is responsible for determining what type of response is sent or whether or not an emergency is happening. Dispatch centers are rarely mentioned in law, but in this case, general municipal law defines that the person designated to receive calls for emergency services for the purpose of dispatching firefighters or rescue squads is the person who makes the determination of whether an emergency exists and that their decision is the final decision. That leads to the question of, first of all, when was this law written? It was quite some time ago. Where does the liability lie for that? I you talk to each county in the state you'll get a different answer from every single one of them. The ability to implement this type of system, we typically see the conversation focused around legal concerns or liability owned by the dispatch center. That's an area through the last Governor's Executive Budget Proposal that was adopted. We previously didn't have the

ability to set any standards. We being, the Department of Health and the SEMSCO didn't have the ability to set standards on dispatch agencies. We now have that ability brand new as of April. More to come on putting some guardrails around dispatch systems. The second piece that we look at is the first response services. There are 682 first response CMS services registered in the state. They are not all required to be registered if they're operating at the basic life support level. Advanced life support, first responder services, meaning those that are operating with paramedics, critical care technicians have advanced drugs and treatments. Those are required to be registered. The rest are not but can voluntarily register with the department. What we see is when you integrate EMD with first responder systems and then an ambulance service, we start to get a tiered response. That's what I'm talking about, how many people do we send in and what resources? And then the follow up question, Dr. Rugge, would probably be where do we take them or how do we treat them? What's the final disposition of that patient? This came out of the report I gave earlier in the year. Just a refresh or recap. There are 977 ambulance services in New York State operating 5,649 ambulance vehicles licensed by the state. Quick breakdown of the different types. This is looking at just the ambulance services and how they staff. 193 of those ambulances I mentioned are fully career staffed. 474 are volunteer only staff. 315 are what we call a hybrid model. They use both career EMTs and paramedics, as well as volunteer EMTs and paramedics. Significant to know, I think I pointed this out in the last meeting, about 78% of all 911 patient transports were completed by career services. What that starts to tell you is the population centers tend to have the more career-based services, and they're doing a bigger chunk of the transportation of patients.

Mr. Dziura Next slide just gives a breakdown of the different organizational structures. We have both for profit, not for profit, federal state agencies and then variations of municipal city, county fire district, town or village operating or owning ambulance services. Again, I pointed this out before. Over the past ten years, we have seen a 9% decrease in the total number of ambulance services in the state, which is something we're studying. We've got a Rural Ambulance Taskforce, rather, that is currently taking a deeper look at that and expected to put out a report at the end of the year on the factors influencing some of these smaller services that have shut down. Finally, the practitioners that are part of the system. While we have 78,000 licensed practitioners in our system, EMTs, paramedics, certified first responders, advanced EMT and critical care technicians, only about 33,000 of those are actually active and out in the field providing patient care. The way we came up with that is based on our data. We looked at the unique license numbers that were showing up on patient care reports over a period of about five years. We're taking a look at that too to figure out why we're seeing such a decrease in the number of active providers that are in the field.

Mr. Dziura Last but not least, I promise last two slides. I was asked a little bit about how EMS agencies are funded. There are two primary funding mechanisms we see most common. The first is a fee for service, insurance, billing and reimbursement or patient billing. As reported to us, I believe the number is probably higher than this. About 46% of the ambulance services in New York State are billing insurance. Some things to keep in mind about folks that do bill insurance. Transportation has to originate or terminate at a covered destination. Some of those covered destinations are hospitals, critical access hospitals, skilled nursing homes, dialysis centers, and obviously the site of an emergency, but that's where we start to see limitations on the ability to take a patient to an alternative care center and an ambulance to get paid for that. That's CMS rules. All of the ambulance trips that are billed have to be certified for medical necessity or justified. You'll see in the slide deck, I'm assuming, we'll push this out that you can look at later. There's a bunch of conditions that generally establish medical necessity, and it's the responsibility of the EMS

provider through documentation much like in a hospital setting or any other patient care setting to document that medical necessity. Finally, Medicare and most commercial insurance companies do the reimbursement based on the service levels that include emergency service levels; basic life support, transport, ALS emergency transport or advanced life support, an ALS Level 2, which means they've done extreme in more than one. I think it's more than two invasive procedures on a call. Specialty care transport, meeting those patients that are on multiple trips or vents or require intense care by a provider with additional training and then paramedic intercept. You'll notice in the thing I want to point out, the key word in all those billable services is transport. If the ambulance wheels don't turn to move a patient there is no insurance reimbursement currently, with one exception that Ryan's going to talk about in a minute. Otherwise, there's no funding model for insurance reimbursement of a patient directly to an ambulance service that doesn't involve a patient transport. Finally, the second type of primary funding mechanism we see is municipal contracts. 14% of the ambulance services in New York State have received some type of funding through a taxing district. There are multiple ways that these taxing districts can be set up. Suffice it to say, it's variations of different special districts created through general municipal law, town law and in real property tax law that can be established to levy tax and assign it to the provision of ambulance services through contract. That was a ton and it was just the treetops.

Mr. Dziura Questions.

Dr. Morley If I may, I just want to reiterate the last sentence that this is just the treetop. Ryan and Steve's life is dedicated to this. Their knowledge base is encyclopedic. For those of you who are too young to know what an encyclopedia is, that's the Stone Age version of Google. Their knowledge does remain encyclopedic on this topic. We could easily spend hours. They spend their careers dealing with these issues. More information can be made available. They're available as references for a lot of folks.

Dr. Morley May I ask a quick question?

Mr. Dziura Sure.

Dr. Morley Just to take advantage of the fact that I have the microphone, when you talked before about community attendance at the meeting, how do you define community? Are those EMS volunteers or are we talking about folks that have no involvement in the EMS system except potentially consumers? Thank you.

Mr. Dziura Good question. When I say community, I'm talking more about consumers or interested community members, not so much the individuals who either are providing care or operating services that provide care. Those folks, the operators, and practitioners, we see them at every meeting. We tend to see the community participation more when we're dealing with a local issue.

Ms. Monroe I have a question.

Dr. Rugge Ann.

Ms. Monroe Two things. There's a lot of responsibility on what you call the dispatcher, which I guess is a 911 operator, right?

Mr. Dziura Not always, but generally.

Ms. Monroe Generally, I'll stay in the treetops. Are you satisfied with the training that those people get at the local level because of their critical importance to the whole process?

Mr. Dziura That's a good question. Currently, there is no required training that I'm aware of for a dispatcher, a public safety telecommunication professional. However, most dispatch centers have taken the initiative to participate or achieve certain certifications, like through National Academy of Emergency Medical Dispatch that does emergency medical dispatch protocols or APCO, the Association for Communications something who does a protocol set and develop standards. In addition, the Department of Homeland Security and Emergency Services a couple of years ago developed an accreditation program for dispatch centers and in emergency management at a county level. Many counties throughout the state have taken advantage of that program. It does add, though not required through regulation or statute in order to attain the accreditation. They have to meet certain minimum standard sets.

Ms. Monroe You're saying in some locations there's no minimum standards for that role?

Mr. Dziura I'm saying in all locations there are no statutory or regulatory minimum standards.

Ms. Monroe Do you think there should be?

Dr. Rugge Yes.

Ms. Monroe That was a good answer. Thanks.

Dr. Rugge Steve, I take it that you will have slides available perhaps and then we will be distributing those just for her minutes. It seems like three key elements are reimbursement for cover destination, medical necessity, and transport, all of which we will take a look at. Not to mention, or certainly also be sure to include training for those EMS dispatchers, because we're looking at really an enhanced role for EMS in decision making and direction for care, knowing that we are well over. Ryan Greenberg, we are depending on you to be at the mountain top level rather than the treetop level to make sure we complete this before this evening.

Mr. Greenberg Yes, I will work on that one.

Mr. Greenberg Just on the dispatch front that you talk about, it's not only about the training that we support, but it's also about having some consistency. You can be in one county in New York state, call 911 and get no pre-screening for medical conditions or anything else. Be in another county who will provide you pre-arrival instructions, how to do CPR, life saving techniques before the ambulance ever gets there. In addition, from an EMS sustainability point of view, the more screening we can do ahead, and it's called emergency medical dispatcher. Those questions are being asked. The better you can design a system. If we don't ask those questions ahead of time. If we don't perform EMD. We automatically assume the person needs the highest level of care because we haven't screened it to be lower. The more that we can do screening ahead of time then we can start to truly use the tiered system that's out there.

Dr. Rugge It seems like working together.

Mr. Greenberg Yes.

Dr. Rugge PHHPC for sure and SEMSCO and the state authorities and our national experts really need to work together to determine how best to do that critical decision making that is prior to what we usually consider to be medical care, but this is medical care for sure.

Mr. Greenberg Absolutely.

Ms. Monroe Just one quick additional question. Medical necessity, if an ambulance is sent out, it brings someone in.

Mr. Greenberg Yes.

Ms. Monroe Is it a post...I mean, what if they don't meet the medical necessity requirements? Do you not get paid?

Mr. Dziura When it comes to emergency responses, there's a lower threshold for medical necessity. The standard is that the person experiencing the emergency believes they have an emergency that needs to be treated much like in an emergency department. It's more in the other service types, like, for example, in a inter facility, transportation. A patient out of a hospital to another hospital or out of a hospital to a nursing home or a nursing home to a doctor's office or dialysis, where medical necessity becomes a bit more difficult and complicated. What I provided is really just the treetops of medical billing.

Mr. Greenberg It's important when you think about the system. I say that because if the medical necessity isn't there and the hospital's trying to move their patients out, then the ambulance service may turn and say, we can't move that patient. They don't meet medical necessity. Well, now suddenly, that patient's still sitting in a bed in the hospital. Now, the E.R. can't move a patient upstairs. EMS used to live in a silo for a long time. It operated well independently, for a while. When we look at it today, it is clear that EMS is a part of an ecosystem, and we all work together to make that happen. EMS bringing patients in, but also EMS bringing patients out, bringing them to the next level of care, bringing them to something else. This is all feeds into that dynamic of what's going on.

Dr. Rugge Yes.

Dr. Rugge I think based upon this kind of overview, under view, interview with the EMS system, now beginning to look at what new opportunities are there? What experiments have been already undertaken? How do we make change for the better? Starting with ET3, and starting with you, Ryan Greenberg.

Mr. Greenberg Terrific.

Mr. Greenberg Thank you.

