CITY COUNCIL
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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON FIRE AND EMERGENCY MANAGEMENT

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HELD AT: Committee Room – City Hall

B E F O R E: JOSEPH C. BORELLI
Chairperson

COUNCIL MEMBERS: Alicka Ampry-Samuel
Justin L. Brannan
Fernando Cabrera
Alan N. Maisel

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

Elizabeth Cascio, FDNY Chief of Staff

Glenn Asaeda, Chief Medical Director Office of Medical Affairs

James Booth, Chief of EMS Operations

Thomas McKavanagh, Chief of Fire Prevention

Oren Barzilay, President, Local 2507 Represents, Emergency Medical Technicians, Paramedics and Fire Inspectors

[sound check] [pause]

CHAIRPERSON BORELLI: Good afternoon, and welcome to the packed house that is the Fire and Emergency Management Committee hearing. I'm Council Member Joe Borelli. I'm Chair of the Committee on Fire and Emergency Management, and I'm joined today by my colleagues. [background comments] The Committee on Fire and Emergency Management primarily oversees the New York City Fire Department and the city's Emergency Medical Services, which are principally responsible for firefighting as well as First Responder Medical Services. Regarding the subject of today's oversight hearing, we are here to discuss the city's Emergency Medical Services response to the opioid epidemic. As EMTs and Paramedics are often the first responders they encounter individuals experiencing drug overdoses and adverse substance reactions. It is important for the Council to examine EMS practices in this very important area. Specifically, the committee hopes to learn more about the Fire Department's efforts to ensure EMS workers are sufficiently equipped to respond to the growing number of drug overdoses that have been occurring in recent years. In addition to

providing life saving treatment following a drug overdose, what other ways can EMS better serve individuals with substance abuse disorder to ensure healthier living and helping people be referred to treatment when appropriate? Additionally, we are also hearing an unrelated piece of legislation in today's hearing, Proposed Introduction 1054 sponsored by myself and Council Members Cornegy and Yeger to require the Fire Department to establish a system whereby individuals can submit fire alarm plan examinations through an online portal. This would be an important step in streamlining—streamlining a currently inefficient process of submitting such plans in person. I would like to now ask those members of the Administration who plan on testifying to please state your name for the record, raise your right hands as the Committee Counsel administers the oath.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions? Proceed. Than you.

CHAIRPERSON BORELLI: Thank you and would you all mind introducing yourself for the record?

ELIZABETH CASCIO: Elizabeth Cascio, FDNY Chief of Staff.

GLENN ASAEDA: Glenn Asaeda: Chief Medical Director, the Office of Medical Affairs.

JAMES BOOTH: James Booth, Chief of EMS Operations.

Thomas McKavanagh, Chief of Fire Prevention.

CHAIRPERSON BORELLI: Thank you and I believe Ms. Cascio, you'll—you'll start. Thank you.

CHIEF CASCIO: Yes. Good morning, Chair Borelli and all Council Members present. My name is Elizabeth Cascio, and I am Chief of Staff for Commissioner Nigro of the New York City Fire Department. Thank you for the opportunity to speak to you—with you today about Fire Department's response to the opioid crisis. I am joined by Chief Booth, Chief of EMS, Thomas McKavanagh, Chief of Fire Prevention and Dr. Glenn Asaeda, the Medical Director of Office of Medical Affairs. Nationally, we are in the midst of a drug overdose epidemic driven by both prescription and elicit opioids primarily heroin and

Fentanyl. In New York City drug overdose is the leading cause of unintentional injury death for all New Yorkers, and the leading cause of death among New Yorkers age 25 to 34. In March, 2017, the Mayor launched Healing New York City, a comprehensive response to the opioid overdose epidemic, which aims to save as many as 400 lives by 2022. One of the key goal of Healing New York City is prevent opioid overdose deaths by distributing Naloxone, a life saving drug that can reverse opioid overdose to communities and social networks where risk of drug overdose is the highest. The city has pledged to distribute 100,000 Naloxone kits per year free of charge, and to ensure that people at highest risk of overdose and their friends, families and social networks are equipped to prevent an overdose death. The Fire Department's role in that plan is the Naloxone Leave Behind Program. My testimony will focus on FDNY's approach to and the methods of dealing with suspected opioid overdoses. As far back as the 1970s, EMS Paramedics carried and administered Naloxone to patients with suspected overdoses. At that time, it was not easy to administer. However, as the technology evolved and Naloxone became easier

