CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON FIRE AND EMERGENCY MANAGEMENT

Jointly with

COMMITTEE ON OVERSIGHT AND INVESTIGATIONS

And

COMMITTEE ON HOSPITALS

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November 1, 2024
Start: 10:06 a.m.
Recess: 1:07 p.m.

HELD AT: Council Chambers - City Hall

B E F O R E: Joann Ariola
Chairperson

Gale A. Brewer
Chairperson

Mercedes Narcisse
Chairperson

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Carmen N. De La Rosa
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A P P E A R A N C E S (CONTINUED)

Lynn C. Schulman
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Susan Zhuang
Diana I. Ayala
Chris Banks
Rita C. Joseph
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Rebecca Mason
Assistant Commissioner FDNY Management Analysis and Planning

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President of EMS Local 2507

Maisha Morales

Santa Morales

Tyler Weaver

A P P E A R A N C E S (CONTINUED)

Stu Weiss

Christopher Leon Johnson

SERGEANT AT ARMS: Good morning. Good morning. Welcome to the hearings on the Committee on Fire and Emergency Management, Oversight and Investigations, and Hospitals. At this time, please silence all electronics and do not approach the dais. I repeat, do not approach the dais. If you wish to testify, fill out a slip at the back of the room even if you singed up online. If you wish to testimony online you may do so at testimony@counil.nyc.gov. That is testimony@council.nyc.gov. If you need any assistance, please contact the Sergeant. Chair, you may begin.

CHAIRPERSON ARIOLA: Good morning. My name is Joann Ariola and I am the Chair of Fire and Emergency Management Committee. I would like to begin by acknowledging my Council Members who are here today, by Zoom Council Member Moya. I'd also like to thank Chairs Brewer and Narcisse for their work on today's hearing, and welcome and thank members of the Administration and the public who have joined us today and will be providing testimony on this important topic. Today, the Committee on Fire and Emergency Management along with Committees on Oversight and Investigation, and Hospitals will be

holding an essential oversight hearing on ambulance response times. As we all know, our first responders, notably EMTs and paramedics, but also firefighters, are tasked with delivering critical emergency medical care throughout our city. These dedicated public servants routinely provide life-saving care and respond to around 1.6 million emergency medical calls each year, and we are forever grateful for their service to tis city. At the same time, we must acknowledge that EMS workers undertake an immensely difficult job due to the stressful work conditions, long hours, and emotionally-challenging work. Not only that, EMS workers, particularly those employed by the FDNY, are vastly underpaid for the vital jobs they do. Yet, despite these obstacles, each day thousands of ambulance workers strive tirelessly to serve this city and deliver timely emergency medical care to all New Yorkers. Despite a dedicated and talented workforce, it is apparent to anyone paying attention that our city has struggled to meet its obligations to provide timely emergency medical care to all New Yorkers. Publicly available data clearly reflects this disturbing trend which began before the COVID-19 pandemic and has

substantially worsened in the last year. For example, the average response time for life-threatening medical emergencies increased nearly one minute in the last five years from six minutes and 22 seconds in fiscal year 2019 to seven minutes and 23 seconds in fiscal year 2024. This is a 10 percent increase. For these most critical incidents, the most serious medical emergencies such as an individuals in cardiac arrest or an unconscious person, every second counts, and the patient outcomes can be dramatically altered by even the slightest delay in the provision of medical care. I am extremely concerned that New Yorkers are facing negative health outcomes due to the delays in the delivery of emergency medical care and the worry this instills in the lack of public confidence in our city's ability to provide vital services when they are most needed. As Chair of Fire and Emergency Management, I expect to hear testimony from the Fire Department that will provide clarity as to why we have seen dramatic increases in response times for emergencies-- medical emergencies, particularly in the last year, and learn more about department procedures related to dispatching, staffing, and

maintenance of ambulances. But also, the Department and Administration are able to speak more broadly hopefully of a commitment to dedicating increased resources to the provision of pre-hospital emergency and truly remain dedicated to examine the agency's operations and interagency coordination to identify how the City can reverse this troubling trend of increased emergency response times, because we cannot continue down this same path. I now yield to Chair Brewer for her opening remarks.

CHAIRPERSON BREWER: Thank you very much, Chair Ariola and good morning everyone. I am Gale Brewer. I'm Chair of the Committee on Oversight and Investigations. I want to thank everyone for joining us. As you heard, we will be examining ambulance response times, the Fire Department's allocation of EMS resources and efforts to improve Emergency Medical Service operations. I do want to thank Co-chairs Council Member Joann Ariola, Chair as you know of Fire and Emergency Management, and Council Member Mercedes Narcisse, Chair of the Committee on Hospitals. I also want to thank the representatives from the Administration. I know it's never easy to prepare to come here today. I know what it's like.

I've been there. Members of the public and all of my committee colleagues. Committee on Oversight and Investigations most recently took up the topic of emergency response times during an October 2023 hearing held jointly again with the Committees on Fire and Emergency Management, and Health, and Housing on key indicators from the Mayor's MMR related to agency performance on inspections and responses. During that hearing the Committees noted that ambulances were taking longer than they had in the past to get people to dire medical need. Today, more than a year later, the available data do not paint a picture of city government performance going in the right direction. I know there are many reasons for that. In fact, in fiscal year 24, dispatch and travel times to life-threatening medical emergency for ambulances and fire companies combined increase 20 seconds compared to fiscal year 2023. From 7:03 to [audio cuts out]-- that's an issue. The number and location of operational emergency vehicles, we want to learn a lot about that, and insufficient personnel to staff them. They all contribute to the overall increase in emergency response times, and hopefully we're here to figure

out what to do about all of this. Today, we will question representatives of the Fire Department and Health + Hospitals regarding several of these issues and what their agencies, what you are doing to mitigate. To understand ongoing trends in EMS response times, the Council's Oversight and Investigations Division staff-- and I want to thank them tremendously-- analyze call volume, response time, and staffing, and ambulance count data. According to the most recent Mayor's Management Report, the overall average FDNY EMS response time to life-threatening medical emergencies dispatch and travel time has increased more than one minute, as you heard earlier, since fiscal year 2019 from six minutes and 22 seconds to seven minutes and 23 seconds with an increase in response times of 20 seconds occurring in the last fiscal year. for non-life-threatening emergencies, the average response time has risen nearly seven minutes during this period, reaching nearly 18 minutes in fiscal year 24, and that is all increased dramatically I should add in some parts of the five boroughs, different places different increases. Further examination of publicly available data on medical response times, as I said,

indicates disparities in response times based on the location of the incident with certain boroughs and neighborhoods experiencing significantly higher response times than citywide averages. Finally, data from FY24 indicates that while call volume has stabilized, response times continue to increase. So I look forward to exploring these trends during the hearing. We need representatives of the Fire Department and Health + Hospitals to explain why the daily workings of city government related to emergency response times have so clearly slowed down and what they need from us and from the public and from the Administration to get back on track. The delivery of efficient and reliable public services are not only a crucial element of governmental administration-- as you know better than I do-- in this case it can be matter of life and death. I would like to thank the following Council Staff for their work on this hearing, from the ONI Committee Staff, Nicole Cata [sp?], Erica Cohen[sp?], Alex Yablon[sp?], and Owen Kotowski [sp?], and from the ONI Division Staff, Meagan Powers [sp?], Zachary Meher-Casallas [sp?], Kevin Frick [sp?], Uzair Qadir [sp?],

and from my staff, Sam Goldsmith. I'll now turn it over to my co-chair Council Member Narcisse.

CHAIRPERSON NARCISSE: Good morning, everyone. I'm Council Member Mercedes Narcisse. Thank you the Committee on Fire and Emergency Management and Oversight and Investigations for holding this hearing, and as the Chair of the Committee on Hospitals and a registered nurse, ER Nurse, if I may say, I'm acutely aware of the critical role of timely emergency medical services and how the health and safety of our communities rely on their swift response. The delays in ambulance response times are putting lives at risk, particularly in the neighborhoods like those I represent in District 46 which are already vulnerable due to a lack of nearby hospitals in our communities where resources are stretched thin and every second counts. These delays can mean the difference between life and death. As someone who has worked in emergency care, I know firsthand the pressure that healthcare providers feel in delivering the best possible care while managing high patient volume, but when ambulances are delayed, the pressure multiplies, not only in the ER but also for families and patients

who are left in critical situations waiting for help to arrive. New Yorkers deserve to know that. In an emergency, an ambulance will be there ready to take them to a hospital where they can receive timely life-saving care. Like I always say, it's a tick-tock moment for someone's life. Yet, today we are seeing troubling data on how ambulance response times have been steadily increasing. We know this issue did not arise in a vacuum. The situation has only worsened with the closures and down-sizing of essential hospital services. The planned closure of Mount Sinai Beth Israel and the cuts to services at SUNY Downstate mean we are not just losing beds, but eroding critical access points for care. This will place an even greater strain on our safety-net hospitals in emergency departments which are already overstretched, undersupplied. When these facilities close, the burden falls disproportionately on hospitals like Bellevue and Kings County which are dedicated to serving all who come through their doors, regardless of ability to pay, but even the most resilient safety hospitals have their limits. We are also facing a national shortage of emergency medical personnel which has further compounded the

issue from nurses and physicians to EMTs and paramedics. All emergency medical staff are overworked and underpaid, forcing many to leave the professions they love. In the past year alone, New York City has seen an increase in emergency department visits of over six percent with wait times for hospital beds rising to 26 hours. Our emergency departments, especially in the neighborhoods like mine that lack sufficient healthcare infrastructure cannot keep absorbing these growing needs without a plan to address staffing and capacity. Our emergency departments are already grappling with the effects of the COVID pandemic. Many patients delayed care during the height of the pandemic, and now we are seeing increased visits from patients with complex and chronic conditions who urgently need help. After these challenges posed by our aging population, the ongoing opioid crisis and the historic shortages of medical staff, and you have a perfect storm that is overwhelming our hospitals. Let's be clear, when our emergency response system is shown [sic] down by overcrowded ERs and extended wait times, lives are put at risk. The staff at our hospitals and on our ambulances are working tireless, often facing

impossible demands. I have seen their commitment firsthand, but even the most dedicated providers can only do so much when resources are so constrained. We owe it to New Yorkers to address these gaps in our healthcare system now, not tomorrow. We need to provide a [inaudible] funding, innovative solutions, and strategic response that brings care closer to those who need it the most. Now, I will stop and say thank you to the Chair. Chair Ariola, thank you, and Chair Brewer with all the Committee Staff and all my staff that make it possible for the hearing. With that, I will now turn it-- oh, now, I would like to recognize Council Zhuang, sorry. Now, I will now turn it over to Chair Ariola to convene this hearing. Thank you, Chair.

CHAIRPERSON ARIOLA: Thank you so much, Chair. I would now like to ask Committee Counsel Nicole Cata [sp?] to administer the affirmation.

COMMITTEE COUNSEL: Thank you, Chairs. We will now hear testimony from the Administration. We will hear from Rebecca Mason, Michael Field, Evan Suchecki, and Doctor Adrian Birnbaum. Panelists, please raise your right hand. Do you affirm to tell the truth, the whole truth and nothing but the truth

before these committees and to respond honestly to Council Member questions? Thank you. You may begin when ready.

CHIEF FIELDS: Good morning Chair Ariola, chair Brewer, Chari Narcisse, and members of the Fire and Emergency Medical-- sorry-- Emergency Management Committee, the Committee on Oversight, and the Committee on Hospitals. My name is Mike Fields and I am the Chief of Emergency Medical Service at the New York City Fire Department. I am joined by Evan Suchecki, Chief of Fleet Services, and Rebecca Mason, Assistant Commissioner for FDNY's Management, Analysis and Planning. I am grateful for the opportunity to speak with you today about EMS response time and actions that were taken at the Fire Department to improve. In recent years, EMS response times have increased. In the years before COVID-19, fiscal year 20, the average response times of ambulance dispatch and travel to life-threatening medical emergencies was seven minutes and 37 seconds. During the pandemic, with more units on the street and far less traffic, that time to fell to six minutes and 46 seconds. However, in years following the pandemic, it returned to pre-COVID times and has

grown higher. In fiscal year 22 it was seven minutes and 26 seconds. In fiscal year 23 it was seven minutes and 59 seconds, and in fiscal year 24 it was eight minutes and 16 seconds. There are a few different factors contributing to this increase. I'll briefly go through these factors and then tell you about actions that the Department is taking to mitigate these challenges and improve our response times. In short, the Fire Department has taken an aggressive comprehensive approach looking for ways to improve every aspect of the 911 process. Commissioner Tucker has made this a priority of his administration, and I am happy to share a number of those initiatives with you today. First and foremost, overall call volume continues to increase. This is a trend that has continued year after year for as long as I have been invoked in EMS. To be specific, the total number of emergency medical incidents in fiscal year 22 was 1,531,959. In fiscal year 23 it was 1,613,316, and in fiscal year 24 it was 1,644,446. Not only is the number of overall calls increasing, but these increases include a growing number of life-threatening calls. Between fiscal year 23 and fiscal year 24, the number of

segment one through three calls which the Fire Department defines as life-threatening increased by five percent. In fiscal year 23 we responded to 605,140 life-threatening incidents. In fiscal year 24 that number grew to 633,361. That's more than a 28,000 additional calls. In response to the COVID-19 pandemic, the Fire Department surged a number of ambulance tours. In addition to bringing them mutual aid units from outside the city during the busiest time periods, we ran more FDNY tours and we asked our hospital partners in the private sector to contribute more tours to the 911 system. Together those efforts meant that we had more units than ever on the streets of New York. At the height of the pandemic, we were running approximately 520 units. Naturally, having more units in service meant that we were able to respond faster. This was especially true to the number of COVID calls dropped off, and we continued running an elevated number of units. Over time, though, we had to return to pre-pandemic levels of ambulance tours. Post-COVID we are back to approximately 460 units per day which is the level that they were at prior to the pandemic. As the number of calls increases, this creates a larger work

load for each unit. We have also experienced some of our private partners with drawing their units from the 911 system. Recent examples have included private hospitals removing a handful or even up to a dozen daily ambulance tours. When a hospital pulls out the 911 system, it falls on the Fire Department to fill the gap. Filling those gaps puts a strain on the rest of the system. There are numerous options available today to individually experiencing a non-life-threatening medical issue. We are undertaking efforts to educate people about their abilities to seek medical care at urgent care centers or other non-emergency room destinations. If we can reduce the number of unnecessary 911 calls, that will free up dispatchers and alleviate the burden on emergency medical technicians and paramedics in the field. The more we can focus our efforts on genuine emergencies, the better we can serve those patients. Council Members have often been very helpful in getting safety messaging out to your constituents. We thank you for that and we look forward to working together on these issues. We are also working with Health + Hospitals to increase the use of telemedicine. In appropriate cases, the EMS crew on-scene is able to

connect the patient with a doctor to learn about treatment options that do not require a trip to the hospital. In cases where the patients opt for treatment without requiring a transport, the EMS members can make themselves available for the next call even faster. As I have testified to the Council previously, another significant factor that drives increase in EMS response times is hospital turnaround times. When an ambulance crew transports a patient to the hospital emergency department, they don't simply drop the patient. They simply don't drop the patient off. Under New York State Law, EMS personnel must remain with a patient until a medical professional at the hospital takes custody. In cases where the patient does not receive immediate emergency care, the EMTs or paramedics who transported the patient must stay with him or her until hospital personnel are ready. We refer to the length of time that it takes from the arrival at the hospital to departing and becoming available to take the next call as turnaround time. In recent years, we have experienced average hospital turnaround times increasing from 34 minutes in fiscal year 21 to almost 41 minutes in fiscal year 24. This means the

EMS units are not in service and are unable to get to the next 911 call for longer periods of time. This increase in turnaround times can be attributed to multiple factors. Hospitals are crowded. With each new hospital closure, the remaining emergency departments become busier. Our partners with Health + Hospitals can discuss this issue in greater detail. Getting units back into service as quickly as possible after a patient transport is a priority. We are attacking these issues with a multiple prong approach. First, we are implementing a pilot reallocating critical staff to serve in the hospital liaison officer position at the busiest H+H hospitals. These officers will be on-hand when the EMS crew arrives and will take possession of the patient until hospital personnel are ready to take custody. In this way, the HLO remains with the patient and the ambulance crew gets back out into the field, available to take the next call. We will continue to assess and evaluate this staff redistribution pilot as we move forward. We are also sending station-based EMS officers to hospitals during the course of their regular shift on a needed basis to assist with the efficiency of EMS drop-off.