Mr. Greenberg I'm going to talk on some of the things and kind of like Steve said, there's some other points of view you're going to hear, I think, in very positive ways as we move through this. ET3 is a program that came out from Medicare and Medicaid for Center for Medicare and Medicaid Innovation several years ago. When it came out, the EMS community was really excited about it because, like Steve spoke about before, we only get

paid when we transport a patient to the hospital. No matter what the motivation to an EMS agency was take the patient to the hospital. This is where they need to go because we'll only get paid for treating this patient and helping them if we take them to the hospital. When ET3 came out, which stands for Emergency Triage, Treatment and Transport, it started to give alternatives, but not only giving alternatives, it gave a payment method to those alternatives. Can we treat a patient on scene? Maybe they don't need to go anywhere. Can we triage a patient to go to somewhere else? Not an E.R. We talk about our mental health patients, talk about crisis stabilization centers or things like that. It comes down to transport those alternatives. When we talk about treating on scene, and I know Steve is going to talk about this one later on. I'm not going to harp too much on it. A paramedic ambulance is a mobile E.R. to a certain extent. When we can add in telemedicine to that visit that patient may never need to leave their home. The care they need, the reason they called may be able to be treated by the paramedic who's on scene. It might also be able to be in a situation to where the medications they have on board and everything else, along with the practitioner, maybe that a physician assistant, maybe that's a nurse practitioner, maybe that's a physician through telemedicine can work collaboratively together to treat the patient and leave them there. We're going to hear about case studies and things that happened where the patient needed that care definitively most likely would have had to be in an ER, but because of that collaboration of not only the paramedic being there, but the telemedicine and everything else coming together, as well as follow up from that we're going to send a script into your pharmacy. We're going to do something else in order to keep them in the right place at the right time. This is what ET3 was about. I talk a little bit in past tense because ET3 in New York State has twenty-five agencies participating. Of those twenty-five agencies, it represents 50% of the call volume for New York State EMS. We do about 4 million calls a year. About 2 million of them are covered by those twenty-five agencies that were approved to do ET3. As we move forward in that, it gave those providers opportunity to have payment not only for taking a patient to a hospital, but payment to treat the patient on scene. If they treated that patient on scene, they would have a payment method to it on the same fee schedule as is if they would have brought them to a hospital. If they brought them to an alternative destination that otherwise wouldn't have been covered, they would have had a payment model to that. These are all things that were very innovative. We were happy about it. Unfortunately, the federal government has decided to terminate the pilot program two years early. It was five-year pilot program. It was a five-year study. They decided to end it at the end of this year. At the end of 2023, this program will come to an end. Now, the interesting part about that is the program comes to an end. The options do not. When this program first came out, we did a study. I sat and looked through our ratings and our statute and sat with DLA, or division of legal affairs. I said, is it legal? We can transport today to alternative destinations. We can treat a patient on scene, everything in the ET3 program we can continue to do past December 2023. The problem that comes up again is though, there's no payment model for it. What's the incentive for any EMS agency to now go on scene, treat a patient, spend all this money on medications and interactions and everything else to then say, thank you so much. We're going to leave now. There's no payment model behind. At our last SEMSCO meeting, actually, sorry, not our last one. Two SEMSCO meetings ago we brought in the ET3 players and said to them, how's it going? Because we were looking at the numbers. We know the numbers weren't high. We know utilization wasn't being used. We turned and said, what seems to be the problem? At our SEMSCO Innovation Committee meeting where they met, they turned to us and said, community awareness. We said, what do you mean? They said, well, most people today when they call 911, they think I'm going to an ER. Their answer is I have to go to an ER. When you get there and you say, but I can treat you here and I can do this. They have spent the past ten or fifteen minutes from the time that they call 911 to the time the

paramedic got there thinking like, I'm ready to go to the ER. Some cases packing their bags and putting a jacket on. When we got there and started to educate them, they sort to be like, oh, I didn't know. It needed that education. We're working on building that community education, working on doing outreach to say not only when the EMS shows up can we take you to an ER, but we might be able to treat you right here. Then the unfortunate news came out that the federal government wants to end the program and is ending the pilot program.

Ms. Monroe Why?

Mr. Greenberg We have not gotten a straight answer on why the federal government has said that they're ending it. The biggest response that we've gotten is due to a lack of participation. Sorry, not participation, a lack of patients utilizing these services. The utilization on it has been what we believe is why they're terminating it early.

Dr. Morley If I may add, I think there's a specific challenge also in recruiting providers who are willing to meet the requirements to deliver patients there. Is that accurate?

Mr. Greenberg I think in some cases you're seeing some providers say it takes me as much work to take you to the hospital. I'm going to take it to the hospital. Same paperwork and everything else. What we've had an issue in participation is, is urgent cares and some of the alternative destination providers because they can't handle the volume as they are today.

Dr. Morley Is there a requirement for hours of availability that is a struggle to meet, or no? There's no requirement for hours. You can go between 9:00am and 5:00pm and not weekends.

Mr. Greenberg The federal government doesn't have a requirement for if an alternative destination is going to be in urgent care, saying they have to operate 24 hours a day, 7 days a week. Where the problem is, is that the regions often would say, if we're going to be a resource for EMS, we need it to be a realistic, dependable resource. It can't be open 9:00am to 5:00pm on Mondays and 10:00am to 6:00pm on Tuesdays. We're closed on alternating Saturdays because at that point it becomes too confusing for the EMS provider to figure out where my options. Where am I going? One of the requirements in many areas were consistency.

Mr. Dziura The other big struggle and we'll pick on urgent cares for just a second, but it could be said of any provider lack of standardization. If we're going to potentially as an EMS service, take a patient to an urgent care, one urgent care may do stitches. They may have the ability to do X-rays. They may do ultrasound. The one right next door may not. That lack of standardization makes it really difficult for a system to figure out where it can transport a patient and not end up just going back there to move the patient again to a hospital because that particular service doesn't have availability.

Dr. Rugge Are there any statutory prohibitions or obstacles to flexibility in giving appropriate care?

Mr. Greenberg Under Article 30, we have not found any. This is one of the things in being able to work with crisis centers and things of that nature because we don't have those restrictions. We have guidelines more on those who are going to participate to say something. Some of our urgent cares have turned and said, well, you have to screen them

first for their insurance carrier, and then depending on who they have, we'll accept them. EMS would say, no. This is an all or nothing. We don't screen ahead. That's not what we do. In the world of urgent cares, they have a front desk person. One of the primary roles of an urgent care center is welcome. We're here to help. What insurance do you have? Will you be paying by self-pay, or can I call 911 for you? We deal with this on a regular basis. That is their model. Not on us to decide anything on that. That's their model. Taking an EMS patient there becomes problematic because if you don't fit into their model their questions are often, well, who's going to pay? That's a little bit about ET3. Definitely a little upsetting on our side from the payment model disappearing. Happy that the options are still there, but it's not a viable, sustainable model to have those options if they have no funding behind them. As we see EMS reducing, the EMS sustainability side is becoming more and more taxed as expenses go up and everything else to then reduce the payment options as we try and not take people to the most expensive place. It becomes another headache. It's just ironic. I got this today in the mail. It was from the Empire Plan. They turned and offered me a nice little spreadsheet of care options. If I have a virtual visit, it costs me no dollars. If I have your doctor's visit, they have two dollar signs. I'm not sure what they qualify as two-dollar signs. If I go to an urgent care it's three dollar signs. If I go to an emergency room, it's four dollar signs. We have the ability to keep people with EMS at the virtual visit and no dollars. We're going backwards to four dollars, the most expensive option. We bypassed the ones in the middle, unfortunately, through this. Timing was just interesting. I thought I'd bring with you. I think you're going to hear a lot more about that going down. I think you should ask not only kind of our opinions, but some national opinions and some different insight.

Ms. Monroe Was Medicare paying only for Medicare enrollees?

Mr. Greenberg Medicare was paying for Medicare enrollees and then we actually worked with Medicaid, New York State Medicaid to participate as well. They had an agreement from the federal government that Medicaid can pay as well.

Ms. Monroe Is that going to continue?

Mr. Greenberg No. The entire program would discontinue with this.

Ms. Monroe It couldn't continue for a Medicaid patient? I mean, could it continue on that basis?

Mr. Greenberg I think you'd have to refer to Amir and the Medicaid office in order to know that one. I wouldn't have an answer on that. The one thing I can say for Medicaid is the alternative destinations might be something that can continue and be paid for. There is some statute right now that we've looked at related to that that alternative destinations could be something that can continue to be paid for because Medicaid has a little bit more leeway on destinations and where they take a patient.

Ms. Monroe And telehealth?

Mr. Greenberg Telehealth, I would refer to the Medicaid office.

Mr. Greenberg Great questions.

Dr. Rugge A great presentation, but no easy solutions. No one step solution for sure.

Mr. Greenberg I will say, and you didn't ask it, but on the private sector, in private insurance and things like that. There were some great conversations that were had too. Even as these programs as ET3 was continuing to advance. EMS agencies were having conversations with the commercial insurance providers to see would they pay for similar models? They were getting pretty good support from that as well because to them they saw the model on the cart.

Dr. Rugge Dr. Lim, I see your hand is up.

Dr. Lim Hi. Hopefully a quick question. You had mentioned the behavioral health crisis stabilization centers. I know that that's going to take time to be worked out exactly what are going to be the criteria of patients that can be brought there. It is concerning to me because it is, I think, potentially a wonderful opportunity. I'm worried that the complexities of that might make it quite difficult to tease out what kinds of patients could be transported. In relation to what you were just talking about how you are limited in terms of alternative sites. How and if are you going to be paid for transport to a crisis stabilization center? Do you know that yet or you're not sure? Is that going to be a barrier at all that needs to be addressed?

Mr. Greenberg Are you asking about the barrier with the crisis centers and insurance?

Dr. Lim Right.

Mr. Greenberg Yeah.

Mr. Greenberg For the crisis centers we haven't seen that barrier yet in the discussions. We've actually had very positive conversations related to that. Unlike the urgent cares, the crisis centers seem to be all welcoming from what we've seen right now. That pre-screening, those concerns are not a particular concern at this time.

Dr. Lim Right, but I guess just in general, you'll get paid for transport to a crisis stabilization center, or does that still need to be worked out?

Mr. Greenberg It would depend. It sounds like from a Medicaid transport, we would get paid for transport, but from Medicare, no, it's possible that they would not.

Dr. Lim I see.

Mr. Greenberg Because they would be considered an alternative destination.

Dr. Rugge Dr. Watkins.

Dr. Watkins Yes, I would be interested in finding out of the twenty-five agencies that were participating in the ET3 program, were any of those agencies located in rural New York State?

Mr. Greenberg They were primarily in metropolitan areas, which is how they increased their volume. That's how they got to the 50%. I mean, especially as you took New York City. I think fifteen of them were in New York City directly, and then the others were; Yonkers, Albany, Syracuse, Rochester. However, if they were in the program they were in the program. If that particular agency serviced, we'll take AMR for a second or GMR. If GMR serviced Syracuse plus three counties around it, but it was all under one license they

were able to participate in that. It was there for their entire geographic area, not just the metropolitan area. That's how you would start to see it in some of the rural areas. It was not predominantly in the rural areas. I think that was more phase two. They were supposed to start adding more agencies onto the program, but they never got to that point.

Dr. Rugge With that, I would think we might move to another innovative program of high interest with our guest all the way from Texas. Sean Burton, thank you for being here.

Mr. Burton Thank you for having me.

Mr. Burton I appreciate you allowing us to spend a little bit of time to describe a really innovative approach to managing a lot of the challenges that we've spoken about today. I am Sean Burton. I'm the National Director for Global Medical Response.

Ms. Monroe Would you speak more into your mic?