to administer the department sought and received approval from New York State to allow Emergency Medical Technicians, EMTS and Certified First Responders, CFRs to use Naloxone to revive patients. As a result, all the EMS personnel and CFR Certified Firefighters are able to administer the medication. FDNY EMTs and CFRs began administering Naloxone in 2014. Our most recent advancement announced in June of this year has been Leave Behind Naloxone kits, which I will discuss in detail later in my testimony. When EMTs, Paramedics or CFRs encounter a patient whom they believe may have overdosed, they use their training and experience to make a decision about whether to administer Naloxone. It's not practical or possible for them to conduct a blood test in the field. So they treat a patient for a suspected overdose based on several factors including physical symptoms such as pinpoint pupils, credible information from a friend or witness, and the presence of drug paraphernalia. Upon determining that a patient may be overdosing on an opioid, Naloxone will be administered like a nasal spray to revive and improve the patient's breathing. Subsequently, the patient will be transported to a

hospital or medical center emergency room. Overdoses caused by stronger narcotics may require additional doses of Naloxone. One trend that we have seen in recent years overdoses caused by heroine contaminated with Fentanyl. Fentanyl is a pain reliever that is 50 to 100 times more potent than Morphine. We are aware of instances in other parts of the country of narcotics being mixed with Carfentanil, which is intended as an anesthetic for large animals, and is 10,000 times more potent than Morphine. We check in on a regular basis with the Office of the Chief Medical Examiner and the Department of Health and Mental Hygiene's Poison Control Center to see if there have been any reports of Carfentanil in New York City. Fortunately, to date we have not seen any instances of Carfentanil in the city. The Naloxone Leave Behind program allows EMS personnel to leave a Naloxone kit with a patient or a patient's friend or family so that it may be used to revive the patient if he or she overdoses again in the future. Research indicates that people who have experienced a non-fatal overdose are at increased risk for experiencing another overdose in the future. Working with the de Blasio Administration and DOHMH, the Leave Behind

Program enables our members to provide life saving tools as well as education and instructions that will prevent loss of life. Naloxone is being funded and supplied by DOHMH, and is provided free of charge to patients and their friends and family. The process of preparing to go live with Leave Behind Program is itself a success story. FDNY registered with the New York State Department of Health Opioid Overdose Prevention Program in April 2018. Between April and August working closely with DOHM, we designed and implemented a training protocol using Diamond Plate, an online training platform that is located at every EMS station and firehouse, we successfully trained more than 4,000 EMS members in time to roll out the program on September 1st and we did it without incurring extra training costs or using overtime. The kit itself is fairly simple. It contains Naloxone nasal spray, rubber gloves, a face shield, alcohol wipes, a handout containing information on the risks of overdose, and an instruction sheet. Each basic life support and advanced life support unit is stocked with four kits for the Leave Behind Program and are not used by the EMTs and Paramedics for treatment. The kits are only distributed in

instances where EMS personnel have already administered Naloxone to the patient. When responding to a suspected opioid overdose, once the patient has been revived and is awake enough to receive a kit, the patient is offered a kit. If a patient declines to receive additional medical assistance after being revived, the patient may be offered a kit if approval is given by our online medical control doctors. A patient has a right to refuse the kit and a patient who elopes from the scene is not given a kit. In addition, if a family member or friend of the patient requests a kit, a kit may be left behind with that person. Once the call is completed, the members update online medical control in order to track the distribution of Leave Behind kits. So far, we have distributed more that 30 kits to patients in the first few weeks of the program.

Introduction 1054: Introduction 1054 sponsored by Chair Borelli would require the Fire Department to create a method to accept online applications for fire alarm plan examinations. The Fire Department puts a premium on customer service and, in fact, we have been working on a program that

would accomplish exactly what this bill would require. We know that providing online applications for fire alarm examinations would make the process more convenient for members of the public, and it is always our goal to improve the manner in which we serve the people of New York. We expect to be able to offer online applications for fire alarm examination soon, and thus, we support Introduction 1054. We would be happy to take your questions at this time.

CHAIRPERSON BORELLI: Thank you very much, and I guess let's just stay on 1054 at first so we can get that out of the way. Just a quick question. What is the ETA on—on rolling out the online application process?