We monitor hospital turnaround times on a real-time basis. As we spot problems developing, we dispatch officers to help facilitate transfers and create a more manageable environment. Another factor that leads to higher response times is the changing nature of traffic in the city. It's not easy to precisely quantify each effort, but there's more traffic and congestion on the streets. There are also more impediments in the streetscape such as permanent bike lanes barriers and outdoor dining structures. While these serve other public safety purpose, one indirect effect of these efforts is that there are fewer places for traffic to move when trying to make way for ambulances and other emergency response vehicles. Speed limit decreased under the previous Administration. With each hospital closure, EMS responders are forced to transport patients longer distance to reach a hospital. Looking at the changing landscape of the last several years, ambulance crews re transporting more patients longer distances and they are doing so at slower speeds. I will detail a few other measures that we are taking to improve EMS response. Commissioner Tucker tasked us with examining every aspect of EMS response to

improve our time, and that means looking at the time that we take to process a 911 call before an ambulance is even assigned. We have found that during times of high call volume, the faster we can gather more information from callers, the more efficiently we can get ambulances dispatched sooner. We have redeployed personnel to strengthen communication staff in the EMS dispatch offices with the goal of improving triage and ultimately improving response. When crews in the field have a better idea of each call before they arrive, thy can get the patient the life-saving care that he or she needs as quickly as possible. We have also piloted an effort known as Adam Response Units, using data to assess the greatest area of need. We position the BLS non-transport unit in busy areas, enabling them to reach patients and initiate care faster while a transport ambulance arrives subsequently to get the patient to the hospital. In this way, the patient begins receiving care even before a transport ambulance arrives. Preliminary pilot shows positive results when tested in two places, one being Randall's Island, the other being near JFK Airport. We also continue dispatching EMS ASAP vehicles to dense areas

of the City that have proven to be difficult for traditional ambulances to maneuver. We place these smaller vehicles staffed with EMTs in crowded locations that experience high call volume so that we can get emergency care to patients as quickly as possible despite the fact that it takes longer-- traditional ambulances longer to arrive. We have been successful placing ASAP units in places like Times Square and at beaches in the summer. I thank the Council for your partnership and your attention to this critical issue. I will be happy to take your questions at this time. Thank you.

CHAIRPERSON ARIOLA: Thank you, Chief. Thank you for your testimony. I'd like to jump right in and go to the portion of your testimony about increased call volumes since that's the whole meaning for this particular hearing. So, has-- you're stating that-- and you gave us all of the statistics and the years, and I appreciate that information. But has EMS headcount increased, and has the EMS headcount increased to account for the rising call volume? Have you looked at increasing the headcount at EMS?

CHIEF FIELDS: So, in respects to the EMS headcount, it has increased over that period of time. We have an open academy in which we try to process at least 180 to 200 members every four minutes. We do that in anticipation for promotional examination that's coming in September of 2025. So, in respects to staffing we haven't had an issue with that. The problem that we're having is attrition. We have a large number of our members that are leaving the Department to seek work other places. So, trying to establish recruitment, to keep the recruitment up with the amount of attrition has been the problem.

CHAIRPERSON ARIOLA: And I think that the reason for them going to other places is because the pay parity just isn't there, and they can't make ends meet with the money that they're getting paid. But according to 2507, the local union overseeing the EMS, they say that they have a vacancy of 90 Lieutenants and that's creating severe delays. Would you agree with that?

CHIEF FIELDS: So, currently we do not have a vacancy, but I do agree that in the past prior to this summer we had vacancies that were upwards of 90 Lieutenants and that was secondary to there not

being a DCAS [sic] list available at the time. Since then, the DCAS list has been made available. We promoted a total of 47 in one class in July and then we just promoted an additional 51 in September of this year. So, our headcount in respects to Lieutenants in offices is on point. It's equal.

CHAIRPERSON ARIOLA: So, that should show us a decrease in response times now.

CHIEF FIELDS: Definitely having supervision in the field will assist us with decreasing response times. We're utilizing that supervision in respects to a pilot program which we call the HLO which is the Hospital Liaison Officers. We're placing those officers into nine of the busiest H+H facilities along with two EMTs and we're utilizing them to transfer the patients. So, when the EMT-- when the EMS crew comes into the emergency room with a non-life-threatening emergency, they pass that patient onto the officer and the two EMTs and then they're made available to go back out to the next 911 assignment.

CHAIRPERSON ARIOLA: So, since we're onboarding people and we're closing gaps in deficiencies in headcount, on average how many

ambulances are out of service at any given time, and what would be the reasons?

CHIEF FIELDS: I'll let Suchecki answer that question.

CHIEF SUCHECKI: If you're talking about from the fleet perspective, from our emergency frontline fleet, we carry an approximate number of 21 percent of out-service. Of that 21 percent, 10 to 12 percent is always our preventative maintenance cycle which we call out every 45 days to ensure that the vehicles are appropriate for emergency response both safety and mechanically. That out of service percentage doesn't necessarily directly impact EMS operations as we maintain a buffer between the total fleet count and the total needed for operational use.

CHAIRPERSON ARIOLA: How many ambulances do you have in your fleet?

CHIEF SUCHECKI: So, currently right now our frontline fleet number is 669.

CHAIRPERSON ARIOLA: And how many are on the street?

CHIEF SUCHECKI: Minus 143 based on the out of service brings us to 526 currently available.

CHAIRPERSON ARIOLA: Currently available. Okay. The ambulances that are out of service-- that they were out of service due to staffing will now be put back in, correct? And but how many of them are ALS versus BLS ambulances?

CHIEF SUCHECKI: So, anything that's out of service based on staffing is more an operational question. Anything that's out of service based on fleet is not necessarily ALS versus BLS. An ambulance is an ambulance. It's based on the personnel that EMS operations assigns to it. So we do our best just to turn the vehicles around so EMS operations can utilize them as needed.

CHAIRPERSON ARIOLA: And what are we doing to get those extra ambulances that are out of service back in service? And what's the turnaround once they go out of service and they need some type of mechanical attention? What's the turnaround to get them back on the road?

CHIEF SUCHECKI: So, the turnaround is really dependent on what the reason they're out of service for. If it's our preventative maintenance cycle, we shoot for two weeks as a max, and we do a full safety inspection to ensure that there are no

mechanical issues that are brought to our attention during that. If it's something other than that, meaning out of service for a mechanical, for a warranty issue, a recall, it really depends on the extent of the issue and whether we're handling it in-house or it's a warranty issue that we have to send out. So it really does vary. But as far as the PM, we try to turn those around very quickly, the preventative maintenance.

CHAIRPERSON ARIOLA: Would one of the reasons why they don't get back out is because you lack the resources to fix them?

CHIEF SUCHECKI: Resources as far as staffing are always welcome. We're, you know, getting the job done with what we have. We were just approved for another 12 hires of auto mechanics and auto service workers, but any additional staffing would always benefit the bureau of course.

CHAIRPERSON ARIOLA: What about resources for the actual parts that are necessary to fix what's broken on the ambulances?

CHIEF SUCHECKI: so, parts is coming back to a normal availability, but we are still seeing

challenges based on COVID and, you know, the past issues from that.

CHAIRPERSON ARIOLA: And is your budget at the right level to make all those adjustments, you know, for the ambulances to get them back out?

CHIEF SUCHECKI: We are able to appropriately use the budget that we have for in-house maintenance and out of service-- out of house as well.

CHAIRPERSON ARIOLA: Okay. Let's go over to geographic disparities. So, data from the City reflects geographic disparities in emergency response times are citywide. There was further public data that shows various areas that had disparity and longer response times. They were upper Manhattan, north Bronx, Astoria, Greenpoint, and I'd like to add to that Breezy Point on the Rockaway peninsula, because they're just seeing enormous response times and there was a fatality that could have been-- fate, its fate, but I would hope that that person could have been saved. So what are we doing? And how would you explain such dramatic changes in response times in certain neighborhoods as opposed to others?

CHIEF FIELDS: So, the uniqueness of EMS in itself is that our resources are-- they may start the day off in the particular areas. So, I want to utilize the 75 precinct. So, the 75 precinct, we have numerous ALS and BLS units that are inside that precinct area, but due to what we call hospital deserts-- only hospital that services that community is Brookdale on the Brooklyn side and Jamaica Hospital on the Queens side. So, any resources that starts the day off inside that respective area, when they're going to taking people to the hospital, they have to leave those respective communities and now they're in Queens. So now, Brooklyn has less resources. So, we're trying-- we're hoping that when we get on board with our new EMS CAD [sic] system, we will be able to leverage the new technology to make that happen less often. So, we're working towards that. We are constantly looking at the amount of outliers, and outliers are level one through three or priority one through three assignments that have response times that are greater than 10 minutes. We look at the data and we try to leverage, reallocate resources to those respective areas.

CHAIRPERSON ARIOLA: And you mentioned also that, you know, that working with Health + Hospitals, you know, you were looking towards telehealth. So, if an EMS crew is on scene and wants to connect a patient with a doctor, are there ways to do that with telehealth, with H+H prior to dispatch? Can we do that prior to an ambulance being dispatched just to save time so that ambulance isn't taken out of commission?

CHIEF FIELDS: We can. We actually have that set up now. It's called telemedicine. It's part of the-- it used to be part of what used to be called the ET3 Program, but with telemedicine, as the ROs are prioritizing the assignments and speaking to the patient or the patient's family, if they fall within a certain criteria, we take those calls and we transfer them over to H+H. Then H+H doctors review those calls and determine whether or not an ambulance needs to be dispatched, or does the call need to come back to 911 for us to respond.

CHAIRPERSON ARIOLA: Okay, and as long as we're on the topic of dispatch-- in what circumstances would 911 for a medical emergency not result in an ambulance dispatch? How often does it

occur and who makes the decision whether to dispatch an ambulance or not?

CHIEF FIELDS: Based on the current status that we have, if you call 911, we're going to dispatch an ambulance to you. We prioritizes those assignments, priority one, two and three or our life-threatening emergencies. Those are your cardiac arrests, you're unconscious, you choke, some cardiacs [inaudible] for the most part. And then we have what we call non-life-threatening emergencies. Those are abdominal pains, sick calls. They're still going to get a response, but the first one, you know, we response one through six with lights and sirens. Priority sevens and eights don't require lights and sirens to go to those emergencies. So everything is about triaging. We want to make sure if you call 911 that we're going to get an ambulance to you, but we take priority on the priority assignments. So, if you call, we're going to send somebody. What we have been trying to do with this system is utilize telemedicine to identify the low acuity call types, the ones that we feel that you can speak to a doctor right away and maybe that doctor can be able to assess you via on the phone and then possibly send

you to urgent care center or provide some other type of care without you going to the emergency room.

CHAIRPERSON ARIOLA: I just want to make mention that we were joined by Council Member Susan Zhuang for the record. So you mentioned about lights and sirens. Is there a way of you tracking whether or not ambulances are using lights and sirens on calls where they shouldn't be?

CHIEF SUCHECKI: All our ambulances have vehicle telematic [sic] devices installed so we're able to track all that information.

CHAIRPERSON ARIOLA: Would you have that information for us, and if-- I know you may not have it today, but I'd really like to see that, because we see a lot of ambulances going through our communities and a lot of complaints that we're getting from our constituents about ambulances with their lights and sirens going on at all hours of the night and the day, and it's hard to believe that they would all be, you know, going to a life-threatening event. So, if you could get that for our council, I certainly appreciate that. I now yield to Council Member Brewer.

CHAIRPERSON BREWER: One question I have is-- you have I think 37 locations where you have ambulances, but you probably-- I know in Manhattan you probably need more. How does-- how do you decide where you're going to put, and do you need more locations to put ambulances? Space is always an issue, I think.

CHIEF FIELDS: So, we have total of 40 different stations.

CHAIRPERSON BREWER: 40, okay.

CHIEF FIELDS: The ambulances do not sit at the stations. They actually sit at cross-street locations. It's-- it helps with response times to have them at a central location as opposed to having them at a station. We always welcome having additional resources in respects to whether ALS or BLS. We look at the data. we allocate the resources based off the needs inside the community, but I think one of the biggest issues out there is that these resources aren't staying inside of those respective communities because hospitals are closing and they are going outside the community that they're supposed to service.

CHAIRPERSON BREWER: Okay. I do want to thank Kristy Marmorato and Chris Banks, both Council Members for being here. The other question I have is when the fire-- this-- I think it's confusing to the public, not to you, to explain to us-- obviously, there are more fire houses than there are ambulance stations. So, the question would be, 911 fire response, meaning the engine as opposed to the ambulance. Can you explain that just so the public understands why the fire engine might respond more quickly and how that relationship works?

CHIEF FIELDS: So, fire engines or CFRDs is what we call them, they respond to medical emergencies high acuity, so priority one through three assignments, not all of them, but quite a few, cardiac arrest, chokes. They are centrally located at their fire houses, and as you see them inside the communities they cover a geographical area. There are less fires than medical emergencies, so the availability is higher, and therefore we utilize them to respond and utilize their training to get there and provide medical care to the patient and until our transport ambulance or paramedics can arrive to the location.

CHAIRPERSON BREWER: okay. And that seems to be working in a sense that they don't have a fire to respond to. Obviously, if you had more ambulances, then maybe you wouldn't need the fire apparatuses as often, right?

CHIEF FIELDS: That would be a way of looking at it, yes.

CHAIRPERSON BREWER: Okay, alright. From my numbers-- I'm not great at math. I think there's 70 according to-- Council Member Ariola was asking, there are like 70 ambulances that are not in use because-- not those that need repairs. Is that correct? Is that about the number, 70 ambulances that are in storage because they-- there's just no staffing for them, I'm assume. Is that the right number?

CHIEF FIELDS: So-- I'll do it. So, ambulances not being utilized versus units. So, ambulance is just the vehicle itself.

CHAIRPERSON BREWER: We need staff. You need staff.

CHIEF FIELDS: Correct, I definitely agree with you. So, ambulances, the unit is-- ambulance is the unit itself, the units are the ones

that we utilize on a daily basis. So, for 12-hour shift, for what we call tour two which is a day shift, we have a total of 330 FDNY ambulance units that service the entire city, right? On top of that we have 120 that are part of our partnership with voluntary hospitals. On the evening shift we have 319 FDNY ambulances, and then with the volys [sic] we have the same amount I think we have in the day time that we have in the evening. So those are the ambulances that are out there daily. There are times in which we run down ambulances based off staffing, that is correct. That staffing could be based off people being on vacation, somebody being out sick and it's a last-minute call-in and we don't have proper staffing to back up that vacancy. So, yes, there are days in which-- you know, flu season, I have dedicated individuals that's out there on the front lines dealing with the sick and injured every day, so therefore they're going to become sick at times, and they're going to become injured, right? And we have to try our best to account for those type of vacancies, but sometimes they come in mass amounts and we can't run ambulances.

CHAIRPERSON BREWER: Okay, but I guess we're all trying-- you got the traffic issues. You got the record call volume, which I love to know what you think the 28,000 increase is from, emergency room delays-- I mean, we've all been talking about that and of course the staffing in the emergency rooms and for you. So you mention telemedicine. It's an idea. I don't quite know if I'm on the street if I know the lady's collapsed. I'm calling. I don't know if I can do telemedicine even though it may not be life-threatening. She may have fallen. She may have gotten hit. It's an idea. I do like your idea of having somebody at the emergency room. How many emergency rooms are staffed with this new staff person who can take over if appropriate or the EMS personnel? How many hospitals have that now?

CHIEF FIELDS: So, this is a program that we did in the past. It was a total of five hospitals at the time spread throughout the City. Currently, we have our members in training for this program and we have-- we're having them out November 10th is when we're going to start the initiative. By December 29th we should have the members 12 hours a day, seven days a week, inside of nine of the 11 H+H hospitals.

CHAIRPERSON BREWER: Okay. That sounds like it will help quite a bit. The other question I have is, again, looking at this list, why do you think the record call volume is up so much? Is there-- I mean, you're on the street, so you have an idea more than we do.

CHIEF FIELDS: I believe, my personal opinion, is that the public needs to be educated. They are utilizing the emergency room as their doctor's office, and they're utilizing the ambulance as ride to the emergency room. So, you know, that has increased over the years.

CHAIRPERSON BREWER: Alright, so it's not that there's another level of emergencies. It's lack of education about what an emergency is. Can you describe the process? Because I think what's happening, at least from my knowledge-- you've got life-threatening and then you have the non-life-threatening.

CHIEF FIELDS: Correct.