Mr. Burton Let me pull that closer.

Mr. Burton How's that?

Ms. Monroe I think it's better.

Mr. Burton Great.

Mr. Burton Thank you so much.

Mr. Burton I appreciate that.

Mr. Burton Some of the challenges that EMS faces as a whole today when we look nationally they are similar.

Mr. Burton There you go.

Mr. Burton Rising call volumes are a struggle for most of our organizations across the country and keeping up with the ability to staff enough EMTs and paramedics to meet that demand has been quite challenging. When we also look at the way people access 911, and why they access 911, we have developed a system that is basically you call we haul environment. Whatever your complaint is we're going to send the most expensive means of transportation to take you to the most expensive means of evaluation. That's not always the right solution for the patient. We created nurse navigation really out of a necessity to improve operational function to allow us to better serve our community.

Mr. Burton We developed a program about five years ago that would allow us to navigate those folks that are calling 911 with very specific low acuity complaints to a more appropriate setting within the community from the point of the 911 call. When we talk about some of the struggles with ET3, we'll describe how Nurse Navigation has developed a program that will help alleviate some of those issues. When we developed this program, we designed it in a way to help keep our first responder and our emergency department resources more readily available for those true-life threatening emergencies. We also designed it in a way that would improve operational efficiencies by not sending all of these critical resources to these low acuity complaints from the point of the 911 call. We were putting those unit hours back into the system, helping operations not have to spend so

much on overtime just to keep up with demand. We also wanted to create a program that would allow us to capture and report in real time quality data outcome and metrics back to the community so they could see what was happening with this program in real time and make adjustments as necessary. Most importantly, we designed a program that would allow us to expand access to care to those folks calling 911 so that it was no longer a you call we haul environment. You called. We would identify what's the most appropriate resource to navigate you to and then connect you to that resource within the community. We did this also with health equity in mind. We don't care if you're calling 911 what your payer source is. We're going to navigate you to the right resource. With this program, we can actually identify who your payer source is and navigate you to the most appropriate in-network resource for whatever your situation is going on. We also designed the program in a way that it is locally driven. It is not a one size fits all because all communities are unique in what resources they have or do not have to appropriately navigate to.

Mr. Burton A little bit about the way the program works. Folks will call 911 just like they do today. Nothing changes from that process. We want to make sure that if there is an emergent need they're getting the resources they need in the same timely fashion they do today. What does change is that if they do have a low acuity complaint that the local medical director has said would be more appropriately managed in an alternative setting based off of their clinical presentation, they can then go to the nurse navigator who will also verify there's no life threatening situation going on and then further screen the individual to right match the resource within the community to their actual complaint. Now, what's unique about the program is it's a time-based program. It is a protocol called NMTARA. Stands for needs matched time appropriate resource allocation. Meaning not only is the nurse determining what's the bright resource, but that we have an appropriate amount of time to get them to that resource. Quickly, if there is any life-threatening event that call is going to get the ALS response, the advanced life support response within twenty seconds, just like it does today. If it's a low acuity complaint, we can now say that we have up to an hour to get them to, say, an urgent care clinic or connected to a telehealth provider or to launch a community paramedic provider team to go on to the scene and further evaluate. We have up to two to four hours, or maybe we just connect them right back to their primary care provider. It really allows us to be the expert and navigate them to the most appropriate setting.

Mr. Burton Now, as I mentioned earlier, this is a fully community-based program, meaning that the local community medical director and team are going to be the ones that are going to be determine what calls are okay to go to the nurse and what resources are okay to navigate to within that community. Making sure that we are using local leaders who are familiar with what's going on in that community to help design and implement the program. We also are going to allow local leaders to determine how we're going to use the program. In some areas the 911 call is the only point of activation for the nurse. In other areas, we also allow when the field crews or the paramedics get on scene and they determine per protocol, you really don't need to go to the hospital based off your presentation. They too can connect to the nurse navigator allowing that unit to get back into service in a quicker amount of time. We also use unique resources. We found that a lot of people call 911, because they don't know what else to do or they have barriers to care like transportation. This is a great example of health equity. When we look at these heat maps here. The heat map on the right, the pink. That is Rochester. That is, I guess, a poverty level map. You can see in the darker areas are the lower poverty levels where we have a large unfunded population. The heat map on the left is the map of nurse navigation utilization, where we were able to arrange a transport and a Lyft or a rideshare service to a clinic. Not only do we arrange the ride to the clinic, we also arrange the ride back home allowing the patients

to stop at the pharmacy to get their prescription filled. You can see that they match perfectly when we talk about reducing barriers to care. The yellow piece there matched the low income and addressed that barrier.

Mr. Burton For the outcomes of the program, what we see typically is of the calls that come to the nurse navigator about 50% total are able to be navigated to an alternative setting within the community. That could be telehealth. It could be an urgent care. Our primary partners are what are called FQHS, the federally qualified health care clinics to manage those Medicaid and unfunded populations. What's unique about that is it's not only about taking care of that episode of care. Those folks are then enrolled into Medicaid and then can get primary care. We have seen it, for instance, in Washington, D.C., the Medicaid organizations have been able to show us when we're able to navigate these folks to the clinic and they get assigned primary care that reduction in ED utilization and hospitalization for that population. Now, we also see that about 50% still need an ambulance transport, but 47% of that 50% are what are called BLS, or basic life support transport. Now, when I talked earlier about the ability to schedule or identify a time frame that's appropriate to get this individual to the hospital. This allows us to be more operationally efficient with our BLS unit. Because now instead of having to roll that unit right away we can say we can schedule that unit for an hour or two hours to actually get them to the clinic, because we have identified that this is a low acuity complaint that doesn't need immediate care but does need care.

Mr. Burton Every caller that goes to the nurse navigator receives a call back from the nurse within 24 hours to do a patient satisfaction survey and make sure that the patient was comfortable with the care that they got and with the process itself. As I said, we've done this program now for five years, put over 120,000 patients through the program and have maintained a 4.5 or higher patient satisfaction score. From their perspective, they enjoy being able to speak to a nurse from the point of 911 call and being navigated to a more appropriate setting within the community. From an operational perspective, we've been able to show in every operation that we've gone into that this improves the operations ability to respond to calls. It decreases the time on task because we have now in some communities decreased the wait times at the ED because we decrease the volumes going to the ED. We've improved things like what are called dry run rates for us. On average in most operations about 20% to 30% of calls that come in end in what's called a dry run, meaning that we get on scene, and we don't actually transport. We've wasted a lot of time and effort and resources getting there, evaluating the patient only to not transport. In every operation that we've put this in, we've been able to decrease that dry run rate anywhere from 10% to 30% based on that individual operation. Again, improving operational efficiencies, putting unit hours back into the system so that we're readily available to respond to true life-threatening emergencies.

Mr. Burton Last slide, just a little bit about where we're doing this. It's not a pilot program. We have now been operational five years. We're across thirteen states. Twenty-five operations. By the end of the year will be over thirty systems and fourteen states. It's a proven model that we are excited to talk to you about. As I mentioned, we put 120,000 patients through the program to date. No litigations have come from this program because we have made sure that we look at patient safety in the way that we've designed the program from the beginning.

Mr. Burton I'll stop there for some questions.

Dr. Rugge I'm sorry if I missed this. I was busy writing other questions. How is this funded? Who pays?

Mr. Burton Great question.

Mr. Burton The partners are the communities that we provide the service to. It is basically a fee for service. It's a price per call that comes to the nurse navigator. We've created what's called a tiered pricing system. That means you only pay for the calls that come over. You're not paying for the butts in the seats to cover the hours to operate 24/7. Now, we designed this in a way that allows most communities to have access to this program from a affordability standpoint. We created what's called a medical command center that is in Dallas, Texas, that is staffed 24/7 with nurses that are licensed in all the states we provide services in. All of our nurses are licensed here in the State of New York. Because we have three operations here in New York, Onondaga County, Oneida County, and Rochester or Monroe County. What's unique about that and the reason that we took... There are two reasons we took that approach. One, it allows us to stack services, meaning that you get to share the cost of the program across multiple agencies, making it more affordable, but also not coming into an area and taking a valuable resource away and putting them into our system. We hire nurses outside of the state and licensed them in the State of New York, so that we're not taking those resources here locally.

Ms. Monroe On your map, you show Buffalo.

Mr. Burton Oh, great question.

Mr. Burton Buffalo, you know, the snowstorm that came through. We utilized nurse navigation to support that critical time. We ramped it up. They called us because they were familiar what we were doing in Rochester and called us the day of the storm, told us what was going on and asked if we could help in any way. Within two hours and thirty minutes, we spun up a whole team of nurses to support those calls that were coming in. Over the three-day time period we took 532 calls to the nurse navigator. The problem there was we couldn't get resources to patients and then we couldn't get patients to a hospital. The nurses were able to navigate or manage 336 of those calls without having to send any resources. We spun that up really quickly, managed that critical incident and then turned it back off. We have the ability to use this program in multiple ways. We saw the same efforts in supporting COVID responses across the country as well.

Dr. Rugge Dr. Lim.

Dr. Lim Hi. I'm sorry if you covered this. My battery died. I had to recharge. Do you take any mental health related calls? If so, what's the nature of those calls and what is sort of like the outcomes of those?

Dr. Lim Thank you.

Mr. Burton We do.

Mr. Burton It is protocol driven on which behavioral health type calls we receive. Those are usually the low acuity, you know, I need my medications refilled type of behavioral health calls or maybe suicidal ideation. It depends on what resources are available locally to manage those call types for us to navigate to. We have communities that have mobile crisis outreach teams. We're able to screen those and then launch those teams to the

scene. In some areas we are able to connect that caller to a telehealth provider to manage that call right there on the phone or to screen that individual and then approve for transport to a direct inpatient behavioral health facility. It just depends on what resources are or are not available and what the local medical director is comfortable with on deciding what we do there.

Dr. Lim Thank you.

Dr. Rugge It just seems that this kind of model is ideal and something that should be aspire to. The question is, is it possible to invoke this across the state as large and as diverse as New York? In our rural communities, we don't have any BLS versus ALS service. We have one ambulance. How is it possible to do a statewide approach and yet accommodate all those local variabilities?

Mr. Burton Well, much like we do when we take a county approach. There's really no difference in that. Onondaga, as, for example covers, I guess, eighteen different agencies maybe, and that's all under one program. What we would do from a state level is look at the different piece apps that cover each of the areas and we work with and through those individual piece apps. We have that ability. Colorado is a great example. We actually had a bill passed there that funded the program for two years to identify what Medicaid savings it would produce. We took on four counties across the entire state, and then we're just finished year one in that. It produced 1.2 million in savings to the state. We hope to then expand at the end of year two across the entire state. We have the ability to do that and excited to have conversations about it.

Dr. Rugge It seems an implication is there's a need and opportunity for pretty dramatic reform of the reimbursement system so that instead of simply paying for an ambulance ride to the hospital, which is the only way that hospital the ambulance can be reimbursed, use the savings by not transport into the hospital for all those other services that are critically important.