CHIEF MCKAVANAGH: Well, we're currently working on the Fires Program, which is expand—we're expecting it to roll out on October 1st. We've just—it was part of the first released. There is a couple of units and the fire alarm plan examination is the second piece of that, and the first release we are hoping by November 1st. We may need a little more time as we're working out some of the details

relative to the final configuration and the reviews of security, the software security clearance.

CHAIRPERSON BORELLI: And—and you don't see any decrease in the quality of review that the plan examiners will be able to give an online application versus a paper application?

CHIEF MCKAVANAGH: No, we don't—we don't expect any drop in the quality of the reviews.

CHAIRPERSON BORELLI: Okay. Alright, so then just turning then to opioids, I—I just want to start out by asking about Diamond Plate. It's something I never heard of.

CHIEF CASCIO: Sure.

CHAIRPERSON BORELLI: Can you explain what that is?

CHIEF CASCIO: Sure.

CHAIRPERSON BORELLI: Can you explain what that is?

CHIEF CASCIO: It's a method that we use to provide electronic remote training out of the classroom, out of the proper classroom setting. Usually it's video based. Sometimes it's journal based with questions, and the members access it from

the station. In the ideal world we would have a mobile platform, but we don't have that at this time.

CHAIRPERSON BORELLI: Like something out of Star Trek it sounds like.

CHIEF CASCIO: It's—we're dragging it into this century.

CHAIRPERSON BORELLI: That's good. Does the department track the number of EMS runs stemming from drug overdoses?

CHIEF CASCIO: Yes.

CHAIRPERSON BORELLI: Is—is there an increase versus the 2017 numbers or 2016? Do we have any trends to say whether we're responding to more or less?

CHIEF CASCIO: [pause] Actually, we talked specific to opiate overdoses because there are a wider range of overdoses. So, if we talk specific to opiate overdoses between July 2016 and June, the end of June 2017, we had 4,608 citywide. In the same period from July 2017 to June of 2018, the end of June so we're talking fiscal year. Citywide was 4,194.

CHAIRPERSON BORELLI: Okay. So, it's fairly steady then you would say?

CHIEF CASCIO: Fairly steady.

CHAIRPERSON BORELLI: Okay. Is there a difference in the response to opioid calls whether it's a ALS or a BLS ambulance service?

CHIEF CASCIO: When you say difference--

CHAIRPERSON BORELLI: [interposing] Are they all different?

CHIEF CASCIO: --do you mean the type of treatment that they would receive?

CHAIRPERSON BORELLI: Correct.

CHIEF CASCIO: So, because of the Naloxone--Naloxone program and being able to administer the Naloxone with a nasal spray rather than a needle, which is how the Paramedics just administer Naloxone, we've been able to bring the Naloxone to the patient more frequently because all of our providers are able to administer it.

CHAIRPERSON BORELLI: So, the technology changed, and now there's really no front end difference between ALS versus BLS?

CHIEF CASCIO: In—In respect to delivering Naloxone to the patient.

CHAIRPERSON BORELLI: And how many hours or training do EMTs and Paramedics receive specifically on treating overdoses?

CHIEF CASCIO: They each receive a different amount of training. [background comments]

CHIEF BOOTH: Yeah, I'm James Booth. I'm the Chief of EMS Operations. The—the training that they receive is—is in their basic training and in their refresher training. It has to do—it's covered under medical emergencies, and overdoses are—are a subtopic of medical emergencies and opiates are a subtopic of—of the—of that topic. So, and they do continuing medical education. The Paramedics do continue medical education so many number of hours per year in order to maintain their certifications, and you will see journal articles that they have to read and take questions and—and pass those questions in order to stay current on how to manage somebody who has not only overdosed from an opioid, but there are other medications also. So, the—I can't give you the actual number of hours. I know that we do train on it. It's buried in the original certifications and refresher.

CHAIRPERSON BORELLI: Is there a—is there a difference in—in response time whether it's ALS or BLS service?

CHIEF BOOTH: A drug overdose can come in as a number of things.

CHAIRPERSON BORELLI: Right.

CHIEF BOOTH: It could come in as a sick call. It could come in as an unconscious. It could come in as somebody behaving irrationally. So, each one of those types of assignments are a different segment. There are nine segments, response segments form cardiac arrest all the way up to standby being the last segment, and depending upon how that person is reported to the 911 system as—you know, we interview the caller. That will dictate whether or not it's an ALS response or a BLS response. If they're unconscious, obviously we're going to try to get the paramedics there as rapidly as possible, which is the ALS Unit. If it's somebody who is not feeling well, and it can come in as a sick or it come as drug or alcohol abuse type assignment, which will be a lower segment, non-life threatening at that point, and it would be a BLS assignment.