CHAIRPERSON BREWER: Can you talk a little bit more about the non-life-threatening, because that's tying up your staff also.

CHIEF FIELDS: That is. The non-life-threatening emergencies are the calls that we consider to be low acuity, things that you can possibly go to a urgent care center or schedule an appointment to go and see your doctor at a later date. They aren't things that are life-threatening such as short of breath, chest pains, somebody having a seizure, somebody being unconscious or having a syncopal episode, or anything to do with any stoppage of circulation, or traumatic or trauma. So, we're trying to make sure that the public understands that when they're calling 911, for instance an ear infection. We get that quite often, right? If I have a unit that's going to that assignment when grandma is having, you know, shortness of breath, is in APE which is acute pulmonary edema or having some type of stroke or a heart attack, my resources to respond to her have now become limited, and sometimes I have to pull people from a further area. So now the response to her has become elevated.

CHAIRPERSON BREWER: Okay. But even the person on the street who gets hit by a bicycle but is not life-threatening. You know, you don't have to be-- then that would be considered-- that's not the

ear ache, but that is what people get told to call 911. So, I think people don't know the difference, to be honest with you. Maybe for the ear infection they should know better, but for something like that they don't know. They're told to call 911 on a regular basis. You'd be surprised, in my opinion, how many times you're called by City officials. I won't name which-- to call 911, even though I think to myself that's not a 911 call. So, I think there's education on city officials also about when to use 911 and when not. It's pretty common. I can't deal with it. Meaning, sometimes PD call 911, and you're going to get PD, but you might also get it for a medical situation. I'm just saying it's quite common. Something else to think about. 911 calls, how do they know when it is life-threatening or not? Is it just based on the person calling saying this is an emergency? How would they-- how would the 911 dispatch know that?

CHIEF FIELDS: so, dispatch has a set of algorithms and questions that they ask each caller. They start the call off by identifying immediately is the patient awake and breathing. If they answer no to either one of those, that call is made of cardiac

arrest which is our priority one assignment, and CFRs, paramedics, the EMTs are dispatched to that forthwith. But based off what they're saying is the complaint, they have a algorithm to ask additional questions, and then it falls into a category of call typing.

CHAIRPERSON BREWER: Okay. Apparently a Council Member staff report that they got a voicemail recording three times when they were trying to report a medical emergency to 911. People are haring this more often. So again, this dispatch, does it ever end up with a call being asked to leave a voicemail and under what circumstances? So that may not be your bailiwick, but is that something that you've heard anything about in terms of 911?

CHIEF FIELDS: No, I'm sorry. I have never heard that.

CHAIRPERSON BREWER: okay. The other question I have is how-- I just want to go back to the prior ambulance again, because that's what people see on the street. Then they call to complain, not to mention the sirens. We won't even get into sirens. That's another whole topic. But with-- how do you-- how does one determine fire engine versus

ambulance? Is it a question of location where the incident has taken place?

CHIEF FIELDS: No, it's a determination on the priority of the assignment. A cardiac arrest, you're going to get an engine as well as a BLS ambulance and an ALS ambulance or a PR unit. So, somebody that has trauma, impaled object inside their chest or leg, uncontrollable arterial bleed, somebody that's unconscious, those type of call types are handled by fire operations from CFRD perspective as well as EMTs and paramedics. If you have somebody who's having chest pain with difficulty breathing, you're going to have a CFRD engine that is dispatched to that as well, along with paramedics. So, it's based off the call type and the algorithm, but when the system assigns a call type, with that call type becomes a matrix, and that matrix determines whether or not we're going to have a CFRD response, EMTs response or paramedics or all.

CHAIRPERSON BREWER: Okay. The other question I have is about staffing. So when is a-- a union contract is how long, until when? The ongoing issue we hear about staffing is-- and you heard there was retention. I think retention is probably because

of the salary. So, when is the next bargaining? Is that something that the City should be stating we need more funding for our staff? Now, that's not your job. That's an issue with OLR. I understand that, but we all should be advocating for that, it seems to me. What's the status with allocating or-- you know, in the bargaining table, more money for your amazing, amazing staff.

CHIEF FIELDS: So, we're currently inside of contract negotiations with both Local 2507 and 3621. I would like to echo the last thing that you said, that my staff is amazing. They are wonderful EMTs, paramedics and officers, but contract negotiations unfortunately is not my purview. It is--

CHAIRPERSON BREWER: [interposing] You could talk about it, though, and advocate.

CHIEF FIELDS: OH, we advocate. I advocate quite often in respects to the great work that these men and women do daily. 4,400 assignments a day, 1,617,000 calls they do every year, and it's going up. 1,100,000 transports. So, I have family that's in the city and any one of them that shows up to save one of my family members, can I put a price

on that? Absolutely, not. My mother's priceless. So that is how I advocate as best as possible. I support them with the initiatives that they need, but unfortunately contract negotiations isn't up to the FDNY.

CHAIRPERSON BREWER: Okay. I want to thank Council Member Joseph, Feliz, and Rivera for being here, and turn it over to-- back to the Chair again.

CHAIRPERSON ARIOLA: I have just a couple questions before I defer to Chair Narcisse. Has the City done-- you mentioned about outreach. Have they done any outreach campaigns that would reduce unnecessary 911 calls?

CHIEF FIELDS: so, we're in the process of doing that now. We are placing together videos. We're working with the Deputy Mayor of Public Safety in respects to that, so we're in the process. We're hoping that next year we should have PSA announcements being pushed out to the public.

CHAIRPERSON ARIOLA: Okay, and just dispatch, you know, respond-- when dispatch gets a call, do they educate or inform a patient when a person says perhaps I have an ear ache, can they make

the call that says, well, that's not really an ambulance response call. Perhaps you should see-- go to your local hospital or to your local doctor. Do they make that call?

CHIEF FIELDS: Currently, no, we do not do that.

CHAIRPERSON ARIOLA: Okay. Can you explain why there are different staffing requirements for ALS versus BLS ambulances, and does the FDNY believe ALS ambulances need two paramedics?

CHIEF FIELDS: Historically, the FDNY runs ALS ambulances with two paramedics. That's the way that we operate in this particular region within the 911 system. If there was a disaster, pandemic, epidemic, we are-- we have parts inside of our operations that would allow us to works as the Mensa [sp?] Medic which is one EMT and a paramedic. Those are in extreme circumstances we would do that. That would be based off severe staffing issues.

CHAIRPERSON ARIOLA: Alright. And I just want to be clear, that I think the more in the ambulance, more personal in the ambulance, the better. Better for the person and better for the

people who are working there. I now yield to Chair Narcisse.

CHAIRPERSON NARCISSE: Thank you, Chair. First, I have to ask you that, what training does the liaison receive to be in the ER? Because once they're transferred to that liaison-- can you tell me what training they have received?

CHIEF FIELDS: So, it depends. We have operated inside of Kings County and other H+H facilities, Lincoln and Jacobi. We work with the administrators and the nursing manager within that emergency room. Mostly, it's the transfer of the tablet. So, the EPCR is no longer written out. We utilize a tablet for that. The crew that's arriving at the location has to transfer that information over to the crew, the HLO group that's inside of the emergency room. But since we're going to be housed inside of somebody else's establishment, meaning H+H, we go by whatever regulations they have. Normally, when we place people inside of those locations, you either have to wear masks or you have to take your shots in respects to the flu. In the past we have had MOAs or MOUs with the facilities. So, those are pretty much the training aspect of it. It's going

over EMS operational calls, understanding how many patients one person can be responsible for inside the emergency room understanding what type of patients we're going to take. EMTs cannot take patients from paramedics. They have to transfer the care to either equal or higher authority, so those are things that we go over with those EMT crew members.

CHAIRPERSON NARCISSE: Do you have data? I'm going to go [inaudible] because you know, I'm an ER nurse, so I'm just going to go my mind off a lot of things that-- let me go to that question, first. Do you have data comparing the number of trauma injuries of cured [sic] overdoses and medical emergencies?

CHIEF FIELDS: I'm sure we have data.

ASSISTANT COMMISSIONER MASON: I don't have that data in front of me, but we're happy to give you further information about that.

CHAIRPERSON NARCISSE: Okay. Have you observed any trends reflecting what type of life-threatening emergencies constitute the majority of your calls that you receive?

ASSISTANT COMMISSIONER MASON: Jut to clarify, are you asking about the severity of the segment or the--

CHAIRPERSON NARCISSE: [interposing] Yeah, the life-threatening, like the one that you-- what are reflecting-- what type of life-threatening emergencies? Like, when you receive the call, the real life-threatening ones?

ASSISTANT COMMISSIONER MASON: We can definitely give you the breakdown by call type and also be priority segment as well.

CHAIRPERSON NARCISSE: Okay. So, we'll follow up with that, okay. Could you provide projections on how are response time for critical emergencies such as cardiac event and severe trauma cases might be impacted when a hospital closes?

CHIEF FIELDS: Yeah, definitely. So, when a hospital closes, let's take for instance Kings Brook Jewish. So, Kings Brook Jewish when it shuts down in the neighboring hospitals, it's either Kings County or Downstate, but as we know Downstate even though it's not closed, it starts to decrease the amount of categories that they're able to accept, right? So, that community as a whole, we're going to

have to go a further distance to get that patient over to that respective hospital. So, when the hospitals close down, we have to travel further in order to get them the emergency care that they need. Those hospitals also are taking on more patients, right? So, if you take something like Kings County, I believe they did about 28,000 calls last year, but they had 28,958 emergencies that were transported by EMS to that particular facility. So take into account that Kings Brook Jewish Hospital now is closed. So the patients that were on average about 6,000 cases were going there, those patients are still-- those numbers are still going to emergency rooms. They're just not going to Kings Brook Jewish, because that one's closed.

CHAIRPERSON NARCISSE: They going--

CHIEF FIELDS: [interposing] So, now they go to other places which is Brookdale, which is Kings County, which is Downstate. Let's also take into account-- and I'm just talking about what the ambulances brought in. Look at the amount of patients that are actually walk-ins which is about three times as many that arrive by ambulance. So, by far, when a hospital shuts down, in infects-- it

effects the entire community, and it definitely has a negative response in respects to response times. We're looking at Kings County Hospital in 2023, average was 41 minutes and two seconds in respects to ER turnaround times. Year to date-- I ran the numbers yesterday. We're at 44:14, 44 minutes, 14 seconds. That is three minutes. Times that three minutes by 28,000 calls that go there. That's the amount of minutes that we don't have resources available to respond to that respective neighborhood. So, it definitely has a huge impact. There's a background things, too, because a lot of folks, by the way, call EMS 911 because they feel like they're going to get services in the ER--

CHIEF FIELDS: [interposing] Faster.

CHAIRPERSON NARCISSE: faster through your service. So, what kind of education that's being done to kind of educate in communities to that approach? Because I've been hearing it when I was in the ER.

CHIEF FIELDS: I mean, respectfully, the education that we take is to take them to the waiting area. You know, when you arrive by ambulance and it's a not a life-threatening emergency-- when it is

a life-threatening emergency, we're taking you straight into the emergency room and you're dealing with the triage that's inside the emergency room. When it is not a life-threatening emergency, we have people who can ambulate that can walk, we take them to the outside waiting area, and then we wait for triage in that area with them. Unfortunately, we can't leave them. We have to stay until we get triaged.

CHAIRPERSON NARCISSE: And about the respiratory complaint to get there faster, so those assessment have to be done to the T so folks doesn't, you know, overcrowd at the ER.

CHIEF FIELDS: Yes.

CHAIRPERSON NARCISSE: What's--

CHIEF FIELDS: [interposing] But it is a systemic problem not just in New York City.

CHAIRPERSON NARCISSE: I know.

CHIEF FIELDS: this is nationwide that the amount of call volume is going up and the resources are limited, but yes, people have-- I call it cracked the code in respects to calling 911. They have tried-- they know what to say in order to get a resource faster, and that's the problem.

CHAIRPERSON NARCISSE: It's unfortunate. I feel like if we had the services that would not happen. What steps are being taken to address unique challenges in high-need communities such as language barriers, traffic congestion or difficulty in assessing certain buildings or areas?

CHIEF FIELDS: In respects to language, our crews that arrive at the location they have phones with applications on them that are able to navigate language barriers. We can utilize the AT&T hotline. We can utilize applications now where we can actually video conference with the patient so that we can have somebody to interrupt the language. In respects to buildings, buildings are getting taller. We advocate as best as possible to make sure that all buildings are up to code, and you know, we keep-- the fire operations side keep SIT [sic] reports which is a breakdown of any type of difficulties they may have had at those locations. As future progressed, we're going to utilize AI technology so that when I arrive at a location I can look to see how often has EMS been at that location. Do we have any patients in that location that have been violent to EMS in the past? So we're building

off of technology, and that will come on board when we get our new CAD system in the future.

CHAIRPERSON NARCISSE: Thank you. Is there is any coordination with DOT when consideration street design and the impact it has on emergency vehicles response time? Is FDNY and H+H able to give input and make-- forget about H+H, because I let H+H do that? When a traffic light on the street congestion is causing delays for emergency vehicle?

CHIEF FIELDS: I think that we are able to talk to one another. The final decision in respects to the street lights is based off Commissioner at DOT. We do communicate difficulties that we are having.

CHAIRPERSON NARCISSE: Because I have complained that even my district I realize it, because for example, in my district traffic on the Nap [sic] Street people been complaining has gotten worse because no ambulance-- the backup of traffic, and it's one lane that's occupying by DEP. They cannot get through. So, all those things when they're being done, are you in communication with those kind of votes, you know, design and

construction work and stuff like that? Have you receiving those reports?

CHIEF FIELDS: When there's new construction in the area, we do receive the reports from DOT. In respect to that particular issue, I'm not familiar with the Nap Street area in that one, so I can't attest to being a part of that or receiving a report on it.

CHAIRPERSON NARCISSE: Okay. Now, ambulance-- for the 911 I was going to ask you that, but I'm going to come back to [inaudible]. What type of training that decision-makers receive before they begin working in the field? The dispatcher, I mean, that's what I mean, sorry.

CHIEF FIELDS: Oh, on dispatch training?

CHAIRPERSON NARCISSE: Dispatcher, yeah.

CHIEF FIELDS: The dispatch training is internal training in respects to 911 call receiving. They also are trained in dispatching assignments. That training is extremely detailed and I believe it goes on for about four weeks.

CHAIRPERSON NARCISSE: When transporting patients who are experiencing a psychiatric crisis, who determines which facility to transport them to

since not all emergency department have psychiatry unit? Are there any procedures that are outlined to help guide responder's decisions?

CHIEF FIELDS: We have a CCC criteria and the suggested unit that comes up within the CAD. So based on the location, it will tell you what's the closest facility that's open.

CHAIRPERSON NARCISSE: Now, I'm having a little hard time with that, because I know most of them don't have those psychiatric unit, and then we have a crisis for mental health.

CHIEF FIELDS: We are definitely in crisis in respects to mental health. According to New York State regulations, all facilities are supposed to have psychiatric facilities. Whether or not they are on diversion may be a totally different thing in which we have to deal with those respective hospitals. The units themselves, they are given the criteria based off suggested recommendations. They look to see which hospitals are showing that are open, and based off that category, the list of hospitals they have, they go from the closest to furthest and normally they utilize catchment, they go to the closest.

CHAIRPERSON NARCISSE: At any point did FDNY or the city analyze how ambulance response times would be have been effected if congestion pricing had gone into effect this past summer. That's one and keep that in mind. And I'm hearing complaint a lot of the FDNY that if that happen, and some level of your worker would have hard time getting to their destination because it would be almost impossible with their income that they're receiving to facilitate them to get to work. So, in that in mind, [inaudible]

CHIEF FIELDS: So, I have not been a part of any project that talked about what happens if congestion pricing goes into effect. So, I can honestly say I haven't been a part of that, nor do I know if that's happening within the FDNY. Is that happening, Suchecki, that you're aware?

CHAIRPERSON NARCISSE: Because I have complains for some folks in my district that it would be almost impossible to get to the place to start to get to work.

CHIEF FIELDS: I would say in respects to any time there's an additional toll anywhere, no matter how much money you make or how much you don't

make or how much you should make, it is definitely going to have an impact on working people.

CHAIRPERSON NARCISSE: So, thank you, Chair. I'll pass it back to my Chair.

CHAIRPERSON ARIOLA: Thank you so much, Chair. Would like to recognize Council Member Kristy Marmorato for questioning.

COUNCIL MEMBER MARMORATO: Thank you, Chair Ariola. Good morning.

CHIEF FIELDS: good morning.