Mr. Burton We're still performing a very important job of navigating them to the appropriate setting within their network of care. One of the challenges was also, like Ryan mentioned, with alternate destinations of knowing what their capabilities are and what payers they take. Well, all of that information is actually built into our system. The nurse is able to identify that. We're going to navigate them to the most appropriate clinic that meets their clinical need and their payer or network need.

Dr. Rugge Dr. Watkins.

Dr. Watkins Yes, I'm sorry.

Dr. Watkins Yes, the nurse navigator, is the nurse navigator deployed to the patient's home? Is the nurse speaking with the patient via teleprompter or through the computer?

Mr. Burton Yep.

Mr. Burton It's all virtual. It's all phone call. They activate the system by calling 911. The 911 screens the patient for life threatening or emergencies. If it's non-life threatening, low acuity complaint, they then do what's called a warm handoff to the nurse navigator. They first ask the patient if they're willing to talk to a nurse and then they'll hand the call off to the nurse. The nurse will take over the call from that point.

Dr. Watkins I mean, I ask that because you talked about that patient with low acuity that might have had a suicidal ideation. I just cannot see how you can talk a person down from that with that type of acuity if they're not there actually face to face with the patient.

Mr. Burton In that situation, the nurse's job isn't to talk that patient down. It's to identify that right resource to do that. In that situation where we do take those types of calls, we don't take them everywhere because then again, it's based off of what resources are available to appropriately navigate to. That nurse where we do take those calls immediately connects that caller to the mobile crisis outreach team who is trained and specialized to manage that situation.

Dr. Rugge Dr. Watkins, it may be helpful to think of the Nurse Navigator program almost like a broker. Their job is to take the handoff from the 911 system, see if there is an identified community resource that can be utilized other than just sending an ambulance with the caveat that there's always a safety net to send that call back to the 911 Center for dispatch of emergency medical services.

Dr. Rugge Excellent.

Dr. Rugge I think we are ready to move along to Dr. Tanski and hearing from SUNY Upstate.

Dr. Tanski Thank you so much. Thanks for inviting me.

Dr. Tanski Chris Tanski from SUNY Upstate Medical University, the Associate Chief Medical Officer. I also still practice as an E.R. Physician. I also have an EMS background. I'm the Medical Director for a number of EMS agencies. I'm going to give you a perspective from several different vantage points here on this topic today of using EMS providers in the hospital setting. Under the auspices of Executive Order Number 4, Upstate began using EMTs and paramedics in the hospital setting in our emergency departments. We have two adult emergency departments at our hospitals and one pediatric emergency department. As this committee is fully aware, we are suffering the staffing crises that everyone else has had. Just this morning I was getting updated numbers. At one point we were down 600 nurses from our hospitals. Today we're only down 400. I say that sort of tongue in cheek. One of the things we talked about was, is there an opportunity and how would that work to use EMTs and paramedics in the hospital setting? I want to give you a little bit of perspective on how it did work and what some of our thoughts are on that today. First of all, what would we use these individuals for? It needs to be made very clear that EMTs and paramedics have an essential and unique skill set. They are not replacements. They don't replace a certain type of provider. They have a unique skill set, advanced and different training than what you might find in the emergency department. With our struggle to hire nurses, whether that's registered nurses, LPNs, any of those things, we created a job description and decided to use EMTs and paramedics in our emergency departments. Depending on the level of provider, as was talked about earlier there's different levels of EMS providers. They have different skill sets that they can practice. Keep in mind, these are folks that generally practice independently in an ambulance, not in an emergency department setting. What we found is that if you're able to use their skill sets fully and to their level of training that they have, and it is extensive training that they really make good partners in the emergency department. Some of the things that we have done would be simple things like having paramedics that are able to start IVs, having paramedics are able to do EKGs, having paramedics and EMTs that are

able to transport patients. That would be.... If that's all we did that would be a little bit of a disservice to the setting. One of the things that paramedics and EMTs can do is that they're really independent practitioners making decisions in an ambulance about how to care for a patient. We can use that in the emergency department setting as well. Sometimes the paramedics actually assist me as a physician because they're doing sort of the same thing that I'm doing in an ambulance setting and can help us with tasks that may not even be something that a nurse either an RA or an LPN normally does. We have also had them help us with critical patients. I was an EMS provider before I was a doctor. I'm lucky as a physician, right? In a hospital I have nurses. I have a controlled environment to some degree. As a paramedic, I was by myself out in the rain on the side of the road somewhere. They are able to help us in critical situations. That's a skill that they possess that I think is quite unique. One of the things that we've done is use them to help with EMS traffic and management of throughput. I know at the previous meeting this group heard about some of the challenges that we've had with boarding of patients, diversion and so forth. One of the things that we also use the EMS providers for is to offload ambulances. When an ambulance brings a patient in there may not immediately be either a bed or a nurse able to take that patient. We can have the EMS providers in the ED take report from their colleagues and take over monitoring and care of the patient to allow the ambulance to get back in service and service another patient and yet not have to have them sitting on a stretcher waiting for a bed to be available. That's something that has been extremely helpful for us, particularly when EMS traffic is high is to try to get those patients offloaded, have the EMS providers in the hospital assume care for them, and then get the ambulances back out into the community where they belong, frankly. We've also used them for transport. This is something that I'm particularly interested in. One of the things that we see more of these days is inter facility transports. Working at Upstate and Syracuse. We're the tertiary care facility, the regional center for the center part of the state. We get a lot of transfers. Nowadays with health care being more compartmentalized, there's more and more inter facility transfers where you go from a smaller hospital to the hub, so to speak. That's something that EMS providers do excellently well because of their training. We're also using them to do intra facility transfers. Not only are they experts in how to get a patient safely from one hospital to another hospital, but they're also really in my opinion the content experts on how to transport patients safely. How do you take a patient who is critically ill and has to go down the hall or to another part of the hospital for a CAT scan or some other procedure? How do you do that safely? Well, obviously, we think we can do that very well. We usually can. That's also another opportunity for EMS providers who are experts in that setting of how do you get a patient from one place to another? Just because it's not from one hospital to another. We've also been doing intra facility transports, using EMS providers, again, giving them experience on that.

Dr. Tanski Now, I want to talk a little bit about what the benefits are. Obviously, from the hospital perspective it's clear that the benefits are that we haven't been able to fill positions for nurses, whether that's LPNs or RNs. We use EMS providers to help us with throughput. I also want to be clear that I think there are benefits to the EMS providers as well. All EMS providers, regardless of what level you are, have to spend a little bit of time in their training doing some clinical time in a hospital. For paramedics that's a lot. For basic EMTs it's eight or sixteen hours something along those lines. What we have also found is that there is learning that occurs on both ends. Our EMS colleagues that work with us in the ED are learning about what happens to patients after they drop them off. What expectations do providers have that can help me when I'm in the field bringing patients in? There's also been learning on the other end. At Upstate we have a residency program and so my emergency medicine residents, trainees are learning how does EMS work. Now, I can have more interactions with the providers and understand what they see in the field that I

don't see in the emergency department. It clearly goes both ways. What's key to this working is that you have to understand the skill set, what you have available and what they can do. If the EMS provider in our ED is kind of... we use them to take labs somewhere or do things that don't utilize their skillset fully shame on us to be honest with you. We need to tap into the resources and experience they have, and we need to use that and then they can also learn from us. That's worked out extremely well in our setting.

Dr. Tanski Now, just a little bit of logistics because of all the open nurse positions we've had the funding for this. We've simply moved money and shifted some of the funding we would have used to fill nurse positions to pay this. It is a challenge. The compensation for our paramedics falls between what would be for an LPN and an RN. They're paid somewhere between that range. I can tell you, if you look at kind of the average reimbursement for an EMS provider in our community in Central New York it's not that high. EMS providers, for a variety of reasons, the reimbursement is not great. We're probably about 30% to 40% higher for the EMS providers we've hired in the hospital than what they would get in the field. This is where I want to take off my hospital hat and put on my EMS Medical Director hat. One of the biggest challenges that we face is how do you avoid robbing Peter to pay Paul? I want to be able to support the hospital and have EMS providers help us with the throughput in our emergency departments. I also want to have providers that are able to staff the ambulances that bring people to the hospital and take care of our friends in the community who need help. I don't want to have to choose necessarily between that. We have to be very careful about how we structure that. How is the pay structure? How are the hours structured? The providers that we had at Upstate, for the most part, would tell us, I'm still doing my regular EMS job. I'm just doing this for either A, a different experience or B, for overtime. Because many EMS providers have to work more than one job. We have to be very careful that we don't try to solve one problem and create a different problem as alluded to in the rural areas where we're taking the only providers available to staff ambulances and putting them in hospitals. I'm very sensitive to that. At Upstate, we've tried to make sure we're not doing that. I think if we look at this on a larger scale, we have to be very concerned about that aspect of it. The last thing that I would say is that the challenge that we've also had is this is a new system for us. How do we integrate people that have not really worked in a hospital into the hospital setting? We had some challenges initially on both ends with the EMS providers saying, how do I fit in here? I know what I do in the back of an ambulance. I know how to take care of patients independently. Now, part of our larger team, how do I fit in in the ED? We've had nurses who have said, wait a minute. Are you coming from my job? What is going on here with this new level provider? 99% of the time that's been smoothed out because these folks a lot of them knew each other anyway. You do have to be careful about how you introduce a completely new role into the hospital setting and make sure that everyone is on the same page.

Dr. Tanski With that, that's a little bit of our experience and I'm happy to answer any questions you might have.

Dr. Rugge Ann.

Ms. Monroe Thank you. That was very helpful.

Ms. Monroe New York has rather restrictive scope of practice laws that protect certain positions. How has that affected the work that a paramedic or EMT can do with the hospital? Has that caused a problem? Do we need to look at scope of practice on a variety of titles, I believe, but what about in this situation?

Dr. Tanski I think that's a good question and I think it certainly is an issue. I mean, as you may know, you know, Upstate, for example, is a state institution, right? We're a state hospital. We had to create a position, create a separate position for these paramedics with a separate. For those of you familiar a teaching hospital title, which is what SUNY uses for employees. We had to work with the unions that we have to make sure that there were no issues with that. Really, what I think it gets down to, in my opinion and Ryan and Steve might have different opinions, is that really understanding what they can do and utilizing everyone to the maximum of their skills. As I said, we have to make sure that if you're using people in an emergency department setting, EMS providers, that everyone understands what they can do, what they can't do, and that they are comfortable with that. I don't want an EMS provider to come in and be relegated to something that does not utilize their skill set. That doesn't make any sense. On the other hand, I don't want an EMS provider to come in and to be uncomfortable and say, well, gosh, Dr. Tanski, you know, maybe he wants me to do this. Boy, that's not really in my skill set. We've had to work hard with our own providers, our own emergency department providers. Just because you're an emergency department physician does not mean you understand anything about EMS and explain to them, we're going to have EMTs and paramedics. Here's what they can do. Here's what they can't do. Make sure that we're utilizing them. Make sure you're not shoving them in a closet somewhere and say, I don't know what to do with them. Make sure you're not asking them to do something they can't do. That's really been a discussion that we've had, and I think it would help to have more clarity on that. Again, the treetop view, you have to get a little bit more into the weeds with this and understand exactly what they can and can't do. The idea that a paramedic can help me as a physician with a critical patient makes perfect sense to me because I did that well before I was a physician. That's what they do every day in their normal EMS jobs. That may not make sense to other people because that's not really a skill that they would have. We have to understand, and even in our own emergency departments, we don't necessarily understand EMS very well. We have to do a better job of that. In Upstate, I've been very deliberate about making sure that everyone knows. If there's questions on either end. It's more often it's been educating my colleagues in the ED about here's what paramedics can do and can't do and make sure you're up to speed on that. Not so much on the EMS side, but on the doctor side.