CHAIRPERSON BORELLI: In any of these cases is the—is the corresponding engine company responding as well?

CHIEF BOOTH: On the higher level assignments, the unconscious you'll see the engine company turn out. On the lower acuity patients where you'll see a sick call or you're see somebody who's acting irrational, you will not see the engine company turn out.

CHAIRPERSON BORELLI: Do—do engine companies receive Naloxone training as part of CFR?

CHIEF BOOTH: Yes, the engine companies are trained. They carry Naloxone the same as the ambulance carries, and it's delivered in the same method.

CHAIRPERSON BORELLI: So, congratulations on rolling out the—the Leave Behind Program. I think it's something that is overdue, and—and very well intentioned and—and—and will probably lead to some unfortunately positive results. Is there follow-up? Is there—do you take any data from the person that you leave the kit with or is it sort of a no questions asked drop-off?

CHIEF MCKAVANAGH: Yes, as part of the New York State Opiate Overdose Prevention Program, we actually come under the—the City Department of Health and Mental Hygiene, and part of the requirements are that we collect data, not personal information because patient information is private, and we can't divulge that, but essentially just for the purposes of where we seem to have friends of where we leave these kids behind and such. So, very limited datasets we do provide.

CHAIRPERSON BORELLI: So, with—with 43 given away so far I think it's tough to—to pinpoint a trend. You know, maybe in next year's hearing you'll have more data, but have you noticed borough based discrepancies in the frequency of calls, and if so, are there ways to address that? Of opioid calls?

CHIEF CASCIO: We mitigate the life threatening aspect of opioid overdoses. So there's not much that changes on that front whether the call volume increases or decreases. We do notice the spikes of these types of calls to be in the Bronx, Queens and Staten Island.

CHAIRPERSON BORELLI: So, the Richmond County District Attorney has started a—a pretty

robust program where they follow up with overdose victims to-to basically establish a lead on any type of criminal prosecutions that can come from it. Has there been any discussions in the department of participating or giving over any data or overdose patients or would that—would that breach HIPAA Rules or--

CHIEF BOOTH: Most of the time these types of questions do breach HIPAA Rules and unless we got a piece of that law changed, I don't see how we're going to be able to provide most of the data that people are looking for.

CHAIRPERSON BORELLI: As I understand it, if—if—if the police respond to the incident that it can easily be given, the information to the DA. So, you're saying basically based on HIPAA if it's just a medical situation, you probably know where to refer the patient to the DA's Office.

CHIEF BOOTH: Yes, it's very difficult. It's not part of the mandated reporting that we're required. For example, if there's a shooting or a stabbing at the hospital and that's mandated and child abuse, things of that nature. Right now, since opioid addiction is considered a medical condition,

it's not something we can divulge. So, I mention we're joined by Council Member Ampry-Samuel, Council Member Cabrera, and Council Member Maisel. Should it be mandated reporting overdose treatment?

CHIEF BOOTH: Again, I think as a medical condition usually, there's no real criminal—criminal intent that someone is harmed besides the patient himself or herself. Technically, it would be against the law, but until legislation changes and such, right now it's not considered to be a mandated reporting piece.

CHAIRPERSON BORELLI: Do—do you think any sort of data collection from the Leave Behind Program would result in patients of family members being less interested in taking the kits? In other words, if they had to give their names and information over to--?

CHIEF BOOTH: We would be speculating on experience and, you know, many substance abusers are free to give their personal information. They're afraid to tell us their names sometimes. They don't believe us when we say they're not in trouble. We do have those types of instances, if that's what you're getting at.

CHIEF BOOTH: And we do quite a few patients that once they wake up, they just kind of leave us because they're afraid of the potential wall, the legal implications.

CHAIRPERSON BORELLI: But as a matter of policy you believe it's better to make sure or encourage the patient as best as possible to leave with a kit rather than to--

CHIEF CASCIO: Yes.

CHIEF BOOTH: We do try to encourage that issue not only, you know, to take the kit, but let us take it to the hospital--

CHIEF CASCIO: [interposing] Let's take you here.

CHIEF BOOTH: --where we can, they can provide even a higher level of care and to monitor you.