COUNCIL MEMBER MARMORATO: How you doing? So, are you guys familiar with the Bronx at all?

CHIEF FIELDS: I love the Bronx.

COUNCIL MEMBER MARMORATO: Okay, good. We had an unfortunate incident the other night in the stadium where the Yankees unfortunately lost and that was terrible. I just wanted to kind of focus on-- I know some of my other colleagues in the borough have complained of wait times with ambulance response times. We had an individual's constituent in City Island, and they had fallen. I think it was like 10:10. They waited 20 min. There was no response. They called 911 again, and then 40 minutes from the original call the engine showed up at this man's

house. Can you just like walk me through the process of you know, what happens once the call is made and the determination and how you decide to call the engine, or if you end an ambulance over to the facility. They're kind of like-- we're a desert where we are, but they really are a desert.

CHIEF FIELDS: you are a desert where you are.

COUNCIL MEMBER MARMORATO: Yeah.

CHIEF FIELDS: In the summertime we provide that particular area with gators as well as a BLS unit that's assigned there because you peak in the summer period.

COUNCIL MEMBER MARMORATO: Yes.

CHIEF FIELDS: so, we look at that data and based off that we're able to reallocate resources. In respect to this particular call type, I don't know the specifics off the top of my head, but the fact that you said it came in as an injury, that would be considered low acuity. That's a priority five, meaning that we're going to dispatch all priority one, two, three and four assignments before we dispatch priority five assignments. You said that you called-- that somebody called in back

in 20 minutes. If they said the same thing, then the call type stays the same which is an injury. However, if they said something different which is now they're experienced shortness of breath or something about the injury is different or he's unconscious or he's going in and out of consciousness, something similar to that, then the call types change. If the call type changes to a low-- to a higher priority in which CFRD is assigned to, then that company that's on City Island would have responded to that person. So that-- it didn't take them 40 minutes for them to respond, but once the upgrade happens then the priority changes and now the response changes.

CHAIRPERSON ARIOLA: And who makes that determination?

CHIEF FIELDS: That's based off dispatch. That's made at dispatch.

CHAIRPERSON ARIOLA: Okay. Okay. Alright. And you said you have additional ambulances on City Island. Is it City Island and Orchard Beach?

CHIEF FIELDS: And Orchard Beach.

CHAIRPERSON ARIOLA: Okay.

CHIEF FIELDS: So, Orchard Beach, we have two gator units that's assigned there. That's starts at Memorial Day. Make sure I got it right. Yeah, Memorial up until Labor Day.

CHAIRPERSON ARIOLA: Okay.

CHIEF FIELDS: And we throw an additional BLS that sits right at the bridge of City Island, because we know that the volume goes up and the next closest BLS is about eight minutes away.

CHAIRPERSON ARIOLA: yeah, that's kind of tough. Alright, well, thank you so much.

CHIEF FIELDS: No problem.

CHAIRPERSON ARIOLA: The Chair now recognizes Council Member Rivera for questioning.

COUNCIL MEMBER RIVERA: Good morning.

CHIEF FIELDS: Good morning.

COUNCIL MEMBER RIVERA: Thank you so much for being here, for your testimony, of course, for your service to the City. I just have a few questions. I want to ask with-- I want to start with hospital turnaround times. you stated in your testimony right now the average hospital turnaround time is increased form 34 minutes to almost 41 minutes for a number of reasons, that they're crowded

and there are hospital closures, of course, and that adds to capacity issues, and I'll get to hospital closures in a second. When an ambulance arrives at a hospital that has a significant wait time for emergency department patients to be assigned a bed, what is a protocol for an ambulance?

CHIEF FIELDS: The ambulance itself, they arrive at the location. They go to registration. Each hospital is unique. So, some hospitals require that you go straight to triage. Others require that you register the patient, then go to triage. So, it depends.

COUNCIL MEMBER RIVERA: And I ask because, you know, if they're there for 41 minutes and-- or maybe even longer as they wait for patients to be admitted, they eventually have to get back out on the street, right?

CHIEF FIELDS: They do.

COUNCIL MEMBER RIVERA: They have to get to the next job. And my question really is around resources and ambulance itself, because you know, I have family and friends that have, you know, multiple issues and they've received excellent care in many facilities and by many of your team who I know do a

lot of work for not enough money, I know that, but there are issues with the resource inside the ambulance itself. Things like bed sheets, how they care for the patient, ensuring that when they're transferred out of their apartment into the ambulance, that they're doing so with dignity. So, when they go to back out onto the street, is there like a protocol for how the ambulance is supplied?

CHIEF FIELDS: So, this is a general. Each facility is different.

COUNCIL MEMBER RIVERA: Okay.

COUNCIL MEMBER RIVERA: Whatever linen resources you brought in, you're allowed to replace. So if I come there with two sheets which is normally what they carry, right, they can take two sheets from the facility.

COUNCIL MEMBER RIVERA: Well, again, I ask, because there's going to be testimony from the public later and people have, you know, personal stories on just their family not being covered with something as simple as a bed sheet, and that can really just compound the trauma of the situation. So I just want to ensure that when we're looking at how stretched they are in their capacity that way they

really have all the supplies they need to do the job. So I just-- I wanted to bring that up. And I know that in your testimony you also mentioned that hospital closures are a very, very big factor. And so in my district, I represent the east side, and so do you have numbers for Bellevue Hospital in terms of their emergency department and turnaround time there specifically? I ask you this because we have Mount Sinai Beth Israel in the area. They receive approximately 70,000 emergency department visits a year, and they're slated to close. So we're very, very worried about the additional emergency room visits that are going to be at Bellevue. We're also very worried about diversions, which I'll ask you about in a second.

CHIEF FIELDS: Alright, so in respects to Bellevue, in 2023, 911 calls that were transported there was 27,308 transports by ambulance.

COUNCIL MEMBER RIVERA: Okay. And in terms of diversion, so I think most people know this. A hospital's emergency department is unable to treat more patients, they direct ambulances to other hospitals. How do you coordinate in terms of

interagency coordination when a hospital diversion happens?

CHIEF FIELDS: so, in respects to diversions, we are very limited in respects to when we grant diversions. So, diversions in its truest form-- so that would be electrical issues, somebody is flooded. Those are true diversions. You saying that we are overwhelmed with patients, we may not consider that to be a diversion. We may place you on redirection. So every facility has a certain amount of patients or incidents in which we will bring to a location. I'll use Bellevue. I'm going to guess a number right now, so don't hold me to this number. But Bellevue can take five incidents, meaning they can take five different ambulance crews coming in with different patients, and if any-- once five of them are at that location for greater than 30 minutes, we go on redirection, and redirection means that that hospital won't come up suggested for any other ambulances that come to that location until all of those incidents have cleared up. And that's how we deal with that. The amount of redirections have gone up because hospitals have closed and we have more individuals going to specific hospitals.

COUNCIL MEMBER RIVERA: And I think that's one thing that we actually found in terms of data from Mount Sinai Beth Israel, which is there are actual redirections happening right now, and it's not even closed. There's been a slow elimination of services, so we're very, very concerned. I just want to thank the Chairs for the time. I might have another question, and I'll let you all know, but I just want to thank you for your testimony, and of course, I encourage the staff to stay and hear from the members of the public who have testimony to give. Thank you. Thank you so much for your answers.

CHAIRPERSON ARIOLA: Thank you, Council Member. Council Member Joseph? Okay, I'd like to recognize the fact that Council Member Restler and Yeger are here, and we have questioning now from Chair Brewer.

CHAIRPERSON BREWER: I know in your testimony you mentioned that the privates have some reduced some of their ambulances. Do you know why that is? Maybe you don't. But how is that impacted? Obviously, more challenges for you. How is that impacted? Do you see the difference in terms of fewer privates?

CHIEF FIELDS: Some private agencies have decreased the amount of ambulance tours that they have within the 911 system. This is capitalism at its best. I mean, it's about money at some point, and they had to cut their bottom dollar, right? So, they have to-- if one place runs 77 ambulances and they decide that they're going to cut 10 percent of that, we as the FDNY, we have to pick up those respective tours, right?

CHAIRPERSON BREWER: So, that has added to your coverage I would assume, necessary coverage, right? In other words--

CHIEF FIELDS: [interposing] Yes.

CHAIRPERSON BREWER: In other words, because I know when I see this list here, it's not listed as one of the challenges that you're also facing. So I just wanted to make sure that people understand that. The other thing, you mentioned this new CAD system. When would that go into effect? I heard you sort of be vaguely say the future, and how would that make a difference?

CHIEF FIELDS: The current CAD system that we're working with is about 30+ years old.

CHAIRPERSON BREWER: That's kind of old.

CHIEF FIELDS: It's the Legacy CAD system.

CHAIRPERSON BREWER: So, it's like Cobalt. Sounds like Cobalt to me

CHIEF FIELDS: MSDOS, I don't know.

CHAIRPERSON BREWER: Oh, God.

CHIEF FIELDS: It's a Legacy system. We are working with OTI currently for plans on establishing a new system. So that's in the works. I don't have a date in respects to that.

CHAIRPERSON BREWER: But how would it make a difference? Other systems around the country I assume are already using some of the new ones, and you probably know from your colleagues.

CHIEF FIELDS: I think technology, the age that we live in now, technology is going to make an immense difference in respects to how the call is entered, how fast we're able to enter the call, dispatch out to respective units, the way that we integrate other systems with that, whether that be Health EPCR, whether that be GPS and so forth, but you know, technology definitely matters.

CHAIRPERSON BREWER: Okay. In terms of the sirens, without getting into the noise, I went

out with PD a while a go to listen to the rumbler versus the screeching siren, I call it.

CHIEF FIELDS: Okay.

CHAIRPERSON BREWER: so, I'm afraid that in traffic, people don't move. I've seen them. I've been in a-- I don't have a car, but I've been in a cab. Even the cabs don't move. Is there some different siren discussion taking place that people would understand that this is really an emergency? They don't move often.

CHIEF FIELDS: I'm going to have the Chief of Fleet talk about sirens.

CHAIRPERSON BREWER: It's my favorite topic, by the way.

CHIEF SUCHECKI: Mine as well.

CHAIRPERSON BREWER: Yours too? Oh, good, we can have a conversation. I live between two hospitals. Oh, my goodness.

CHIEF SUCHECKI: Yeah, as far as the rumbler siren, what that is it's a low-frequency siren.

CHAIRPERSON BREWER: I know what it is.

CHIEF SUCHECKI: So, it works in conjunction with the actual siren itself. You know,

we feel that we're using the most appropriate siren, but we are always looking at the next advancements and the most innovative technology for the safety of our members and the safety of those around us. So we're always looking to explore, but at the end of the day for EMS operations, we ultimately need to get to the job. We also do have, you know, a custom-made siren for us, so you know, to kind of eliminate some of the concerns with the pollution and the wailing all hours of the night. So we feel like currently we are doing everything, but are exploring options.

CHAIRPERSON BREWER: What does exploring options mean? Are you discussing it like with siren companies? Are you having-- union, I know, likes the current, I understand that. But please describe to me current discussion what that means. It's not just the people complaining. It's also the traffic not moving, and I don't know if there's some other way to get the traffic moving. New siren? This is, you know, we're serious. I don't know, but they don't move.

CHIEF SUCHECKI: We work with multiple different siren companies who are always advancing their technologies similar to, you know, CAD system

as well. So, you know, they feel like if they could come out with a different tone or a different option for siren, that may be more effective in traffic. We're also looking at other options where we could possibly plug devices into our vehicles which may transmit to third-party vehicles and applications that could notify you that an ambulance or an emergency vehicle is approaching. So these are all different types of options that we are looking at.

CHAIRPERSON BREWER: Okay. And then just finally, I know I'm sort of discussing this again, but can you just be, again, specific about the numbers of ambulances that are out of service, and exactly-- not for repairs, but for those that are just out of service, and how much staff you would need to make them serviceable, just very specific?

CHIEF SUCHECKI: So, for my perspective, I would only have the out-of-service for repairs. As far as units that wouldn't necessarily be running, that would be Chief Fields. Everything I deal with is on the mechanical side, the fleet component. It doesn't--

CHAIRPERSON BREWER: [interposing] And how many do you-- and what did you say, how many are out of service for, you know, maybe on average?

CHIEF SUCHECKI: So, as of today's numbers there's a 22 percent out-of-service rate, and that includes a 12 percent out of service for our preventive maintenance. So those we pull out to make sure that they're ready for the road and safe to operate, and anything above that 12 percent, the delta between the 12 and the 22 is out of service for either a mechanical, other type of maintenance issue, any type of warranty issues, maybe a recall, anything that is other than preventative maintenance.

CHAIRPERSON BREWER: So, Chief, do you have-- now, I get some numbers here. So are there some that are out of service because-- not because of mechanical, not because of prevention, but because there's not enough staffing?

CHIEF FIELDS: That can be day-to-day, and yes, there are days in which we may struggle with staffing. Currently, we're trying to improve our staffing model. So to run an ambulance for 24-hour day, if it's a 12-hour vehicles, that means that you need a total of eight people. But in reality--

CHAIRPERSON BREWER: [interposing] Eight people--

CHIEF FIELDS: [interposing] NO, not 80, eight--

CHAIRPERSON BREWER: for the full tour.

CHIEF FIELDS: Eight people, right?

CHAIRPERSON BREWER: Eight people, yeah.

CHIEF FIELDS: So, to staff that particular ambulance for a seven day week, you need eight. For that particular day you're going to need four. But with the staffing model we have to take into consideration that people are going to be on vacation, people are going to get sick, so for that particular ambulance you may want to up what you require to be staffing. So we're working with our analytical staff to see what's the best number so that we can ensure that we're running a higher percentage of ambulances.

CHAIRPERSON BREWER: Okay, so you don't-- you're not going to give me a number as to how many are out every day from, you know, not having the eight or the four? Do you have some number to that effect?

CHIEF FIELDS: I can--

CHAIRPERSON BREWER: [interposing] We hearing-- we're hearing a large number, and it's looking and sounding to me like a lot of them are mechanicals. Your colleague is willing to take that one.

CHIEF SUCHECKI: I don't know about all that. I do just want to add something that our out-of-service number, our 22 percent number, that's an out-of-service vehicle. That doesn't directly equate to an out-of-service ambulance. We have numbers built-in to ensure that with our projected out-of-service, which is the preventative maintenance and anything over that, we're always fulfilling our obligations to EMS operations to run their units. So 22 percent out-of-service vehicles could mean that EMS operations is still running 100 percent of their ambulances. We make sure that that is always that safety buffer.

CHAIRPERSON BREWER: Okay, because the public thinks that it's 22 percent out of service because there is no staff. That's what's coming-- I know, but I'm just saying. So, chief you don't-- there's no-- so you're thinking that most of the

ambulances that are able to be run are being running, basically?

CHIEF FIELDS: Most-- they are. Today, we were-- today we were scheduled this morning to run 330 ambulances. We ran 333. So we were three above headcount for today. It varies day-to-day. It depends on sick leave. Right now, my sick leave percentage is about 6.4 percent. That's what it was at the last emails that I received. Sometimes that fluctuates up. Sometimes that goes down. It will vary. During the summertime we have more people on vacation, so we have to allow people especially in this job to be able to decompress in every measure. So when vacation time is up, therefore we may be running less units, but we are up in respects to EMT personnel currently, so we run our BLS units. We're down in respects to ALS personnel. The reason why we're down is because we just promoted 100 paramedics-- I mean, 100 lieutenant. In order to make lieutenants we have to utilize the paramedic ranks. However, we have 80 plus 78 members. So that's 100-- and forgive me-- 58 members that are currently in school to become paramedics. So we're constantly backfilling those particular ranks. It is

a very dynamic and fluid process in which we promote and then we're down, and then we promote again.

CHAIRPERSON BREWER: And then you have retention problem at the other end.

CHIEF FIELDS: And we have recruitment problems, yes.

CHAIRPERSON BREWER: Retention and recruitment.

CHIEF FIELDS: I agree with you.

CHAIRPERSON BREWER: So, let's finish. We got the traffic issues. We got the call volume which is an education plus issue, the emergency room delays-- it does seem to me that maybe the individuals will help, but closing hospitals. When you go to St. Vincent, I call it St. Vincent, but now it's Lenox Hill, in Manhattan, is that just-- that is a semi-hospital in the-- I don't know if it's in--

CHIEF FIELDS: [interposing] The Health Plex [sic]?

CHAIRPERSON BREWER: Yeah, is that something that you can take patients to or not?

CHIEF FIELDS: Yes, we can.