Mr. Greenberg On the EMS side from that same aspect, you know, during COVID, when our hospitals are truly being taxed and particularly during the second wave, and we were looking at other options to be able to support the system, we actually had set up task force, which normally was two EMTs and three paramedics who the hospital would be able to request, and they would come in for six to twelve hours into an E.R. that was having a surge or whatever is going on and work hand in hand with those teams. That's really where this kind of concept of the paramedics, I think it was always there, but it's really kind of the proof of concept, I would say that it works, and it works as part of a care team. It's not trying to replace someone or do something else. It's taking the skillset that they have and working hand in hand as part of that care team. During that time worked on putting out some documents that show very clearly what the skill set of an EMT is, what the skill set of a paramedic is, what they can do. Our guidance to our hospital partners was to say here's what they can and can't do. They need to stay within what they've been trained to do. That was very much embraced under EO4 and that ability to allow those providers to work in what we referred to as a nontraditional environment. For us as well in EMS sustainability, we believe that, you know, there are two components that we need in order to keep people in the EMS field. One is things that recruit them into the field that make it attractive, but things that also recruit them in the sense of what's my retention? What's my opportunities? What's my growth opportunities? We know that you can work on an ambulance. What

happens when you want to move up next that you want to do the next thing? That opportunity to working in an ER while using your skill set that otherwise was only allowed to be used on an ambulance. Imagine that paramedic who could run a cardiac arrest on their own today if they went and worked in the ER, which many did. They were working as an ER tech. They can do basics. They weren't working to their level that they've been trained to do that they would do on the other three days a week that I think Chris was even just describing. Those are just some of those dynamics they can do.

Mr. Greenberg And if I called Ryan or Steve and said I need one of those task forces in my hospital to help me, then it's on me to use them and they should be reporting back to Ryan and Steve. We were used appropriately when we were there. We were not used to just take vitals. We were used to the highest level of our training. That's on me to ensure that.

Ms. Monroe Are their other hospitals in the state that are using EMTs and paramedics in their emergency departments? Is it still pretty much a proof of concept at Upstate?

Mr. Greenberg There are many hospitals that during EO4 were using it in hospitals. I think you've seen EMTs for many years, but the EMT skill set aligns very much in some cases with what New York Tech can do. You agree with that one. I think we've seen that for a number of years, but the paramedic concept really was allowed through Executive Order 4 and continued. When that Executive Order ended, many of the hospitals who had that happening had stopped because they couldn't work to their skill set.

Mr. Dziura There was just to add on to that a little bit. Ann, you asked a specific question about really protecting the setting. The EMS providers are very specifically limited to settings that involve the initial emergency medical assistance. The definitions a little bit longer than that, but the important part is it's the initial emergency medical assistance. Department of Health Division of Legal Affairs has determined that an ED in a hospital does fit into that definition of settings where EMS providers can practice. However, that does not just blanket extend to the rest of the facility. It has to meet that definition.

Dr. Rugge Dr. Morley.

Dr. Morley Could I just expand on that a little bit? Who specifically or what specifically regulates scope of practice for EMTs and paramedics?

Mr. Dziura That's specifically regulated under Article 30 of Public Health Law that defines the setting and more specifically when it comes to the development of regulations and regulatory sets. That's by the SEMSCO, the State Emergency Medical Services Council and the SEMAC, the State Council of BMC Physicians who defined the drugs that can be used, the treatment and triage protocols and policies, as well as invasive procedures and equipment that can be used by providers.

Dr. Morley Thank you.

Dr. Morley The point that I'm trying to highlight, though, is that it's not state education which regulates all of the professions. It's DOH for EMTs and paramedics, but there is actually one piece, one thing in the state education regulations in terms of, you know, I'm not sure if it's the Nurse Practice Act, but there is something that defines what a nurse is, and folks can't tread on that territory. While DOH, BEMS, and SEMAC and SEMSCO all

impact on the scope of practice you can't tread on state education statute for what nurses can do.

Mr. Dziura You start to see a bit of a gray area is when it comes to an assessment of a patient, development of a care plan. Those things are more traditionally left to a nurse. However, EMTs and paramedics in the field do an assessment of a different sense to identify that immediate issue and build their immediate treatment protocol. In addition, there are things that EMTs and paramedics can do that nursing staff are not permitted to do. Paramedics, for example, are authorized for invasive airway procedures. They can do intubation. They can do needle creaks. They can do nasal intubation or intubation. They're allowed to do chest compressions. They're allowed to work on standing orders, standing medication orders. Non patient specific standing protocol driven medication orders and have a toolbox of medications that they're allowed to deliver to a patient without a direct physician's order. The scopes are a little bit... They're similar but different. In that way, we believe that EMS providers in this specific setting are more of a supplement or a complement and are part of a full care team package inside of a hospital not meant to replace.

Dr. Rugge Just speaking as a family physician, I remember when primary care was a doctor in an exam room, possibly with a nurse, to take vital signs. Now, it's a team, a big team of care managers, care coordinators, health educators, etc. Likewise, we're seeing team development across the board with a need for keeping up and catching up and going forward with new regulations, sometimes new statute and certainly reimbursement that's appropriate. No small challenge. There are more challenges ahead of us today.

Dr. Rugge Moving forward with prehospital use of paramedicine. Glad to have Steven Kroll with us and interested in hearing what your experience is and what we should know.

Mr. Kroll Good afternoon. Thank you very much, Dr. Rugge. It's a pleasure to be here. I am the volunteer Chief of Delmar-Bethlehem EMS, which is the EMS agency that covers the Town of Bethlehem here in Albany County, New York, but I'm really here as an unaffiliated person with a lot of experience in the sense that I'm going to just give you a quick bit of my background and then I'm going to tell you about a program that I think we developed in my last employment that was highly successful. Then I'll tell you that the program has sunset, but I think it leaves you a lot of information on the possibilities. In addition to my EMS leadership position, I have about twenty-five years of experience in health care policy with the American Hospital Association, the U.S. Congress, and the twenty years that the Health Care Association of New York State. As mentioned, I'm a member of the SEMSCO, I'm a past Chair and I currently Chair the Finance Committee. I serve as the Chairperson of the Board of Trustees of Cobleskill Regional Hospital, and I serve on the Board of Directors of the National Association of EMT's. I bring a diversity of lifelong experience to what I'm going to talk about today. Shortly before the federal ET3 program was announced, I had the opportunity to join a local telemedicine startup company that was being backed by venture capitalists called UCM Digital Health to begin a treat in place, an alternate destination program. As I talk with you about it, you're going to hear a lot of the common themes, what Ryan talked about under ET3. I've long felt that EMS was transporting many patients to hospital ERs by default. It was the exact wrong place for them to receive care. It wasn't a person-centered experience, and it wasn't integrating with the health care system. I always dreamed of a way to change that dynamic. Meeting this fateful meeting in a Dunkin Donuts with these venture capitalists gave me the launching pad to start what we have done. All these things, of course, have been exacerbated by the E.R. crisis and overcrowding issues that you've been studying

over the last year as the Public Health Council. The Treat in Place Program that I'm going to talk about grew to support more than two dozen EMS agencies in the capital region here, Northern New York and Central New York, including my own agency that I volunteer at. Mark will talk with you about his experience in Cambridge Valley later, including the three ET3 participants here in the Capital region of New York State, Mohawk Ambulance, Clifton Park Ambulance and Colony EMS. The difference between our program and ET3 is, as Ryan talked about, ET3 was limited to fee for service Medicare patients and then the extension into Medicaid that was developed by the New York State Department of Health. Our program was developed in collaboration with two Capital region insurers, CDPHP and MVP, that made payments to ambulance service conducting treat in place in alternate destinations available to their commercially insured population, their Medicare Advantage population, and the Medicaid managed care members. We were able to span across all types of patients that were members of these insurers. Of course, here in the Capital region of New York State, MVP and CDPHP are really a substantial portion of the population, and this is an important distinction. Ryan talked about the barriers of ET3, and one of them is EMS providers do not like to make what they call the wallet biopsy. We have in our DNA that we treat everybody equally and give everybody the same care. We don't ask people what their insurance is. It's a real cultural divide to say to an EMS provider, I can offer this service to people that are in one group and I can't offer it to people in another group. Another important distinction is that treat in place and alternate destinations has to meet a set of clinical criteria. We developed those clinical criteria working with our medical directors in the EMS community here in this region. One of them is even minor things that maybe don't belong in the hospital E.R. have to be looked at in the lens of the comorbidity opportunities of people's chronic illness. The Medicare population really isn't the best place to start because by the virtue of their age, things that might appear in a younger person to be low risk become higher risk in the Medicare population. We were able to look at this across all populations within the Capital region and in Northern and Central New York and not be limited to patients that would be categorically ineligible just because of the co-morbidities they have as Medicare patients. We developed the list of circumstances that were appropriate for what I call TIP, treat in place, telemedicine encounters. Those circumstances tended to be more prevalent across the population and especially prevalent in economically challenged populations. We completed approximately 1,500 EMS telemedicine encounters in conjunction with trained EMT's and paramedics between November of 2020 and June of 2023, when the program began to wind down. This was across urban, suburban, and rural agencies in New York State. The EMS trade in place experience was very similar to the way Ryan described ET3, a telemedicine physician, a regionally credentialed emergency physician, would participate in a three-way conversation with the EMT and paramedic and the patient to determine the next steps for that patient. After a three-way telemedicine visit, the emergency physician could then make decisions on what the appropriate outcome would be. Often, physician self-directed self-care instructions were given very similar to the way Sean described it and the nurse navigation model. Electronic prescriptions could be sent to the patient's pharmacy for a prescription for any number of drugs. Referrals could be made for diagnostic testing, primary care specialists or therapies. Similar to the way Sean described it, the timeline changes when it's not an emergency. You may not need to be seen in the E.R. today, but you do need to see primary care tomorrow or you need to see a behavioral health specialist within X number of hours, or you need to have bloods drawn and then get back to us with the results of those. Those things don't need to necessarily happen in the E.R. Tese patients would sometimes be navigating the E.R. when it was appropriate. Of course, the ambulance crews in the house right now with the patient. If the physician says, no, I really think this person belongs in the hospital the transport occurs. When we envision this, Ryan gave us some ground rules. One of the ground rules was the

patient always had to have the choice to go to the hospital E.R. We offer people the treat in place or the alternate destination, but the patient and physician will always make that final determination. Let me tell you a little bit about the outcomes of this program. 74% of the encounters, ambulance, transportation to the hospital E.R. was not needed. That means three out of four patients in these 1,500 patients or about 1,100 patients were either treated in place or taken to an alternate destination. These EMS telemedicine encounters lasted about forty-five minutes from the time of the ambulance dispatch to back in service. That placed the units back in service for the next ambulance call much quicker than a transport to the hospital. Now, there's a caveat to that in an inner-city environment when the hospital is right down the street. It's probably faster just to take people to the hospital. That doesn't mean it's the right thing. When you get to where Mark lives, his turnaround time for an ambulance run is a couple of hours. If we can do something in forty-five minutes or an hour that gets his crew back on the road, which is of limited resources as a community, then we're adding back into the system. I'm also going to comment about TIP versus alternate destinations. I think Ryan covered a lot of this, but we found here in the Capital region destinations willing to accept alternate destination patients by ambulance are very hard to come by. The federal ET3 program did not succeed with the treat in place with the alternate destinations, because we couldn't find the right places to go. With the exception of Saratoga County that has two hospital affiliated emergent care centers in Clifton Park, the major urgent care providers in the Capital region just were not interested in having ambulances bring them patients. Ryan talked about the business model, right? Those are not emergency rooms. It's not everybody that comes gets treated. We ask you about your insurance later. There is a screening process. Ambulance providers really weren't interested in saying, well, I can't bring the Medicaid patient to the urgent care center, but I can bring the Blue Cross patient. Second of all, frankly, they didn't want to have ambulance crews bringing patients through their waiting room. It's not an emergency room. Third of all, and timing came up. What do we do at closing time? You brought us somebody at 6:00pm. We close at 8:00pm. We need to work for a couple of hours. We go home at 8:00pm. We're not a 24/7 setting. Therefore, Clifton Park Half Moon EMS is really the only agency in the region that had substantial success with alternate destinations. We couldn't find anybody else that wanted to take them, quite frankly. I believe the potential for treat in place, at least today under the current regulatory scheme, the current business model of urgent care is much more robust, the possibility than treatment for alternate destinations. My colleagues around the country really do report similar outcomes. This program at UCM Digital Health has been terminated. UCM Digital Health suffered some setbacks in the downturn of venture capital market in early 2023 and were unable to sustain the EMS telemedicine program. I share a very positive message about what we did over a couple of years and recognize I have to tell you that the program has sunset. After spending four years building the program at UCM, I'm frankly trying to figure out ways that people like I can add this back into the mix in New York State. Unfortunately, there is no organization yet to sustain the program. I believe EMS Treat in Place is an incredible way to deliver patient centered care that allows EMS responders to use their talents and competencies to deliver community-based care and help patients that don't belong in the E.R. and stay out of the E.R. As each of the previous speakers have said, one of the best ways to help decompress our ER's is not take people there that don't belong there. I can tell you a little bit about patient satisfaction. Our program had a 95% patient satisfaction, and if familiar with the Net Promoter score, we had a 79% net promoter score, which is almost unheard of in the health care setting. One of the keys to success was getting the payers on board. We had two great payers on board in discussions ongoing with others and broad payer acceptance as needed. EMS agencies balk at the possibility of offering a program to patients based on payer. EMS agencies, however, can't afford to make the decision to do something that would be paid for if they

transport to do something else that's not paid for because their budgets are basically built on volume. We're in a financial crisis just like other EMS providers. When I met with the EMS agency leaders to talk about this, they were pretty blunt for me. It may be the right thing to do, but if we get paid X number of dollars and we're going to take a thousand patients to the hospital this year, and now you're going to tell me I only get paid for 950, I've got a budget hole that I have to fill, and I have no way of filling it. If we get paid to take the patient to the hospital, we have to also be able to pay them for any one of the different options that we're talking about today. I personally am working through my role at the NAEMT on federal to treat in place legislation to replace the ET3 program. I believe we need to do something here at the state using our state and regulatory ability to enable EMS agencies to be paid for the care they render in the home, as well as for the telemedicine physician that works for them to get paid by all payers. Another key is finding the right organization to provide the telemedicine physicians to operate the telemedicine program. I know I'm hoping that we identify the right organizations in New York State. I believe programs like this will succeed because they align incentives for all stakeholders. TIP will ease overcrowding and free up what space we have available in ERs for real emergencies. It allows paramedics to use their skills in a professionally fulfilling way. Talks about some of the career growth Ryan talked about. It shortens the time on tasks for the EMS agencies. It creates incredible payor savings. ET3 being terminated was judged as saving $550.00 per each encounter because instead of paying an ER bill, we were paying a telemedicine physician or qualified health care provider's bill. If you take that across thousands, $550.00 encounters a lot. That money can be plowed into the health care system in other ways or simple savings. It creates savings for the insurers. The insurers are paying out less in claims. That aligns their incentives with everybody else. It also gives us a chance to move past the treat them and street them reality that our ER's are now. We're so busy that we do what we have to do to stabilize the patient and we push them on out into the street. One of the nice things about a three-place program, we followed up with every patient afterwards. We called them back two to three days later to see how they're doing. If they weren't doing well, we did another telemedicine visit with them. We navigated them to therapy. We navigated them to behavioral health. We became a resource for them because our telemedicine physicians would be seated at a desk and a monitor working their shift. They're not in an E.R. where I've gotten more charts stacked and I've got to get on to the next patients. I really do hope we can develop a business model and regulatory model that supports this in New York State and work with our payers to ensure they're willing to pay for the telemedicine encounter and for the ambulance service to provide this kind of care. I appreciate the opportunity to present here today. I'd be glad to answer any questions.

Dr. Rugge Thank you very much.

Dr. Rugge Do we have questions?

Dr. Rugge Just one number. You said 74% of the encounters for treat in place did not need transport to the hospital. That's not the total number of ambulance rides that's only the number there were selected to be qualified for treat in place.

Mr. Kroll That's correct. If we began to treat place, in other words, the paramedic contacted the physician and said, Let's try a treat in place. 74% ended up finishing as a non-ER transport.

Dr. Rugge Do you have a number of how many ambulance calls resulted in treat in place or qualify for treat in place?

Mr. Kroll We did 1,500 treat in places. Do you mean how many could have been that may not have been...

Dr. Rugge No, just how many ambulance rides went directly in the hospital without consideration of treat in place?

Mr. Kroll I don't have numbers for that, but it would be in the tens of thousands. The dataset that I can look at is when the paramedic triggered the hey, let's try and do this. A little bit out of the scope of this conversation, but something else we discovered, interestingly, is the treat in place physicians were also used by paramedics to help convince patients that needed to go to the hospital to go. The 55-year-old with chest pain, who says, no, I'm going to be fine. The paramedic says, no, you're not. In that 74% were also some patients that the telemedicine physician was contacted to basically have the one-on-one conversation with the patient say, look, you really got to go.

Ms. Monroe Was this a for profit company that was doing this work?

Mr. Kroll Yes, we were. We were venture capital backed community medical. We were telemedicine practice based in Troy, New York, that was backed by venture capitalists to expand and grow this program.

Ms. Monroe They've stopped doing this program now?

Mr. Kroll That is correct. I'm no longer employed there. The EMS division was sunset when the venture capital funding. In early 2023, the venture capital markets in the United States were very badly hit by the bankruptcy of a particular bank, Silicon Valley National Bank, which is where the venture capitalists keep their money. We didn't have any way to fund the continuation of this problem.

Ms. Monroe The funding stopped. Was it because of the productivity and the results of the program or was it because of an external reason that the money no longer was there?

Mr. Kroll Well, the goal was to make the program profitable, and the venture capitalists provided the funding to do that. The venture capitalists pulled. the venture capital relationship ended before we were able to grow enough volume to make it profitable.

Ms. Monroe It was not yet profitable.

Mr. Kroll It was not yet profitable. As an observer, I don't know if this will ever be profitable to the person running it. The insurance companies will save a lot of money. The hospitals gain from the throughput they gain in being able to accelerate their E.R. and having less patients in it. The ambulance agencies get paid. We as a independent company were running the program. We had to make enough to... You know, we hired the telemedicine physicians, we had built the technology.

Ms. Monroe With this concept and the success of the concept, who in our macro system is in the best position to manage something?

Mr. Kroll I think about that a lot.

Ms. Monroe We don't have a lot of time.

Mr. Kroll I mean, frankly, a hospital system could lead this, right?

Ms. Monroe Yeah.

Mr. Kroll An insurance company can invest in this. The State of New York can invest in this. It can be built into a system. I believe it can be built into a sustainable business over time. Once the volume has been achieved. It's a high technology business. The technology exists. Sean uses a lot of that technology in his world. We've all benefited from a lot of startup businesses in health care that have built the information system.

Ms. Monroe We'll talk about that at other time.

Ms. Monroe Thank you.

Mr. Kroll You're welcome.

Dr. Rugge I think we are ready to go to the opposite approach post hospital care with Mark Spiezio.

Mr. Spiezio Thank you, Sir.

Mr. Spiezio Thank you to the committee and to the Director for the invite today.

Mr. Spiezio There's pros and cons of being the last one. The pro is that I've got a lot of notes from comments made. I can hopefully address some of those. The other, the downfall is everybody is probably at the end. I'll try to be quick and cover what I need to do. I'm Mark Spiezio. I'm the Chief of Operations for the Cambridge Valley Rescue Squad, which is in Southern Washington County. Even though we're simply forty miles away from where we are right now, we are in a county that does not have a hospital, does not have an OB-GYN practice, does not have a pediatricians practice, has somewhat limited primary care, although most communities have some level of primary care. We have one urgent care, which is in my community, which is the Southernmost community of a county that's ninety-five miles in length from North to South. Very limited in resources. I want to talk quickly about the concept of community paramedics in a program that we have launched and have been very successful with. The concept of community paramedicine is to utilize existing EMS resources in the community to fill gaps in health care that that community may be seeing in a non-emergent way to help reduce the need for ambulance rides, urgent care visits, hospitalizations in areas that, again, it doesn't have to be in a rural area. These are thing programs that can be in urban centers, suburban centers, but ideas to fill health care gaps and services that patients may need. It's to expand the role of those EMS providers, not necessarily to expand the scope. There are some programs nationally that have had expanded expansion and scope of practice, but really most programs are just an expanded role using the scope and the skill set that already exists. Some of the first programs nationally were launched in the first decade of the 2000. Our's started in 2016. Really, the emphasis was relative to some of the readmission, fines or payment structures associated with the Affordable Care Act put people that were sent back to the hospital that necessarily didn't need to go. The hospitals were losing funding or not being reimbursed to the same level. How can we keep these people from going back to the hospital? That's where community paramedicine started. Our program started in 2016. We were one of a handful of programs that started in the New York State prior to COVID under certain regulatory restraints or based on Article 30, there was not a lot of permissive