CHAIRPERSON BREWER: Okay, because something like that at least we should have more of

CHIEF FIELDS: I agree with you.

CHAIRPERSON BREWER: Half the people-- I have to say, they don't have doctors, you know, the ones who call, some of them don't have a doctor. They don't even know-- urgent care costs money. They don't have any money. I'm just saying, we got to think of some other kind of education program that addresses their needs as well as yours. They don't have a doctor. They don't have any money, and so they're not, you know-- and they're not going to pay the ambulance fee in the end. I'm just saying. So all of that is something, a different kind of education program in my opinion. Thank you very much.

CHIEF FIELDS: You're welcome.

CHAIRPERSON ARIOLA: Chief, if you could just clarify. You spoke about how EMTs cannot transfer and paramedics. Can you just-- just kind of like break that down a little bit for us, the transfer once they get to the hospital, how they're able to leave and who isn't?

CHIEF FIELDS: So, our paramedics are advanced life-support. They deal with advance life-support measures such as IV access, administration of

IV medications. They intubate. They utilize CPAPs and a litany of other things that they all do. If they have a patient who has received any of those types of treatment, when they come to the emergency room, they have to transfer that patient either over to a nurse, higher medical authority, or a doctor, higher medical authority. Inside the emergency room we want to place HLOs which is Hospital Liaison Officer which is one lieutenant as well as two EMTs. So that paramedic transport unit, if they did ALS treatment, cannot transfer that patient over to the EMTs, because their medical training is less than the paramedics.

CHAIRPERSON ARIOLA: Okay, thank you for that. And also for clarification, the Mayor's Management Report said that the average time to life-threatening calls was seven minutes and 22 seconds, but in a previous statement that you made you referred that it was over eight minutes. Can you clarify if that's a cumulative average for response time for life-threatening and non-life-threatening calls, or was it inaccurate in the MMR report?

ASSISTANT COMMISSIONER MASON: So, I think here we're referring to two separate metrics in

the MMR. One of them is the combined response by both ambulances and the CFR companies which are fire engines, and then the second one would be the average response time to life-threatening medical emergencies by ambulances alone. So that one for just the ambulances is eight minutes and 16 seconds for the fiscal 24.

CHAIRPERSON ARIOLA: Okay, thank you for that clarification. Chair Narcisse?

CHAIRPERSON NARCISSE: Thank you. We've been joined by Council Member Riley. My question, since we have retention problem, what is the top reason for retention? Why you think that you cannot retain your staff?

CHIEF FIELDS: I'm pretty sure there's tons of great reasons why we can't maintain. One is nationwide reason that we don't have enough EMTs in respects to recruiting. After COVID people saw that there were better jobs to do or safer jobs to do, not better, safer jobs to do. Dealing with frontline healthcare you became exposed. I mean, you see-- for those-- I'm pretty sure you still have friends in the emergency rooms. They were exposed to, you know, the pandemic and the circumstances of that pandemic, and

a lot of people I honestly have to say are just scared to do the work now, and they choose safer careers. In respects to retention, we have people that retire. We have people that move on to different aspects of their lives. They may move to other places that may have better wages or better benefits now. We have a lot people who get to work from home, and that's not a job that you-- you can't work from home working on ambulances. So you have to show up every day. I don't think we can change that aspect of it, but we're working to improve, and we have an all-hands-on-deck approach towards recruiting additional people, offering training to people who aren't EMTs already. We're willing to train them. So we're trying our best to improve on our recruitment numbers so that we can long-term retain more employees.

CHAIRPERSON NARCISSE: So, what's the plan that-- since you're seeing the problem, what is the plan? What is the solution you think that's going to be solving, because now-- well, we're not at the height of the pandemic, might have been changed. So what are you doing internally to make sure that they stay with you? I know the pay is a problem.

What are the steps we taking to make sure that we keep on actually-- because this is the first line of defense before even get to the hospital to a nurse?

CHIEF FIELDS: I mean, we-- I think the biggest issue that we're having right now-- or the best thing that we're doing to retain people is to make sure that we have the personnel. So we're trying our best to make sure we have a large sum of EMTs that are either coming on board or trainees which are the ones that we can train. So, making sure that we have staffing, that's a good problem. Making sure that there's promotional opportunities within the Fire Department is another solution. We have made it so that EMTs now can promote to a rank called sergeant, right? So, that gives the EMTs a respective ladder in respects to promotion and becoming officers. So the EMT can become a paramedic. The paramedic can become a lieutenant, but we added to sergeant so that the EMTs can step to a role of supervision, and I think that that will help in respects to retention. We're getting newer facilities, increased technology, and sometimes it's just the approach of better leadership. We're training. We're spending a lot of time training our

lieutenants, our captains on how to lead, on how to mentor, right? When you show up at your workplace you want to make sure that the people that are leading you that you have some confidence in them, that they can empathize with you, that their levels of just-- you know, emotional IQ is relevant, and I think that all these things are important. We offer more peer support because we're on the front line and we are seeing these things, and nobody ever thinks about the person that's in the mix and that's in the mud. So we're dealing with those circumstances day-by-day just trying to increase morale and hopefully that's going to work towards increasing retention.

CHAIRPERSON NARCISSE: And I do appreciate your work and I appreciate the work that-- actually the first line that we have to protect the City of New York, getting folks to the hospital and hoping that we can keep our hospitals open so we don't have to overburden the work that you do. Thank you. For FDNY, I have complained a lot for the sirens. I heard my colleague talking about. People are calling me all the time for the sirens. So, some-- my question is about-- like, some of the complaints that I receive like for three o'clock in

the morning, four o'clock in the morning, and the traffic is not the same. So why we have those loud sirens going on.

CHIEF FIELDS: So, the first thing, and I'll let Evan--

CHAIRPERSON NARCISSE: [interposing] But both-- yeah.

CHIEF FIELDS: jump into it. We are not exclusive in respects to sirens. So, FDNY runs the amount of ambulances that I told you about. We have other private companies that also work within the city, right, dealing with nursing home transports and other things, and we do not regulate their uses of sirens or how-- which sirens they choose to pick. So you may have constituents that are seeing another ambulance company and assuming that it's ours, and it may not be.

CHAIRPERSON NARCISSE: But in the middle of the night, usually the one that do like homecare and stuff like that, they're not functioning most of the time at three o'clock in the morning as much, so--

CHIEF FIELDS: [interposing] Not as much, but they are definitely functioning, I agree. But

we-- I think from a point of operations, I can't tell somebody not to transport in emergent mode to an emergency, because at the end of the day, two things that I am beyond responsible for and I take serious, the safety of my members is my top priority and the safety of the public. And knowing that somebody could have gotten into an accident because we said it was the difference between 11:59 p.m. and 12 o'clock that they didn't have on their siren, I don't think I want to bear that responsibility. We say that you should utilize dual caution at all times, respond with your lights and sirens to go to that location. This city is extremely louder than the studies that they do in Europe and so forth, right? This is a loud city. We need to make sure that people can hear us coming and make sure that we're able to stop and, you know, readjust to those respective emergencies. So I do understand everybody's, you know, complaints in respects to noise pollution, but we have one of the best fleet services and they are constantly on the front lines looking for better technology so that you don't have to hear the sirens as much, but they are definitely necessary.

CHAIRPERSON NARCISSE: Thank you. You want to answer that one? Those big trucks making a lot of noise.

CHIEF SUCHECKI: Right.

CHAIRPERSON NARCISSE: People say they cannot sleep. I'm not kidding you. Me, I don't have that problem, but I know a lot of people have problem-- because I sleep deep.

CHIEF SUCHECKI: I think Chief Fields, you know, really addressed it as far as the safety component and the operational use, but you know, it is relevant to point out that we do purchase a custom siren for the FDNY. That is a lower-powered siren that is commercially available. So, you know, we are doing our best without impacting safety, because that's the safety of the members and the safety of the, you know, citizens of New York. As far as the operational use, that is something that dictates and is also, you know, the EMT or paramedic responding to an emergency. So, you know, that's a judgment call as far as when the siren is appropriate as well.

CHAIRPERSON NARCISSE: Thank you. Thank you, Chair.

CHAIRPERSON ARIOLA: Council Member Restler followed by Council Member Rivera, and then back to Chair Narcisse.

COUNCIL MEMBER RESTLER: Thank you so much, Chairs Ariola and Narcisse and Brewer, for convening this important hearing. I'd also just like to give a special welcome to two special guests that we have today, Brooke and Kate from the Bronx. Thanks for being here. Council Member Kevin Riley's daughters, so it's always fun to have them with us at the Council. So, I just wanted to ask about a couple of the items that were in your testimony today, Chief Fields. You noted that from the peak of the pandemic to the present there was approximately a 12 percent reduction in units. Has-- during the tenure of Mayor Adams we've seen a significant reduction in the number of EMS vehicles that are out there on the streets responding which has driven up response times I think is the primary explanation that we've seen-- that you articulated in your testimony today. Has FDNY requested new needs, additional staff, from OMB from Mayor Adams, and has that been rejected? Can you give us some insight into why this mayor has

failed to provide more support and staffing to EMS to reduce response times?

CHIEF FIELDS: So, in respects to during the pandemic, 2020 and beyond, we were allowed to up-staff. We changed the tour. We changed the way that we staffed the tours. Prior to, we were utilizing eight-hour shifts. We went to the entire service going to 12-hour shifts which allowed us to have additional resources out into the field.

COUNCIL MEMBER RESTLER: Right.

CHIEF FIELDS: Utilizing the same personnel. Back in 2023 we went back to pre-pandemic measures because we were being fiscally responsible in respects to the resources that we were being provided. So we went back to pre-COVID measures. We re-evaluate response times--

COUNCIL MEMBER RESTLER: [interposing] So, just at the beginning of the Adams Administration you shifted back and have significantly fewer tours out on a daily basis that have increased response times. So, I mean, I just want to-- these are the facts. I'm just repeating back what's in your testimony and saying it plainly.

CHIEF FIELDS: Okay.

COUNCIL MEMBER RESTLER: And distilling it just so everyone can understand exactly what's transpired over these three years and why we've seen response times go up as much as they have. So, I just want to ask about another topic, if that's okay.

CHIEF FIELDS: No--

COUNCIL MEMBER RESTLER: [interposing] You want to finish on that one? Go ahead.

CHIEF FIELDS: Yeah, I do want to finish on that, because you recap, but I didn't say that. I said nothing about the Adams Administration.

COUNCIL MEMBER RESTLER: You didn't. You just gave a timeline--

CHIEF FIELDS: [interposing] I--

COUNCIL MEMBER RESTLER: [interposing] You put a year on it. I chose to add who was the mayor at that time.

CHIEF FIELDS: I did-- I did give a timeline in respects to.

COUNCIL MEMBER RESTLER: Yeah.

CHIEF FIELDS: COVID itself went over-- went-- COVID itself, we dealt with that emergency for approximately two to three years. At the end of COVID, we went back to the response matrix that we

had pre-COVID which was 2019. So, we went back to that response matrix, alright. That was based off fiscal needs. We have a budget that we have to work within and this is what we was based off.

COUNCIL MEMBER RESTLER: Right.

CHIEF FIELDS: So, operationally, I'm working with that budget. Just give me one second.

COUNCIL MEMBER RESTLER: Alright, because I got tight time, and they're going to kick-- they're going to tell me to shut up in two minutes.

CHIEF FIELDS: As-- I'm-- if you-- you want the answer--

COUNCIL MEMBER RESTLER: [interposing] I do. I do. I'm just looking for brevity. So, I appreciate it.

CHIEF FIELDS: So, in respects--

CHAIRPERSON ARIOLA: [interposing] Council Member, let's just let him answer the question, and then if you need a little extra time, I'll be happy to--

COUNCIL MEMBER RESTLER: [interposing] I appreciate it, Chair. Go ahead.

CHIEF FIELDS: So, in respects to response times, we constantly re-evaluate those

response times and we constantly are putting in measures that we think can facilitate us making better response times, right? We have problems in respects to supervision. That problem was based off of COVID and the fact that there was no examination that was placed out during that time, and we exhausted the entire list. So, now, we have measures in place on the pilot program to place HLOs into respective hospitals and to utilize other resources such as paramedic response units which are non-transport units. Adam [sic] response units which is non-transport BLS units, and we're hoping that those measures are going to make a turnaround [inaudible].

COUNCIL MEMBER RESTLER: In the Mayor's Management Report there are a dozen different metrics that look at response times, and when we compare FY21 at the height of COVID to FY22-- it got worse in 22, got worse in 23, got worse in 24 for almost every single metric that FDNY has for measuring response times across the board. So, what my question was that I don't think we got to was did you tell OMB and this mayor that FDNY needs more headcount, needs more personnel to be able to drive down response times? That's what your testimony says is that's the biggest

challenge. You went from 520 tours at the peak of COVID to 460, approximately to where you are now, and even in your testimony to Council Member Brewer a moment ago, you referenced a much lower number operating today, but we're still talking about dramatic reductions. Where is FDNY saying we need more headcount, we need new needs? Because we'll champion it. You have a great Chair in Council Member Ariola who wants to help advocate for more FDNY support. You have a City Council that wants to advocate for FDNY support, but we need to hear it. So, have you been advocating to OMB and to this mayor that the response times are going up and up and up, because we don't have enough people?

CHIEF FIELDS: I agree that--

COUNCIL MEMBER RESTLER: [interposing] Okay.

CHIEF FIELDS: having more in any system will make a system better, right? But we also have a fiscal responsibility to utilize the resources that we have currently. We are trying our best to do that. We do advocate to say that we can utilize additional resources, but this system as a whole isn't 100 percent FDNY. It is 68 percent--

COUNCIL MEMBER RESTLER: [interposing] True.

CHIEF FIELDS: FDNY, 32 percent voluntary agencies.

COUNCIL MEMBER RESTLER: Understood.

CHIEF FIELDS: Whenever--

COUNCIL MEMBER RESTLER: [interposing] But as you said--

CHIEF FIELDS: a voluntary agency pulls out of this system, the FDNY has to pick up that slack.

COUNCIL MEMBER RESTLER: That's right.

CHIEF FIELDS: And when we pick up that slack, sometimes we have the personnel, sometimes we don't. Every instance when a voluntary has pulled out of this system, we have advocates and asked OMB to give us those additional resources, and they have complied.

COUNCIL MEMBER RESTLER: Okay. Could I have two brief questions if I'm quick?

CHAIRPERSON ARIOLA: if you're quick.

COUNCIL MEMBER RESTLER: I'm quick.

CHAIRPERSON ARIOLA: Thank you.

COUNCIL MEMBER RESTLER: Alright, well, I'll be quick in my questions. Hopefully, we get quick answers. One major disappointment from this year was the Governor's delay and potentially elimination of congestion pricing. Did FDNY do modeling on how the implementation of congestion pricing would improve response times for EMS vehicles?

CHIEF FIELDS: I didn't--

CHAIRPERSON ARIOLA: [interposing] That question was asked--

COUNCIL MEMBER RESTLER: [interposing] It was, okay. I apologize. Then the other question I just wanted to ask is, in addition to FDNY response times going up, we're seeing major increases in NYPD response times. On the most serious types of crime, shootings, violent incidents, the kinds of things where we need the NYPD there, it had always been five minutes and change from years and years and years. Now we're up at seven minutes, about a 20 percent increase, major problem. Is there a citywide effort to address response times that you're not trying to figure this all out on your own, but working with PD, working with operations, working with the other

entities so that we are developing holistic, comprehensive solutions to address this issue?

CHIEF FIELDS: I can only speak in respects to EMS operations.

COUNCIL MEMBER RESTLER: We need to see that leadership from City Hall. That is a major problem, and you shouldn't have to figure this out on your own. Your job is hard enough. These are the types of places. These are the types of places.

CHAIRPERSON ARIOLA: You have to wrap up Council Member.

COUNCIL MEMBER RESTLER: These are the types of issues where we need a comprehensive response. Thank you, Chair.

CHAIRPERSON ARIOLA: Council Member Rivera?