legislation to allow us to do what we did, but we all found ways to stay within that with the help of the Director to meet those goals. When COVID occurred, with the Executive Order, specifically Executive Order that's been talked about 50 or more community paramedicine programs started in New York State, and they handled things like vaccinations, COVID vaccinations, COVID testing and COVID related responses. Now, that the Executive Orders have expired, those programs are unfortunately not continuing. However, we are very fortunate this year in that permissive legislation was passed that allows for some pilot, community paramedicine programs to develop and to be evaluated over the next couple of years. That's really, really a strong, strong point for us to have. I do have a one-page handout that I'll leave on the desk or on the table on the way out that overviews our program. Specifically, what we did is we took a county wide approach and created a steering committee early on that included folks from the health care community within our county and includes our county public health office, our hospital system, two hospital systems that we particularly work with Glens Falls Hospital in Southwestern Vermont and included our County Office of the Aging. It included the Adirondack Health Institute, which is our regional health home and such. From that we developed what we call the Community Check Program. The Community Check Program is an integrated program that works with patients that either have chronic illnesses or high system utilizers or basically need additional eyes and ears on them in order to avoid the use of EMS services or ER services where the primary care physician can have them in every three months but can't have them in every week to evaluate them, to keep them safe, to keep them healthy while they're at home. We saw our first patient in 2016. Through the end of 2022, we had conducted 3,200 visits within our county and in parts of neighboring Rensselaer County. Of those, we've had 255 total participants in the program with an avoidance rate of 11.1%. How the program generally works is we receive referrals. Initially, most of them came from primary care, but we now receive referrals from inpatient in ER case management. We receive them obviously from primary care. We are now receiving them from some specialty care physicians, certainly from community members, patients, patient family and even from EMS providers who actually are one of our strongest referrals is now that we are doing this program a lot of our own regular EMS providers recognize the need for these folks to be treated or to be assessed further at home outside of the actual 911 environment. When the referral comes in, we first make contact with the patient's primary care physician, or if it's a specialty care physician, we obviously go with the specialty care physician, but primarily it goes to the PCP where they determine if it makes sense for the patient to be in the program. We get patient permission. The primary care physician provides us with a set of parameters. In addition, we get the patient's medical history, their medication profile, recent discharge instructions, labs, anything that may be pertinent to keeping this patient well at home. We then send out a specially trained EMT or paramedic to conduct an at home visit. That visit, the general visit includes a very comprehensive assessment. It includes a physical assessment, vital signs, physical exam. We can do diagnostic testing as well; blood glucometry, EKG's, weights, those types of things and record those. We also do a general, how are you feeling assessment and take those questions into account. We also do a med inventory. We can't because of scope of practice do a med reconciliation, but we do what we call a medication console or inventory. Do you need prescriptions? Are you taking your medications? We'll even look at their pill sorter. Is the little pink pill laying on the floor? Are they not able to get it out of their pill sorter? We're able to determine that and talk to the physician about that. We also do a social and environmental assessment every time we're present as well to determine if activities of daily living, social determinants of health are being met. What kind of support system does the patient have? What kind of transportation system does the patient have? All of those type of things. The visit is recorded on a comprehensive data sheet, and then that data sheet is transmitted to the primary care within four hours after the visit. If while

we're at the particular visit, we notice that something or observe something that's outside of parameters, our protocol is to contact that primary care or specialty care practice immediately from the scene. Generally, we end up talking to a case manager, to the physician's nurse. The range of instructions go from thank you. We'll note it. We'll put it in the file. Things like, well, their blood pressures high. Maybe we need to change their medication. Can you go back every day for the next three or four days and recheck the blood pressure just to make sure that we're doing the right thing medication wise? Wow, this patient sounds really sick. You probably should call an ambulance and have that patient transported to the emergency department. We've had a tremendous amount of success with the program. The patient satisfaction, family satisfaction, and primary care satisfaction rate is well over 95%. We have actually had no complaints from any one of the above regarding the program with the exception of during COVID, we really scaled back and for quite a period of time in 2020, 2021, we did not conduct home visits specifically because these same providers were exposed to COVID patients in a 911 setting. We did not want to potentially bring those particular illnesses to the patient. Some of our success stories of one patient in particular, as some of you here are primary care physicians. We had a patient that was a chronic COPD patient and was starting towards the end stage of the illness was calling 911 once a week for an exacerbation. Got into the program and after a couple of weeks we were able to develop a protocol with the patient's primary care and our service medical director to be able to do treat in place. If the patient exacerbated it, we could do this once every 48 hours. If the patient exacerbated our treat in place protocol was to go there upon request. We able to administer two breathing treatments, steroids, reassess the patient. Certainly, if the patient was alert and oriented and still didn't want to go to the hospital, we didn't take him. If we found that there may be an infectious process or something else taking place, then after the treatment we would take the patient to the hospital if he was no better. We felt that it was really a need to go. We did that over the course of about four years. We treated that patient over sixty times. In each case, without that particular protocol in place, we would have transported that patient to the hospital that number of times. We figure that from a life expectancy perspective, we added at least eighteen months or more to that patient by checking, by being involved with the primary care physician and such. Anecdotally, we don't really track this particular data. The number of times we've gone to a patient's home, and they might have been febrile, slightly feverish. They may not be feeling well. Well, one of our assessments is to talk about, you know, continence issues and such. The number of UTI's that we have uncovered, if you will, by early intervention, by symptomology, then calling the primary care physician, going to our urgent care center, picking up a specimen cup, running it back, grabbing the sample, running it back to urgent care for analysis, and then having a prescription filled and in some cases us going to the pharmacy to pick that script up for the patient bringing it back have been well over two dozen in that time period. If we pick that up on a Thursday afternoon, if we didn't do that, the next intervention anybody would have with that patient would be at 4:00 on Sunday morning when the patient is septic. We're taking them to the E.D. under a sepsis protocol. We've had a ton of successes. One of the themes that I've heard today is the patients with with mental health and certainly crisis, we don't necessarily get involved with this type of program. I would say that somewhere between 40 and 50% of the patients that we deal with have an underlying behavioral health diagnosis. Even the patient population generally we have is the geriatric population. The majority of those have depression and have some other behavioral health. That's complicating their chronic medical conditions. In some cases, it's really causing medication compliance issues. In a lot of cases, these are the patients that are referred and we're able to address those types of things. The biggest obstacle for us is funding. We relied on grants and pay for performance initiatives early on for the program. This funding source has completely dried up. It dried up in 2021. We continue to provide the program, but not to the level it's

needed. We have just incorporated that into our general operating budget. As all the folks have said prior to me, ambulance operating budgets are very slim. Our particular agency relies on 95% of our income from the actual transport of patients and volume to the hospital. We receive very, very, very little in municipal funding. We're kind of pushing it along a little bit at a time. The need has increased significantly. The availability of home health care in our particular area has become incredibly limited. We have actually been asked and have had to turn down several referrals because of scope of practice issues that are beyond what we would do, such as wound care. That's an issue. We were funded substantially early on through Disrupt, and that was a great benefit for us through the program. The other challenge and obstacle that we have and I kind of feel funny bringing it up, but I think it's important to bring up and the Director said it was a good thing to bring to the attention of this group is we've had had some difficulty bringing these programs to the actual hospital setting, the out of hospital health centers, if you will, that are affiliated with the hospitals, love the programs, but getting that within the hospital has been difficult. I had a conversation with an ED physician from a health center, a hospital system a few months ago and asked them why there was such difficulty. Because when you bring this up, the ED folks are excited about the possibility because it relieves the burden on them. The concern was, is that from an administrative level, some health care systems are more concerned about heads and beds than they are about reducing that burden on the ED staff. That they want to see numbers through the front door rather than finding initiatives to relieve that pressure from the ED. From an EMS perspective, I can tell you that recently, you know, as a true story, last week, we transported a patient that we were diverted from one hospital to a higher level hospital with a patient that was in a traumatic injury with bilateral extremity fractures and bleeding that was not to the level of a tourniquet used, but not well controlled otherwise where we waited ninety minutes to offload that patient. Actually, our paramedic had to call medical control from inside the hospital to get orders to continue to do pain management on the patient because they had exhausted their standing orders. I feel truly as everyone else here does, that whatever we can do to reduce that stress on the E.R. is going to be better for the patients. At the end of the day if our program can keep people out of the hospital, though, these recurring people from going back all the way to nurse navigation, you know, not getting EMS called there initially to being able to treat these patients in place. I have story after story of Steve's program with the UCM of successes there. We also continue to branch and open up our community paramedicine programs. During COVID, we established a program called Sick at Home. These were more of a one time or two time visits with patients that were at high risk for readmission that were being discharged from the hospital, that we would go we would check out and make sure they had their meds, make sure they had their discharge instructions, and understood those discharge instructions, and then we would connect them with their primary care kind of quicker than they would from the hospital discharge information. Unfortunately, again, that's a hospital-based referral. That hasn't really developed to the way that we would have liked it to. Certainly, that's a program that's out there that's really great. The Telemedicine Assist Program is again, a program that we've used a little bit. This is for the folks that do not have the technology to actually do a face-to-face telehealth visit with their specialty care physician or their primary care. We bring the technology to them. What's great about us being there is if that physician or mid-level provider would like an assessment done prior to that telemedicine visit, we can do that. We can take those vital signs. We can do that medication inventory. Rather than just a blind telemedicine or telehealth visit, we can do those components and add that as a component to the visit. That's a component that we do as well. We also do fall risk assessments on all of our 911 calls where a patient has fallen. We have a form that we fill out and we get permission to transmit that form to the patient's primary care physician. 50% or more of the patients that fall at home we never take to the hospital. Their

physicians never know they fall at home. By filling this form out we connect those dots quickly. That's our program in a nutshell. The handout has a little bit more detail, but again, I think the success over 3,000 visits with an avoidance rate. An avoidance rate is any time we have to call the primary care. We look at that as a diversion because who knows what would have happened if we weren't there, didn't make that connection. Would that patient have ended up sicker? Would they have ended up needing more medical resources? Again, thank you for the opportunity.

Dr. Rugge Your presentation and your predecessors, I think, show the need for innovation and also how difficult it can be. All the more need for us as a counsel and all of us in the room and on the screen to be working together to find those final solutions. Just a very elementary question. This may go back to our regulators. Does EMS have a requirement to respond to all calls by 911?

Mr. Greenberg Short answer, no. It's a real problem in New York State. In many ways EMS is not an essential service. EMS is a luxury, not a requirement. Most people assume if you pick up a phone you will get an ambulance. That is not the case in every community, in every part of the state. There is no specific municipality or level or anything that sets that expectation and requirement to provide the service.

Dr. Rugge There are communities or there are instances in which no response is available?