COUNCIL MEMBER RIVERA: Thank you. Well, I just want to thank the Chairs, again, for giving me one more quick round, and I want to thank Chair Brewer for bringing up the sound of the sirens. I do have legislation for two-tone more European-sounding siren that I don't think you all are exactly feeling, but I think we're going to get to a point where we can figure something out, and I think the only person

that likes the sound of those sirens is my toddler at home who says "wee-ooh, wee-ooh" whenever he hears you all coming through. Alright, so I want to ask about free-standing emergency departments. I realize that they're not for major trauma. They're for non-life-threatening illness and injuries, and they're usually provided, of course, for people with insurance or low-cost. This is what they did in St. Vincent's with Lenox Hill, and I had a conversation with Dr. Katz actually not too long ago, and he said that, you know, in the beginning people were very reluctant to accept free-standing emergency departments in their community, because-- well, I know the history is that typically when community hospitals close amid like very heavy financial losses because of gentrification in the neighborhoods you'll see them pop up, but in mostly prosperous areas, places that have changed, and I think that happened in Greenwich Village specifically because that's a very affluent place with a lucrative market. Anyway, I do think that they fill an important void in areas without full hospitals and that they've proven helpful in your response times. I want to assume. I say that because I'd like to get a free-standing

emergency department in place of Mount Sinai Beth Israel when it closes, and I'd like to know if you have any information or data that supports that the emergency-- the free-standing emergency departments that have come in unfortunately in place hospital closures has bene beneficial to response times and to your teams. Do you have information or data related to free-standing emergency departments that have proven they have been beneficial in response times and to care?

ASSISTANT COMMISSIONER MASON: We haven't looked specifically at free-standing EDs. However, like the Chief has said multiple times, you know, having access to these resources in geographic areas that would be considered hospital deserts could be quite beneficial. We would have to take a closer look at them.

COUNCIL MEMBER RIVERA: Okay, yeah, and like, I know even stabilizing a person is always important. So, if you could-- maybe we could work on that together. I would love to talk to your team about how we can advocate appropriately and effectively to make sure that we have care for people, especially in neighborhoods that are losing

beds per person. That was really my question. I just want to thank you. I really just have appreciated your testimony so much. I think it's been very, very honest and comprehensive. So, thank you.

CHIEF FIELDS: Thank you.

CHAIRPERSON NARCISSE: Okay. Now, let's focus on H+H. Increased patient volume, right? We note in our committee report that there has been an increase in visits to emergency room, and that hospital in Brooklyn and the Bronx experienced record patient volumes in the past year. This additional patient numbers are driven in part by the needs of an aging population, the ongoing opioid crisis, the limited access to primary and urgent care services. Could you please elaborate on any other factors to have led to increase patient volume at H+H hospitals and health centers and whether the primary reasons for hospital visits vary by borough? It's long-- too long to answer?

ASSISTANT COMMISSIONER MASON: Thank you for that question. Yes, it is indeed true that we have had increasing volumes at all of our Health + Hospitals facilities in the emergency departments increasing since 2020 to the present time. That's

inclusive of the most acute types of patients that we see, but also inclusive of lower acuity patients. So we're both seeing a higher volume of high-acuity patients and most complex, but also seeing, as was mentioned before, increases in the number of patients that come to our emergency departments with less acute. So, non-urgent and less-urgent problems partly related to the difficulty in accessing primary care, and I think patients view us as knowing that we are always there 24/7 and is a place where they can get, you know, immediate care when they need it. So we really had increases in volumes across all the levels of acuity.

CHAIRPERSON NARCISSE: since we're talking about primary care, because I'm always say preventive is better than curing. It's cost-effective. What is the hospital doing when you see those cases? because me personally I know what I used to do, but when you see those cases what kind of educational brochure that you can provide to those folks, because you realize they could have benefit from the primary care instead of coming to emergency room. Do you have any literature that you can provide or someone to talk to them?

ASSISTANT COMMISSIONER MASON: so, yes, and then also I'd like to mention-- it was mentioned earlier to some extent, but we are also providing alternatives to patients rather than going to the emergency departments. So, it was mentioned earlier that we have what we referred to as our ET3 program which stands for Emergency Triage Treatment and Transport. So, this is a way in which we hope to decrease visits, unnecessary visits for those lower acuity problems, from going to the emergency department. So, what we do is we have a virtual express care program and we work closely with FDNY. So we actually receive calls directly from their operators and they use an algorithm to determine lower acuity problems and complaints. They transfer-- the operator transfers those calls directly to us, and we have emergency medicine providers that are able to provide care virtually to those patients if it's appropriate. If it turns out that it's a higher acuity problem that needs transport to the emergency department by EMS, then we absolutely re-up that, you know, to EMS, and they do respond. But other options that we provide through that service or that if it's a visit that can be handled virtually, we can do

that, and complete the whole visit and there's no ambulance needed to be dispatched, and no emergency department visit that's required. The other option is that if it is somebody that needs to go to the emergency department, but doesn't have a level of acuity that requires the EMS level of care, then we can arrange alternative means of transportation for that patient to get to the emergency department. And then the third thing that was mentioned earlier was the treat in place. So we are available through that same virtual express care to treat patients. This would be patient where EMS is already on the scene, but they evaluate the patient and feel that it might be appropriate for us. Then they can also access our service, and we could treat the patient right in their home without them needing to be transported to the hospital and then also getting the ambulance back out for the next patient more quickly.

CHAIRPERSON NARCISSE: And prevent overburden the ER.

ASSISTANT COMMISSIONER MASON: Exactly.

CHAIRPERSON NARCISSE: Staffing ratio, what are the average doctors to patient and nurse to patient ratios across the H+H emergency room?

ASSISTANT COMMISSIONER MASON: So, we have a nursing staffing model that's based-- that was rolled out in 2022 which takes into account many factors. So, including the time of day and arrive-- that patients are arriving to the emergency department, their level of acuity, the length of stay that's expected based on that level of acuity and that staffing model has been used by our nursing leadership to make calculations about what the appropriate staffing is based on all those factors, including seasonality because we have significant variations based on the season.

CHAIRPERSON NARCISSE: Okay. Thank you for the answer, but I would like for you to be a little more specific, because let's say-- so it depends on the time of the day, depends-- so all this data have been given, right? We are aware of the data. So can you roughly tell me, like, in the mid-day or early in the morning or evening where you have an increase? What's the ratio look like for nurses before we get to the doctors?

ASSISTANT COMMISSIONER MASON: I mean, we would have to get back to you on that specific information.

CHAIRPERSON NARCISSE: For the Doctors as well.

ASSISTANT COMMISSIONER MASON: Well, doctors, we also have a staffing-to-demand model, and we are constantly-- both the nursing and the physician models, we're continuously reapplying them and adjusting our staffing appropriately. For the physicians we have a model that uses arrivals per hour and capacity of the providers that are working in the emergency department to be able to treat those patients, and we relate that to our needs in terms of physician and other advance practitioner staffing.

CHAIRPERSON NARCISSE: So, in any given time, do you have like PA? Do you consider them in the level of the doctors? What-- how that work now?

ASSISTANT COMMISSIONER MASON: It varies to some extent by facility. We always have attending physicians in all our facilities, but we do use Advance Practice practitioners as well. Partly, the distribution might depend on whether there's a resident-- an emergency medicine residency training program and other residents working the emergency department, but if not then we certainly supplement with Advance Practice practitioners. And even in

those situations where we do have residents working there, we often supplement using advanced practice practitioners always supervised by emergency--

CHAIRPERSON NARCISSE: [interposing] Attending physician. So, in roughly on the time of shift, how many attending physician you have? You have each for each different department or just one to cover the whole ER or two to cover the whole ER?

ASSISTANT COMMISSIONER MASON: Well, it really depends on the facility and the volume and also to some extent the geographics of the individual department, but we base it-- we base our staffing models on the knowing in that particular facility the number of patients that are expected to arrive on average, and we really base it looking at every single day of the week and the time of arrivals when we-- you know, that we know when our busiest times are, and we map it out, you know, down to the hour of the day and staff according to that, and then that calculates-- we use that to calculate the number of providers that we would need to staff.

CHAIRPERSON NARCISSE: So, the model that you're referring to, is that a name for the model or

just who will collaborate for the model or is the model that within [inaudible].

ASSISTANT COMMISSIONER MASON: It's a model that literally takes the number of arrivals per hour and every day of the week, the average number of hours. It uses the capacity based on the number of providers, physicians, residents, APPs that are present during that hour of the day, and we use that to calculate whether there are any gaps and we base on our staffing calculations on that.

CHAIRPERSON NARCISSE: So for now it's working, that's what you're saying, in the ER?

ASSISTANT COMMISSIONER MASON: It has-- it's working, and it has been validated in multiple situations in which we've applied it. So we do have confidence in the model.

CHAIRPERSON NARCISSE: Because I get a lot of complaint of the residents now when they-- I mean, not specifically for the ER, in general. Like, they feel overwhelmingly in amount of patients they have to see in a minute. Let's move forward with that. Emergency department wait times, we know that is increasing. Do you have any data that you can share regarding wait times at H+H emergency

departments, and if so, are there any notable differences that you observe regarding the wait time based on borough or the type of the emergency?

ASSISTANT COMMISSIONER MASON: When patients present to our emergency department, they are always seen based on their level of acuity. So we use a system called Emergency Service Index to evaluate the patients, and we always see them and p prioritize their care based on their level of acuity and the resources that they need in order to be seen.

CHAIRPERSON NARCISSE: Are wait times for patient who arrive in ambulance different than with times for patients who arrive at the emergency department on their own?

ASSISTANT COMMISSIONER MASON: Well, as I said, we evaluate patients based on their level of acuity and their-- you know, the resources that are needed to treat them, and we do that systematically for both walk-in patients and ambulance patients.

CHAIRPERSON NARCISSE: You know for some folks-- not a lot-- the myth is when you come with ambulance services you get the care faster, right?

ASSISTANT COMMISSIONER MASON: Very aware.

CHAIRPERSON NARCISSE: And I had to explain to them there's a triage nurse that you have to see. Thank you. Hospital bed capacity-- in a recent report by Politico the average wait time for hospital bed has rising to over 26 hours. What additional steps are being taken to improve hospital bed availability, especially in H+H hospitals in underserve areas?

ASSISTANT COMMISSIONER MASON: Well, we always try to provide the same level of care for patients whether they're wording [sic] in the emergency department or whether they're in a bed upstairs in our hospital. So, we admit those patients and care for them regardless of their physical location.

CHAIRPERSON NARCISSE: Ambulance transfer wait times, what is the average wait time for ambulance to transfer patients from H+H emergency department, and how have these times changed over the past three years? We heard it before, like they have to transfer the patient. Sometimes they have to give it to-- another step. Can you answer that question?

ASSISTANT COMMISSIONER MASON: so, the ambulance turnaround time is the total amount of time

from when the ambulance would arrive at the destination facility until that ambulance is back in service for the next patient. Our part in that process is to take the handoff from EMS and transfer the care to our hospital staff. We're very much looking forward to the implementation of the hospital liaison officer that was discussed earlier. We think that that will really be a great improvement to improve the efficiency of the handoff from the pre-hospital care to the emergency department care.

CHAIRPERSON NARCISSE: Delays, what are the primary reason for ambulance delays, and how has H+H adapted protocols to address these challenges?

ASSISTANT COMMISSIONER MASON: The primary factor leading to increased turnaround times is related to the volume of patients that come to our emergency department. So we have seen increases in our emergency department visits from 2020 to the present time, and we-- despite that, we have been able to scale up and see those patients and we will continue to do that in the future.

CHAIRPERSON NARCISSE: One other thing I don't understand. I know there's changes, but don't you have a triage nurse that receive the ambulance

when they walk in-- I mean, when they bring the patient in? Because I don't understand why the-- I was processing it. Because before, in my time, once the ambulances come in, they stop by the triage and we pick up the patient and we take it away and then that's that. So, I don't know what took place. It's the volumes that's the problem, that the triage nurse cannot get to it, or understaffed? One person can answer. I don't-- because I'm confused about it. Because once the ambulance come, we take it as an emergency. So, other nurses that's on the floor will be in an emergency room, will take the walk-in patients, and the one for the ambulance we try to get them out back. So I don't know where we-- what's going on. So can you explain to me how that happen?

ASSISTANT COMMISSIONER MASON: Well, it certainly can be related to the volume of arrivals and the-- and also surges in that volume, right? So, for example, our busiest facility during the busiest hour of the day could receive 28 patients in an hour, not all from ambulance, but includes the walk-ins as well. So, those sorts of surges, you know, can lead to that. but we always see patients in terms of their acuity, and so those that are, you know, have

most urgent and life-threatening problems are immediately taken and cared for regardless of how many patients are arriving at a given time. But we also do receive a fairly large amount of lower-acuity patients at the same time.

CHAIRPERSON NARCISSE: So to me it sound like lack of staff or the capacity of the emergency room.

ASSISTANT COMMISSIONER MASON: We're constantly re-evaluating, and we staff up as we need to. You know, but volumes certainly have increased over the last-- since 2020, including the acuity of the patients and also the volume of lower acuity patients.

CHAIRPERSON NARCISSE: So now, that bring me to another question. The space, capacity-- because I know some of your ER. The space is very limited. You have patient all over the place. What are we doing to make sure that we increase the capacity too of the space and the staff together? What are we doing?

ASSISTANT COMMISSIONER MASON: In situations where we either have limited space or are anticipating, you know, having more volume over time,

we are always advocating for, you know, for improvements in the space, and we do appreciate the support that we get from the Council when we come with those sorts of requests when the budget is being created.

CHAIRPERSON NARCISSE: Because I know some-- one of the ER specifically is crying out there's no space. So we need to do something about that, because it's really impacting the services, the healthcare, because folks are complaining as well, and it's not good. How has the increase in ED visits impacted ambulance arrival and float [sic] times at high volume locations like Jacobi and Bellevue?

ASSISTANT COMMISSIONER MASON: ED arrivals have increased at all our facilities, some more than others, but we continue to see all the patients that come to us and provide care for them.

CHAIRPERSON NARCISSE: Okay. What type of language access supports does H+H have at their facilities, particularly at the triage station for patients who have limited English proficiency?

ASSISTANT COMMISSIONER MASON: We have interpreter services available throughout our facilities, including the emergency department for

all the languages that we see commonly spoken at our facilities.

CHAIRPERSON NARCISSE: Okay. I know you kind of answer that partly, but I'm going to dive into it again. Are certain H+H emergency departments experiencing higher ambulance offload delays and what target intervention are in place at those locations?

ASSISTANT COMMISSIONER MASON: All of our facilities have experienced increase in volume, some more than others. so, some of the things that we have put into place are-- first of all, we're looking forward to the Hospital liaison officer joining us, but we-- we also have implemented a number of our facilities a provider and triage system where there's in addition to a nurse or instead of a nurse, there may be a provider actually stationed in triage, and that person can actually start the evaluation going for some of the-- I mean, the highest acuity patients would be pulled in and treated and addressed immediately, but for those that are less urgent, the provider in triage can provide the start-up of some of the treatment and the studies that need to be done in order to get to the disposition for that patient.

CHAIRPERSON NARCISSE: What protocols are in place when ambulance wait times exceed acceptable limits, and how are patient's needs managed during the extended offload periods?

ASSISTANT COMMISSIONER MASON: We always see the patients as, you know, as they come to us based on their priority and their needs. As I said before, we continuously re-evaluate our staffing needs and we are able to staff up as we need to, and when-- if patients are boarding in the emergency department, we manage those patients so that they get the same care that they would get if they were admitted upstairs by, you know, our teams admitting them and caring for them while they're in the emergency department.

CHAIRPERSON NARCISSE: How does H+H coordinate with FDNY EMS during peak hours to manage patient transfers, and are there any joint initiatives to improve communication and reduce the wait times?

ASSISTANT COMMISSIONER MASON: Well, we are very much looking forward to the implementation of the hospital liaison officer. I think that will be a really positive thing for us in terms of being able

to increase the efficiency of that hand-off that occurs between the EMS crew and our staff, and we'll be able to get the unit out, ready to take care of the next call even more efficiently. Also allow us to communicate, you know, on an ongoing basis.

CHAIRPERSON NARCISSE: Okay, triage model. Can you share how much wait times at H+H emergency department have decreased since implementing provide in triage models? I mean specifically at the highest volume locations.

ASSISTANT COMMISSIONER MASON: I don't have data on that to provide right now, but I can get it for you, but I can tell you from my personal experience when we implemented it at one of our facilities, we saw significant decreases in the number of patients that were leaving without being seen as well as increases in the patients experience scores.

CHAIRPERSON NARCISSE: Can you please tell us more about H+H Express Care model and how effective has it been in reducing the number of non-urgent patients presenting to the emergency room? What metrics are used to assess its impact, and are

there any future expansion plans for this model in 2024 and beyond?

ASSISTANT COMMISSIONER MASON: Sure. Our virtual express care program has seen approximately 22,000 patients since it was implemented in 2020, and of those patients about 50 percent were able to be managed in a way that did not require them to be transported to one of our facilities.