Mr. Greenberg There are communities that could face that. We don't believe that's happening often today because what happens is the community next door or maybe two towns away or three towns away will support them, but that is becoming more and more challenging. That's further growing with it. Was talking about before, you know, everything kind of just steamrolls. To go and become a paramedic it takes almost two years of schooling. You can come out and make whatever X dollars is. To go become an RN you go to about two years of schooling and then normally go on for your bachelor’s as well in order to work in a hospital. It's normally a multiplier of what a paramedic would make, you know, one and a half times or anything else. If you're that person who enjoys being an EMT, enjoys pre-hospital care, and now you're looking at the long-term vision, there's a portion of people who say, I want to be on an ambulance. This is what I'm good. There's a portion of the workforce now that turns and says, I need to look at what will pay more in the future. Those opportunities are there. When we start to combine all this, we start to look at volunteerism, we start to look at what Deputy Director was talking about earlier today of, you know, our systems. About a third are career, meaning fully paid about a third are hybrid and about a third are volunteer, if not more. That doesn't equate exactly to the volume. You definitely see more. The call volume is done by career services. Particularly, as we start looking at the rural parts and they're not here any longer, but two of our staffers for the Rural Health Task Force, which is looking at EMS in our rural communities is looking at a lot of these factors and trying to figure out, you know, what are those next opportunities? One of the conversations that actually came up in, again, just trying to get ideas out there was what they had called a PUC or a paramedic urgent care. The theory behind it was in a rural community we put a paramedic in an urgent care with telemedicine to someone sitting at Upstate. Can that be another level of access that otherwise wouldn't have been there? Can we work to get that destination to be approved to be a destination that they can take a patient to because they don't need to go as far? They don't need to drive two hours to Upstate Medical Center? think the Chief was just talking about, you know, we have one urgent care in Washington County. There are access levels. These are all things that compile and continue to make it more challenging.

Dr. Rugge Ann.

Ms. Monroe I just want to understand. Are you saying that if I call 911, they can say na. We don't think we'll come. Is that what you're saying?

Mr. Dziura I'm going to tell you a little story and I'll make it really quick. Last year, I met with a group of EMS providers who told me in their community specifically, a patient had called 911. This is a patient who had undergone a cardiac procedure a week or two before. He had called 911 early in the morning, 1:00, 2:00 in the morning. The county went through seven services and weren't able to find anyone to respond.

Ms. Monroe It's that you don't have the capacity to respond. It's not that you just don't think this person is worthy of a pickup.

Mr. Dziura 911 centers, as I showed you in that General Municipal Law, they do have the authority to do that. Most of them, in fact, I don't know any that just blatantly say no. The issue becomes, is there availability of services? To finish out the story, the patient ended up waiting until 6:00am. 1:00am he called. 6:00am is when an ambulance finally arrived at his house. That was the earliest time that they could get an ambulance to come for an emergency call. It does exist throughout the state.

Dr. Rugge We have our work cut out for us. As I mentioned earlier, this activity of the Planning Committee really started with a simple referral or at least a cry for help in terms of saying that too many times there's offloading delays that are simply unacceptable in terms of service by the EMS, unacceptable in terms of clinical care of the patient. The Health Department then helped us to identify two particular areas that seem so often inappropriate to be in the E.R, mental health problems where there's not the expertise and dental problems, which also there's no clinical resource available. Our previous education sessions were about mental health and what alternative services there could be, oral health and likewise. Finally, we've come to EMS to try to understand where we are and what can we do have two basic problems, and that is how to help care be redirected so every 911 call doesn't mean a trip by the ambulance, to the hospital? How can we do appropriate triage? As a second follow up, equally important issue is, how can we develop the necessary community resources other than hospitals, other than the emergency departments to provide that care? Again, at a time when the entire health care system is under stress and arguably approaching possible collapse, you have to start somewhere. It seems that starting the reform process, the reform thinking at the hospital ramp is appropriate as one necessary place to go. I can only thank you for this kind of explanation of what's in place, what should be in place and intimations of how we should get there. Yes, indeed, I will. Absolutely. I'm not trying to go on and on too long.

Dr. Rugge Denise Soffel, can you help us?

Dr. Soffel You know, John, it's really interesting because as I'm listening today, it feels like the challenges in EMS are almost a microcosm of the challenges facing the entire health care delivery system. I mean, we've heard about scope of practice issues. We've heard about the fact that urgent care is unregulated, and they can choose who they want to see and who they don't want to see and turn people away based on their own financial necessities. We've heard about how payment policy pushes people. We all know whatever the financial incentives are, that's what drives the behavior that follows it. I feel like a lot of what we've been talking about today is not unique to our EMS system and the ambulance

back up issues that we were asked to try to grapple with, but really reflect directly on things that we have been talking about as long as I've been a member. If we can solve it here, maybe we can solve it with everybody. I worry that we won't be able to solve it here because it's fundamentally a much more profound problem. I'm sorry. I have to leave in just a minute, because if I don't get on a ferry now, I will not get to Albany tomorrow. I'm going to be leaving in just a minute. I apologize for missing the end of this conversation.

Dr. Rugge Thanks for joining us.

Dr. Rugge Dr. Tanski

Dr. Tanski Thanks very much.

Dr. Tanski I have to leave, too, because the New York State Fair is starting today, and I need to make sure the medical care there is good. I wanted to make two final points. One of the things that I think that I tried to portray that I've heard from all of my colleagues today is you've seen some examples of some really neat development projects, some creative solutions. Part of that was some of the Executive Orders that were in place. If I had two wish lists for the council and the Department of Health, it would be help us to do some of those things outside of having to have an Executive Order. That might be number one. This is just me speaking. Number two, you know, we heard about ET3, and I understand that that was something that a CMS decision that's a federal decision. I guess what I would say is it's a very complex problem. You've heard examples of four or five really interesting projects trying to address that. I'm not even being asked for funding because I know that's not an issue. The flexibility to try to keep doing those things I think is essential. That's just my opinion. Let's take the projects we've done and make sure we can continue to do those. For me, that's the really essential thing.

Dr. Rugge I can only hope that Shaima is taking notes carefully. She also has a transcript to work from. These are really important points for us to be mindful of and to work together.

Mr. Greenberg I will say on kind of Chris's point. We've also had some great steps. We've had community paramedicine that's now in a pilot program. Even the ability to take some of those and expand them during the pilot period would be amazing. The other big thing out of all this in and this is really, you know, I want to thank Steve for this one, is he's the one at State Council at the meeting who said, we should really go talk to the partners and started these conversations. I just want to say, I think these conversations have been amazing. We really enjoy the collaboration. As we look in the ecosystem, I think even pointed out before, you know, our problems are all similar and so if we can work together. I just want to say thank you for your time and everything on that.

Dr. Rugge Thank you.

Dr. Rugge We're not quite done.

Dr. Rugge Dr. Lim.

Dr. Lim I was just going to actually say something very similar to what was just said. I think, you know, there's been many wonderful projects. I think part of our challenges is that when there's a lot of different innovation and the sources of funding have dried up. It's also hard to sort of pick out, well, which are the ones that we should really focus on and invest

in? Because I think part of the challenge is when there's a lot, you know, when you have too many of different types of services, there creates another level of complexity with that. Maybe there is variations according to region. I think what would be helpful and you don't have to say this today, but just sort of in thinking about all the different innovative projects which are like the one or two that would be really worth focusing on and maybe that's different by region and or, you know, what is sort of like the basic barriers that connect up all of those that we can address to make concrete recommendations on? What is sort of like the driving themes? I think Denise mentioned some of them that we can sort of concretely tackle as opposed to, you know, sort of supporting individual projects because I think if you got too many types of services that creates another kind of problem. Perhaps in another setting we sort of think about what the commonalities are or what are the single things, one or two things that we can really sort of focus our time on.

Dr. Rugge It sounds like you have been working on the agenda for our upcoming committee meeting, most likely late September, where we have to grapple with exactly those issues. What kind of proposals can we come up with that are both workable and effective? That is our challenge for sure.

Ms. Monroe I agree with you, Dr. Lim. And to me, there's an overarching commitment that I don't hear from the policy at large, and that is that we should definitely try to have alternative destinations and treatment in place. If there's a large policy commitment to that, that will drive several different activities, but some of which may not include EMS. I have been in a million meetings where everybody's talking about their care coordinators. They're the kind of thing that you talked about that you're doing in people's homes. I thought that was happening all over the place with different funding sources and whatever. If there's a real overarching commitment to treatment in place and alternative destinations, I believe that can drive some of those discussions that we've been talking about in a more productive way than in small groups here or there who may in fact, be competing with one another. I'd like to see that as something that we might take on, is that this is a strong commitment as a whole, as we design the systems of the future.

Dr. Tanski Please include telehealth in that.

Ms. Monroe What?

Dr. Tanski Telehealth?

Ms. Monroe Oh, I forgot telehealth, but you're right.

Dr. Tanski It's an essential part of that.

Mr. Spiezio In addition, one of the other hats that they were, as I do, sit on the Rural Ambulance Task Force, as the Director had mentioned. One of our tasks is to create a list of legislative agenda items or recommendations. One of our discussion points has been to advocate and lobby other EMS related state associations and such. I'm thinking that this particular group may be also a group to bring some of those some of our recommendations too for possible endorsement or backing as well, and maybe have a powerful backing to to have you folks on board because we're discussing those exact same things. Certainly, they are on the high level of the priority list of that particular group as well.

Mr. Greenberg I will add that third to that, which is the treatment in place, the alternative destinations, and use the providers, these well-trained health care providers, to the capabilities of what they have. I think you saw that down with each step, you know, in the E.R., in a pre-hospital environment, in a post care environment. That's probably one of the biggest obstacles if you'd ask, you know, what's the obstacle? It's being able to use the talent and the expertise based on the training that they have in more settings than where they are today.

Mr. Dziura I'd like to just add a comment.

Dr. Rugge Yes.

Mr. Dziura Most of what we've heard about today and most of what we've talked about in previous meetings has been driven by the fact that the system reached a point where it couldn't sustain what was happening anymore. A lot of all these great projects are really driven by necessity. One of the things I want to make sure that all of us and I know in the back of our mind it's there and probably, you know, somewhere in the forefront. It hasn't been said is, what is the public expectation? I think you hit on it earlier. When you call 911, your expectation is an ambulance is coming. How do we get to that expectation? A patient doesn't expect to be in an ED for two, three, four hours waiting on a stretcher, on an ambulance stretcher. They don't expect to be waiting 24 hours in a waiting room. I think a lot of what can drive the decisions that need to be made is the simple question of what is it that the patient, our patients or the public expects of us, the regulators to create? I think if we start with those fundamental questions, we can almost build the list itself of things we need to fix.

Dr. Rugge Unfortunately, many patients now do understand they will be waiting not two or three hours, but eight or twelve hours. That's yet another problem that we may have to come to. All I can do is say thank you. Once again, give my condolences to Shaymaa for trying to put all this together in a way that is workable. I'm going to give this my condolences and the thanks go to our presenters who are incredibly effective and inspiring and to see the collegiality that you all have with one another is also very heartening. It's what we need all across medical practice.

Dr. Rugge Any other comments?

Ms. Monroe Thank you very much.

Dr. Rugge I thought everybody knew that. No, thank you for sure. This is very helpful. We couldn't move forward without this kind of background and this kind of telling.

Ms. Monroe Go to the state fair. Don't forget the butter cow.

Mr. Greenberg Tell me when we're off camera.

Dr. Rugge Thank you to our screen presenters to very much.