CHAIRPERSON NARCISSE: That's that a good improvement [sic]. With NYC Care expanding to all boroughs, what impact has it had on reducing emergency visit by increasing primary care access, which [inaudible] before, particularly in high-density areas like the Bronx and Brooklyn?

ASSISTANT COMMISSIONER MASON: I can't comment specifically on how NYC Cares has affected that, but you know, we continue to see all our patients without regard to their insurance or their ability to pay in our emergency departments.

CHAIRPERSON NARCISSE: Alright. So, I'm going to pass it to my Chair Ariola. Thank you.

CHAIRPERSON ARIOLA: I believe we can dismiss this panel if there are no other questions?

CHAIRPERSON NARCISSE: No, just a second. Just a second, because psychiatry. It's very important.

CHAIRPERSON ARIOLA: Oh, sure.

CHAIRPERSON NARCISSE: Can you please tell us about the H+H comprehensive psychiatric emergency programs? How do this mobile crisis intervention services assist psychiatric cases in the emergency room, and what impact have CPEPs had on reducing ER over-crowding at H+H sites?

ASSISTANT COMMISSIONER MASON: I'm sorry, could you repeat that?

CHAIRPERSON NARCISSE: Oh, sorry. Can you please tell us about the H+H comprehensive psychiatric emergency programs? How do this mobile crisis intervention services assist psychiatric cases in emergency room, and what impact have CPEPs had on reducing ER over-crowding at H+H sites? And now opioid crisis, we getting to that. Opioid crisis, we are currently experiencing a nationwide opioid crisis. What are the key factors contributing to emergency department delays related to this opioid crisis and what specific interventions are being

pursued to support overdose-related case-- I mean care-- and does the CPEP cover such cases?

ASSISTANT COMMISSIONER MASON: I can't speak to the CPEP program, but I can speak to the fact that there is expansion going on of the services to treat patients with opioid use disorder in our emergency departments. I know that there's a group that's working on that right now creating guidelines that are hospital-wide but specifically will be implemented in the emergency department, especially around strategies to manage patients that present with opioid use disorder and get them started on modalities like buprenorphine when it's appropriate and then refer them to the appropriate next step, you know, next service.

CHAIRPERSON NARCISSE: Okay. Does H+H have contract with private ambulance providers? if so, you please provide their names and does each H+H facility have a separate ambulance contract, or does H+H have a whole-- I mean, who will enter into ambulance contracts?

ASSISTANT COMMISSIONER MASON: I would have to refer to Sidney [sic] about that. I'm not aware of any private--

CHAIRPERSON NARCISSE: [interposing] The contracts? Okay. Can you answer ambulance contracts?

CHIEF FIELDS: Certain H+H facilities use a fire company called Ambulance [sic] I don't have any specifics on their actual contract. They don't work for the 911 system.

ASSISTANT COMMISSIONER MASON: I think that's primarily for inter-facility transports as far as I'm aware.

CHAIRPERSON NARCISSE: Alright. The Adopted Capital Plan allocated $2.2 million for the creation of the ambulance bay in Bellevue Hospital's department. One of the conditions for Mount Sinai Beth Israel's closure is that Mount Sinai health system will provide funding for the expansion of Bellevue's emergency department. What specific changes to the emergency department does H+H plan to make with all this combined funding, and what impacts will those improvements have on Bellevue's emergency services?

ASSISTANT COMMISSIONER MASON: I don't think I could speak to the specific improvements that are planned at Bellevue. I know that there are

expansion programs underway, but I'm not prepared to speak to that right now. I could get back to you with that information.

CHAIRPERSON NARCISSE: Okay. It's another department that's in charge of the transferring and the funding and stuff? You can't-- so you're going to get the answer and send it to us?

ASSISTANT COMMISSIONER MASON: Sure.

CHAIRPERSON NARCISSE: Okay. Let's shorten this. Thank you. Thank you, Chair.

CHAIRPERSON ARIOLA: Thank you. I'd also like to note that Council Member Gennaro has joined our panel. Are there any other questions from members? Nope? Okay. Then I believe I want to thank you so much for coming, for answering all the questions, for answering them informatively, and you can be dismissed. Thank you. I now open the hearing for public testimony. I remind members of the public that this is a formal government proceeding and that decorum shall be observed at all times. As such, members of the public shall remain silent at all times. The witness table is reserved for people who wish to testify. No video recording or photography is allowed from the witness table. Further, members

of the public may not present audio or video recordings as testimony but may submit transcripts of such recordings to the Sergeants at Arms for inclusion in the hearing record. If you wish to speak at today's hearing, please fill out an appearance card with the Sergeant at Arms and wait to be recognized. When recognized, you will have two minutes to speak on today's hearing topic which is ambulance response times. If you have a written statement or additional written testimony you wish to submit for the record, please provide a copy of that testimony to the Sergeant of Arms. You may also email written testimony to testimony@council.nyc.gov within 72 hours of this hearing. Audio and video recordings will not be accepted. I'll now call our first panelist, Oren Barzilay and he is on Zoom.

SERGEANT AT ARMS: You may begin.

OREN BARZILAY: Good morning Committee Chairperson and honorable Council Members. My name is Oren Barzilay. I'm a 29-year veteran of FDNY EMS. I am President of EMS Local 2507. I am here today to speak on behalf of more than 4,400 uniformed FDNY EMTs, paramedics, and fire inspectors. New York's EMTs and paramedics serve in the most renowned fire

department in the country and the worst busiest medical first responder's agency. My members are tasked with responding to an incredibly large number of emergencies each year. In 2023, EMS responded to 1.6 million medical emergencies, another record-setting year for the department, a nearly 40,000 increase from 2022. Since the start of the pandemic in 2020, responses by New York City's medical first responders are up 14 percent. As emergency numbers continue to rise so does the amount of time necessary to respond to them. Ten years ago, it took EMS members 9.6 minutes on average to get to life-threatening call. The response time now is 12.4 minutes. It is not surprising that medical response times are consistently going up. It will continue to go up as funding to improve EMS is stagnant. We have 11 percent fewer units on the streets to respond to priority calls. With more and more bike lane, street closures, and speed cameras which our members are forced to follow during emergencies, how does anyone expect response times to improve? We saw a spike in EMS activity during the pandemic where we required additional resources. We have returned to pre-pandemic levels for--

SERGEANT AT ARMS: [interposing] Your time has expired. Thank you.

OREN BARZILAY: but calls have not declined. Our EMS Chief is doing a great job, but he is not given the proper number of resources needed by the pencil-pushers of OMB. People are dying every day due to their negligence which is proven by the new cardiac arrest numbers released in the latest Mayoral Management Report. It should be alarming to every citizen and visitors of the City, that if you go into cardiac arrest in our city, survivability rate has dropped from 28 percent in 2023 to 20 percent. We should be striving for that survivability number to go up, not down. In emergencies minutes matter. Multiple studies indicate that an extra minute of two can be a difference between life and death. Today you will hear from a Bronx resident, Tyler Weaver [sic], a father who told me it took EMS over 20 minutes to arrive and treat his son, Nicholas Costello [sp?] who was not breathing. His son has passed. Cases like Nicholas are not one-off occurrences. OMB is costing people’s lives. If things don’t change, unless the city takes EMS seriously as an essential service.

We're witnessing a total collapse of the system. As I stated before in an ABC interview, anyone suffering from cardiac arrest with a 12-minute response time, you might as well take them to the morgue. Our men and women do amazing heroic work every day. However, we are stretched thin. EMS headcounts are consistently fluctuating and regardless we don't have additional units and less available vehicles. More resources and personnel are the only solution at this time. These stats are a reflection of OMB refusing to invest in EMS as they do to everything else in the City. Thank you for your time.

CHAIRPERSON ARIOLA: Thank you, Oren, and thank you for always bringing great light to a really impossible situation. And you're right, this Administration, OMB, they have to put more resources into EMS and they have to make sure that we have those vehicles that they're saying are off the road back on the road, because if there's 22 percent because they need fixing and there's 23 percent because we don't have staffing, I don't think that we were getting the right amounts. Chief Fields was doing a great job. Everybody in the panel did, but they're towing the company line, and that's just not

acceptable. We need to get more EMS on the streets. We need to get more ambulances on the street. We need to make sure that they are getting the pay parity that they need, and that can be done with the Administration. I know it's a collective bargaining issues, but the Administration can make that call right here right now, and then we would not see a retention problem and we would not see a hiring problem. Thank you so much.

CHAIRPERSON BREWER: I have one question which I forgot to ask, and maybe you don't know, but I know DocGo, very controversial company-- did he leave? DocGo which is a controversial company does have some of the ambulance contracts. Do you notice any difference in terms of whether it's funded by DocGO and their operation? Health + Hospitals-- I know you don't represent the private company. This question is have you heard anything about this contract or it's not come to your attention?

OREN BARZILAY: DocGo, from what I know, is a-- they don't provide ambulances. They provide EMTs and paramedics through special events.

CHAIRPERSON BREWER: Okay. So it's not the ambulance services at all then, okay.

OREN BARZILAY: No.

CHAIRPERSON BREWER: Thank you very much.

OREN BARZILAY: Okay. I just want to clarify. Yes, in the past we mentioned that staffing was the issue. The issue is no longer staffing. The issue is now the amount of resources we have. The call volume simply cannot be sustained with a level of employees that we now have. We need more units out there.

CHAIRPERSON ARIOLA: Okay. So, that would translate to staffing, and that's what we have to get. We have to make sure that we can get staff and retain it. That's the problem, the retention. Thank you, Oren. Next, we have Maisha Morales and Santa Morales in-person.

UNIDENTIFIED: My daughter is going to speak for us today. Thank you.

MAISHA MORALES: Because this is emotional for my mom, so I'm going to take a little more than two minutes because I'm testifying for both. Thank you. Good afternoon and thank you for holding this hearing. It's extremely important. And I'll be emailing you my testimony as well. My name

is Maisha Morales and I'm here today to honor the memory of my father, a proud Bodicua, a proud New Yorker, Antonio Morales, who dedicated his life to service, community and justice. My father served this country during the Vietnam era where he realized the profound complexities of war, shaping him into the person he became. Upon his return he married his childhood sweetheart, my mother, the love of his life. Together they raised two children. My father lived life fully, helping everyone he encountered and instilling in me the values that guide me today. On August 25th around 2:35 a.m. I received a call from my mother who had fund my father lying on the floor surrounded by a pool of blood and bloody diarrhea. We immediately called for an ambulance knowing he needed urgent care. As we waited for emergency services to arrive, each minute felt agonizing filled with mounting fear. To be fair, the 911 operator herself quickly connected us to the emergency medical services, and we were assured an ambulance was on the way, but it didn't arrive until nearly an hour later, sometime after 3:35 a.m. When the EMTs arrived there was no sense of urgency. In fact, they looked like they just woke up from a nap. They lifted my father

onto the gurney without a sheet or a cover to protect his dignity. When we asked for a sheet, we were told they had none. After they transported him to the hospital, the ER doctors found that his blood pressure was dangerously low and his potassium levels were critically high. The hospital team initiated a blood transfusion to stabilize his blood pressure so they could proceed with an endoscopy, but they forgot to bring his potassium level down in time. My father went into cardiac arrest and passed away in the emergency room. The tragic loss of my father has left my family devastated. My mother has lost her partner, her lifelong love, and I've lost my father who raised me to be the person that I am today. Some of you know me as a community leader, activist. Financially my mother now bears the strain of rent that consumes nearly 95 percent of her income, a burden faced by many seniors on fixed incomes who after losing a spouse are pushed into poverty. Our family's experience shines a light on the struggles of others in our community who face similar losses without adequate support. My father's life was marked by service. He was a respiratory therapist and later a recreational therapist for Catholic

Charities for persons with disabilities, and he became a Special Olympics coach for over 30 years, even into his retirement. As a young girl, I remember him speaking passionately about the injustices he saw in healthcare, particularly in communities of color where patients often face neglect and inadequate care. He raised these issues back in the 1980s, long before they were publicly acknowledged. The pain in witnessing this neglect in his field led him to leave respiratory therapy, a profession he loved, as he couldn't bear the suffering it brought to others and himself. Despite this toll, he continued his life of service in every way he could. he was an active community member who helped the unhoused, shared from his community garden with anyone in need, and treated every person with respect and dignity no matter their background. He believed in standing up for what's right. He cared deeply about our community's wellbeing. While I'm still waiting to understand the full case of my father's death which may have involved medical practice as well-- medical malpractice, as well. I know that the delay in ambulance services played a critical role. Waiting nearly an hour for an

ambulance during a life-threatening emergency is unacceptable. It's a failure of our system. No one should have to fear that emergency help will arrive too late to save a loved one. The men and women in EMS, healthcare providers and doctors are entrusted to protect life, not to leave families abandoned in their greatest time of need. I urge the Council to take action. We need a system that provides timely, equitable care to all, investments in emergency response infrastructure, and supports for families who like mine face financial hardships after losing their primary providers. My father's life was a testament to kindness, justice and compassion. His legacy deserved to inspire change so no other family member may endure the heartbreak we have faced. Thank you for your time and thank you for considering the steps we can take to build a more just and compassionate system. [speaking Spanish]

CHAIRPERSON ARIOLA: thank you so much for your testimony and please accept our deepest condolences on the loss of your husband and your dad. This doesn't seem like it was just a loss to you, but a loss to humanity here itself.

UNIDENTIFIED: We were married 52 years. We met when we were 16, old school. He had to visit twice a week and leave at a certain time. My parents came from Puerto Rico, came here and made a life for themselves and I proud of them and I'm proud of my daughter and my son and my grandchildren, great grands I have.

MAISHA MORALES: I wanted to just add something as I was hearing them testify and the different levels of responses depending on the severity, right? Patients or their par-- whoever's calling on behalf of the patient, sometime-- you're distressed, right? You're calling. You're like-- you don't even know what to say. I don't even know what I told-- I mean, I know that I told them, but I was half asleep. It was two something in the morning when my mother called me, right? I was just like my father's on the floor. I don't know. There's blood. They're asking me all these questions. I mean, it disturbs me because from what I've been told by other people that-- EMS technicians is that there's different levels. And they're like, yeah, call like yours, you're all the way at the end. Who-- the system needs to change. We can't play God, right?

Because they probably thought oh, this is a man with diarrhea and ignored the part that I said there was blood and he's on the floor, right? And put him for last. When clearly it had a direct impact in his death. And so I think that-- how they approach-- they need to approach every call as if it's life and death, because they can't play God, none of us can, to decide which is a priority and which is not. So I just wanted to add that, and I wanted to highlight, because I know there's some State Senators as well who are talking about these things, and they're connecting it to congestion pricing, right? And I'm not saying that the traffic doesn't have impact on ambulance response time, but I want to make it clear, I called at 2:46, 2:45-- I have a screenshot of it-- a.m. They showed up almost an hour later. I ran. My mother told me they're still not here. I ran over, because I was going to meet her at the hospital not to delay any time for her, and I ran over. There were no cars in the street at that time, you know what I mean? So, I also don't want this to turn into some little ploy where folks-- we need to do something about our environment and congestion, yes, but to use instances like ours just to push their

congestion pricing agenda. In my father's case, there were no cars in the street at that time. So I just want to highlight that. And--

CHAIRPERSON BREWER: [interposing] Did you ever get a response from anybody as to what happened? Did you--

MAISHA MORALES: [interposing] So, at the emergency room, he was laughing and kind of joking because they gave him the IV and we were trying to cheer him up, and then just went into cardiac arrest. The machines didn't go off and so clearly because something was wrong. We were behind the curtain because they were changing him, his pad. Every one stood quiet and everyone-- all the doctors, they refused to talk to me. I was begging them what just happened, what just happened? So, I don't know if they went on protection mode, and that's something I'm fighting for as well, but apparently Methodist Hospital, it's a thing there. I'm just finding out. But yes, no one has given me ans-- they didn't even-- I was asking for where do I sign up for an autopsy. They ignored me. I finally was able hours later to get-- request an autopsy, and it's now been almost two and a half months and I haven't received it yet.

CHAIRPERSON ARIOLA: So, was there a reason given for the long response time? Was it because it was not designated as an acute situation by the 911 operator?

MAISHA MORALES: I think-- so, I don't know-- to be fair, I didn't ask like what took you so long, right? I didn't ask that, because we were just worried about my dad, but I will say when-- because when I got to my mother's house the ambulance had just got there, and I saw the-- how they got out the truck, right, how very, you know-- like, literally like they just got up from a nap. Even when they showed up to the apartment, they were just like very-- they themselves could barely lift my father. My father was not an overweight man, okay?

UNIDENTIFIED: He was like [inaudible] his underwear off and full of blood. When they put him in the gurney, [inaudible] they take him out. I said, don't you have a blanket? He says no. I had to take his bed-- his blanket and cover him.

MAISHA MORALES: so, yes. So to be fair, I didn't ask because at that-- I was just fed up and furious, but just wanting them to attend to my dad, so I didn't ask that.

CHAIRPERSON ARIOLA: Alright, thank you.

UNIDENTIFIED: Thank you.

CHAIRPERSON NARCISSE: When you got to the emergency room, did they get him right away? Did they get him right away?

MAISHA MORALES: They brought him straight to the back.

CHAIRPERSON NARCISSE: Okay. They were-- okay. So, I hear you, like the Chair said. I want to say thank you, because most folks-- because it just happened, you would not be here to testify and let us understand what's going on and dealt [inaudible] forward to make sure we address them. I'm an ER nurse, former ER nurse, so it's very-- as you can hear, the time increase like I said is a tick-tock moment for the person life. So it's very important. So, I thank you.

MAISHA MORALES: I just want to share, at some point when my father was able to talk before he died, because they had given-- remember he had diarrhea so I guess he was dehydrated as well. So when they gave him the IV it helped him a little. And he said come here. He says is it me, am I going crazy or did it take the ambulance almost an hour to

come? And I said no, dad, it took almost an hour. He said that is unacceptable. He's like, "I think I'm going to be okay, but what if it was someone who had a heart attack?" He didn't even know he was going to die shortly after, and he said, "Maisha, on Monday I need you handle this. This is not okay." Because he knew I'm an activist. I also came here because this is what my father wanted me to do. we didn't even know you guys were having this hearing, and so thank you former Council Member Rosie Mendez for informing me, and yes, I just thought it was important to know, and if there's anything that I can do as someone who experienced this-- if you need support in changing legislation, that's what I'm here for. Thank you.

CHAIRPERSON ARIOLA: Thank you so much. And again, I'm sorry for your loss.

COUNCIL MEMBER RIVERA: I just want to-- can I just mention one thing to the-- I just want to tell you that you know I love you. So, I think it's the-- and I don't know what else to call it, but a grievance process, right? You're trying to figure out what happened and you're trying to get information and it's on FDNY and many other agencies

involved and they testified today that they're trying their best, but I also feel like you're owed information, you're owed an explanation, and I can't even imagine someone as-- you're so informed, Ms. Morales. You are-- you actually spent your life helping people navigate bureaucratic processes and yet you still continue to find yourself up against a wall in getting simple information for your own personal justice. So I just want you to know that we're here also for you.

MAISHA MORALES: Thank you.

COUNCIL MEMBER RIVERA: Thank you for being here, and thank you, too.

CHAIRPERSON ARIOLA: If I can just hold you for one more moment, because your story is just so heartbreaking and how you describe it in such detail makes me wonder. In your opinion, do you feel that that response time, that slow response time and then the slower response from the medical team that was going up to get your dad, do you think in your opinion that that did contribute to the fact that he did not have a positive outcome?

MAISHA MORALES: Absolutely, and again, while I'm not 100 percent sure, right-- I'm still

waiting for the autopsy. Even if it didn't, he suffered longer than he needed to, right? But I believe he did-- it did. And on both parts, on the hospital-- I couldn't believe what I was seeing. It's just low energy kind of like whatever. It's two in the morning. Like, they're-- I didn't see any compassion, and maybe it's because I'm a person who cares, right, and I fight for everyone. I don't care who you are. But this level of-- this lack of compassion. That alone, like they weren't happy to be at their jobs, you know, and I feel that contributed to, as well.

CHAIRPERSON ARIOLA: Thank you so much. Anyone else?

UNIDENTIFIED: I was going to say that I hear a lot of chit-chat, you know, like staffs were working around just talking and walking up and down. At one point, whatever they-- they had to put blood in my father-- my husband, excuse me. And then, I saw the whole little table was full of papers and stuff, and somebody came in and said, "Has anyone removed this yet?" You know? Yeah, so.

MAISHA MORALES: And I know that we're here for the [inaudible] but yes, the hospital has--

the ambulance has contributed to it, but since we have folks from the hospital here as well, it's something that it's more than just me. Our whole healthcare system is failing. Thank you.

CHAIRPERSON ARIOLA: Thank you. Our next person giving testimony is Tyler Weaver, and he is on zoom.

TYLER WEAVER: Hello, can you hear me?

CHAIRPERSON ARIOLA: Yes, I can hear you.

TYLER WEAVER: Okay, alright, thank you. I'll get started. Hi, my name is Tyler Weaver. Ambulance response times are at record highs. These long ambulance response times tragically impacted my family in December when our adult son Nicholas Costello suffered a cardiac arrest at 5:00 a.m. in the Bronx. Again, that's a time when there's not a lot of traffic, and he waited 20 minutes for an advanced life support paramedic unit. The back-up basic life support unit took 24 minutes. He was taken to the ER, but he had already suffered major brain injury because his heart had been stopped for so long. Due to this extensive brain damage our son was taken off life support, pronounced dead the following day. After my son died I was so appalled,

especially because I used to be an EMT, at the long response time to his cardiac arrest that I investigated further and discovered a couple of things. Number one, the ALS unit for my son came from 24 blocks away. The back-up BLS unit was stationed 66 blocks away and had to travel through three different police precincts to get to my son. Why were there no ambulances available locally in this area? Well, the answer is an hour and a half earlier at 3:30, all the local ambulances were apparently sent to standby at a multi-alarm fire bring a row of unoccupied stores. This move meant that the Bronx communities of Riverdale, Kings Bridge, Spuyten Duyvil, and Fieldston which is about 65,000 residents, appear to have been left without quick access to ambulance services for several hours, and unfortunately my son needed a rapid ambulance time during that time window, tick-tock moment as Councilperson Narcisse mentioned. FDNY should take measure to reserve a local ALS ambulance to be available to handle life-threatening calls whenever there is also a major fire going on elsewhere in the same area. The inability to properly resource both EMS incidents at the same time that night is

alarming, and demonstrates a serious lack of Bronx ambulance resources. Second thing, Bronx ALS response times are much worse than the other boroughs, such as Manhattan. According to official city data, only 22 percent of Bronx ALS responses in September arrived in less than 10 minutes. This meant 2,600 Bronx patients waited more than 10 minutes for an ALS ambulance in September. In contrast, the same Manhattan data was much better at 42 and Brooklyn was 48. This disparity has been going on for many years, and it's only getting worse. And I believe this is a EMS health equity issue. In closing, I call on the City Council to eliminate this EMS health equity issue and that they mandate a certain amount of FDNY's 2.6 billion dollar budget be used for properly meeting the ALS ambulance needs of the Bronx so that other families won't have to suffer what mine did. If I may, I also want to just touch on if I'm allowed to the grievance process. I opened a complaint with the FDNY in June complaining about the 20-minute response time and why none of the ambulances that were at the fire which was 300 feet away from where my son was having CPR done on him, why none of those ambulances could have been sent to

help him. They were only three minutes away by foot. But they sent a different ambulance from 20 minutes away. I opened a complaint with the FDNY. They told me someone would call me to get additional information. That never happened. Whenever I contacted the civilian complaint unit at the FDNY EMS to inquire about how my case was proceeding, they couldn't tell me anything else besides, "Oh, it's been escalated to a different team." And they refused to give me any information on how to contact that other team. So I went through that for two months. I eventually called them at the end of that two-month period and inquired, you know, what's going on with my complaint. And they said, "Don't worry, as soon as the complaint is closed, we will let you know." And I raised my hand, I'm like, so they're going to close it without talking to me? And they're like, look, we empathize with your point of view, but that's how the system works. So, I ended up contacting the Office of the Inspector General, Department of Investigation in New York City and spoke to a helpful woman there who then placed her own call over to the civilian complaint unit. And remember this is two months in. And she got back to

me, she says, "Oh, your investigation is completed. You should be getting a letter in the next few days." So, I'm like, okay, thank you so much for your help, because obviously I wasn't able to prompt a quick response to my complaint. It's now November. I was told in the letter that they sent about my complaint which was a form letter saying they had filed their internal procedures to the letter as far as complaint investigation goes. And the letter said if I want the results of the investigation, I have to file a Freedom of Information Act request, which I did immediately. And I've been waiting about four months now for that Freedom of Information Act request to go through. So, you know, and many, many months, this-- the grievance process is not friendly to grieving families, and I just wanted to add that. It just kind of like rubbed salt in the wound, and I know it's a little off the topic of what this meeting is about. But last thing I'll mention is that my written testimony which I submitted does have a little bit more data on the disparity between the different boroughs as far as ALS response time goes, and if you're able to review that written testimony there's

more useful information in there. And I just want to thank you for the opportunity to talk to you today.

CHAIRPERSON ARIOLA: Thank you so much for coming on. It's a very difficult topic for you. No parent should ever have to bury their child, especially one that could have received help sooner. I appreciate you bringing up the grievance issue that you did, because I will get in touch with FDNY and that department, and also we have your contact information, so I'm going to ask the Councilperson in your district to reach out to you to help you navigate that so that you don't have to go through that alone. Everything that you mentioned, you know, but that's what we want to get to the bottom of. We want to find out why is staffing-- is it that they don't have the right amount of vehicles? Is that they don't have trained personnel that were close enough. To be 24 blocks away or 66 blocks away is just ridiculous. You could never save a life if you're that far away. And yes, we understand that there was a big fire, but we do have to-- this is why we're always fighting for the fifth firefighters so that areas in the gap aren't left alone and always have emergency services available. So again, Mr.

Weaver, I thank you so much for coming on. Your testimony will be read in its entirety by this committee staff, and again, sorry for your loss. Any other questions from anyone?

CHAIRPERSON NARCISSE: Sorry for your loss and we have to do better. Thank you for coming to testify.

TYLER WEAVER: Yes, thank you. And I could say, you know, as a former EMT, the issue is insufficient number of ambulance shifts being staffed. Everything else you're hearing is-- when I was an EMT 35 years ago we were talking about how people misuse the system and call for stuff that has-- that they don't really need to call for. That's been going on for 35 years. You know, I wish the department luck in solving that issue so that they don't have to get more ambulances, but I don't think that-- my opinion, it's not realistic. They need more ambulances and yeah. And if anyone has any questions, you know, feel free to reach out to me. I am ready to be an advocate for this not to happen to other families as well. Thank you again.

CHAIRPERSON ARIOLA: Thank you so much, and just rest assured that we do have a new

Commissioner now, Robert Tucker, who is looking into all of these different issues with response time, and he is willing to put in the work to make sure that it's alleviated. So, thank you.

TYLER WEAVER: Thank you.

CHAIRPERSON ARIOLA: Our next panelist is Stu Weiss. He's here in-person.

STU WEISS: Good afternoon now. I'm sort of new at this, so excuse me if I don't know what I'm-- the order I'm supposed to do things in. Thank you for giving me a chance. I wanted to comment on a couple of things I heard in the testimony today. First is that when they talk to you about two paramedics versus one paramedic. I'm an emergency room doc, retired now. And there are studies showing that actually in other parts of the country using one paramedic versus two does not statistically change the level of care. So one of your comments having more people in the ambulance is helpful, but just remember that the first paramedic, one of them is driving. There's not two paramedics in the back and a third person driving. There's one in the back and there's one driving, and in other cities they use the EMT to drive and the paramedic stays in the back.

So, there's a study in pre-hospital care looking at two paramedics versus one paramedic. So that was one issue that you should take up as you're studying this. Second of all, in Local Law 119, statistics that you're looking at do not include vertical response time and do not include the ambulances you heard. The crew's sort of gathering their gear. When they clock-- when they push the button on their CAD system that says on-scene, the clock stops. So there's a couple of minutes extra where they're going up. In New York City there's a lot vertical transport time, but also there's a lot of getting your gear together, that kind of stuff, so you might want to ask those questions about well what's the actual? Because you heard the union person talking about 12-minute response times. There may be three or four minutes more of them gathering their gear. The CAD system is really old. I've worked many events with the CAD system. It's a text-based system from like the 1980s. if you could push them-- the new CAD system have visual, have you know, complex displays and you can see the ambulances moving around, there's GPS. Oh, I'm sorry, I'll finish up. GPS that you may want to look at as well. The new

HLO, Hospital Liaison Officer system, that they talked about is wonderful except they're EMTs so they can never take paramedic calls. Like you have to always sign off a patient to a higher level of care, not a lower level. So that hospital liaison will help EMTs, but not with the higher levels of care. And also, in your question, the biggest risk as an emergency physician is the hand-off time. So now you're adding a level of hand-off from the EMS crew that was on-scene to a third-- a second HLO that's not on-scene, and then they have to hand off to the ER doc. So you're introducing a level of complexity that could increase patient risk. You may want to think about that as well. As far as sheets go, there are many times when I worked in the city hospital, we didn't have sheets in the ER. So there's no sheets to give to the ambulance. So when you heard them say they didn't have an ambulance-- a sheet to pick up her dad, that is in fact fairly common. And lastly, lights and sirens, there's been many studies about lights and sirens in an urban environment do not significantly increase response time. It makes a lot of noise. Some ambulances, and I'm not going to mention names, have two, three-- I can't even tell

sometimes how many sirens they have on the ambulance. There's one of them that sounds like it has 15 sirens on it. It doesn't make people move over any better. And in fact, the crew should be looking at every intersection and depending on the noise to make them safe. And lastly, DocGo owns Ambulance [sp?] and Ambulance is the ambulance company that provide service. So just a couple points that I heard today I thought you might want to-- thank-- you're welcome.

CHAIRPERSON ARIOLA: Our next speaker is Christopher Leon Johnson and he is on Zoom.

SERGEANT AT ARMS: You may begin.

CHRISTOPHER LEON JOHNSON: [inaudible] Hey, hello. Hey, Chairs. My name is Christopher Leon Johnson. Thanks for having this hearing here. So, I want to make this clear for-- I'm on a bus [inaudible]. but I want to make this clear that the unions, the UFOA and the EMS [inaudible] unions, they need to advocate for the eradication of open [sic] streets, of Barry [sic] Street and 34th Avenue open [sic] streets and 31st Avenue open [sic] streets in Queens. All the open street [inaudible] be eradicated and hope the Fire Commissioner, because I know you oversee the FDNY, Mr. Robert Tucker, I

believe he's a better choice than Kavanaugh. She-- they-- he advocates for the eradication of open street because the open street situation in New York City has helped the problem with ambulance response time because if someone gets hurt across one area and the open street's in the way, then it's a big chance that ambulance can't go through, especially if there's a special event, you know, especially if there's a special event. That can mean [inaudible] for anybody that needs that attention from the ambulance. They might die. They might be seriously injured. It might be a situation where they could never recover. The City Council I know that [inaudible] nothing but a scam and we need to open and eradicate 34th Avenue open streets and 31st Avenue streets. We need to call investigation to transportation alterative, because if anything happen [inaudible] right now [inaudible] of the elderly and people that's fighting this open street program. But we need to call for investigation and defunding of transportation alternatives and the RISE alliance, and 31st Avenue open streets. And we need to call investigation of Shekar-- of Council Member Shekar

Krishnan, because Shekar Krishan is about to pump $88 million to 31st Avenue--

CHAIRPERSON ARIOLA: [interposing] Two-minute warning.

CHRISTOPHER LEON JOHNSON: Yeah, 31st Av-- 31st and 34th Avenue--

SERGEANT AT ARMS: [interposing] Your time is expired. Thank you.

CHRISTOPHER LEON JOHNSON: streets. So, one more thing. Thank you. And one more thing is yeah, we need to [inaudible] Shekar Krishnan because he's pumping all that money to open streets and this happens. We need to look into this Council Member. Thank you.

CHAIRPERSON ARIOLA: Thank you for your testimony. Is there anyone either on Zoom-- I don't believe so-- or here in the chamber that would like to testify? Not seeing anyone. I'd like to thank all our committee council staff and all the support staff that worked so hard to put this together, including our own council staff and chiefs of staff. So thank you so much. And for all those who testified, especially from the public, thank you for sharing your stories with us and making us understand and see

and feel what is really like to have something so horrible happen in your life and to having a professional like the ER doc who is now retired talking to us from your vantage point because that was very enlightening as well. So thank you for taking the time out of your day. Thank you so much, and this committee hearing is now adjourned.

[gavel]

# C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.


Date November 12, 2024