CHAIRPERSON BORELLI: I just have one more question back on Intro 1054. Our Finance person just gave a great question. The—the policy that you're implementing that—that corresponds with Intro 1054, are you able to implement that with existing resources or are there more resources financially needed to implement it?

CHIEF MCKAVANAGH: We're expecting that we're going to need a small group of additional resources to meet some of the demands. Not just for this bill, but for some of the others that are coming with Ultimate Agent and the Fire Protection Plan, but—but not—not a large number. We're—we're pretty much handling all the fire alarm examinations with the folks that we have now, but the workload has increases such with the construction in New York City that we may need to ask for a few more resources just to keep up with it.

CHAIRPERSON BORELLI: Sure.

CHAIRPERSON KING: Formally, it would be ten days for—when we would get the plan 'til we got to examine it. Now, we're—we're somewhere in the area of two weeks, two to three weeks. So, the—the plans are-are coming at a high rate due to the construction there so--

CHAIRPERSON BORELLI: But by—by the Buildings Department of Standards that's like the flash, you know, like that that's—that's incredible. I—I have no questions. Do—do any of you fine folks have questions? Yes. Council Member.

COUNCIL MEMBER ALICKA-SAMUEL: Good afternoon. Just a quick follow-up to just the back-end exchange related to when someone may refuse to be transported to the hospital, what does that look like when you actually decline? I have an all-men's shelter in my district, and any—like every other weekend I see about four ambulances in front of this particular facility on Eastern Parkway and Ralph Avenue, the Renaissance, and I stood there and watched some of the men like kind of come out of what—what they're going through, and they say, no, no, no, no, no and kind of like stagger off, and EMS workers are just kind of—are standing there talking to the other guys, and it's—it— So, what does that look like? Like the process or political? How long do they stay there to observe the individual and with the level of encourage to try to get them to—to be transported? What does that look like?

JAMES BOOTH: Yes, once we receive a call through the 911 system for—for any patient, we definitely try to get them to the hospital. Fortunately or unfortunately, public health law as long as you have what we call decisional capacity so you understand the risks and benefits of going or not

going, we cannot force you to go to the hospital short of being detained by the police and things of that nature or being a threat to the public. Sometimes they're taken in to custody by PD because they're just not making sense. They're a threat to others, but short of that, even someone having a massive heart attack can actually refuse to be transported to the hospital. So, we try to explain to them that hey if you in that case if you go to the hospital there are these cath labs. They might be able to prevent this—this damage to the heart. We really encourage that you go. So, any time there's a high risk issue, we—we—our protocol is that the EMTs or paramedics must contact our online medical facility, which has a physician during any given 24-hour period where a discussion we had with the physician and the patient on a taped line recorded to say listen, I'm not there with you, but from what's being described and the EKG that they just sent me, you're having a massive heart attack, and we—you—your really need to go to the hospital. If you decide not to go, there's a great risk that you may actually become disabled or maybe even die. We try to let them know that is a very life threatening condition. At

the end of it, if they still with decisional capacity and they understand that. Often times they'll say well, if I'm going to die then I'd rather die at home, which is a difficult conversation to have, but we just cannot force them to go, and in those cases after trying to encourage them, we will let them know on the taped line that this is a high risk case, high in suspicion. You really should go. If you do not go there may be consequences, and often times we'll tell them what they are, and if they still understand that and refuse then we'll have them sign a form essentially that says that they understand and they refuse the medical transportation and assistance. And then we try to encourage them, listen, if you have pain again later, give us a call right back. We're happy to come back, and—and we definitely do try to encourage them to go.

COUNCIL MEMBER ALICKA-SAMUEL: I'm not sure if you asked this question already, but do you leave any like pamphlets or like any information? Do they carry that with them in the—in the ambulance?

CHIEF BOOTH: So, I have an example of what we leave behind for you. I can show you what's

in the kit. It has a pamphlet on the use of the drug, and the drugs that it works on and how to use it.

COUNCIL MEMBER ALICKA-SAMUEL: But outside of the kit like just other like—like places they can go for treatment in the area or just the catchment area of where the—the ambulance is dispatched out of or—I don't know clean syringe information and--

JAMES BOOTH: interposing] Well, that's one of the reasons we encourage people to go to the hospital with us. The ambulance crew may not be from the local neighborhood. The ambulance crew may be relocated for the day. It may not be familiar with the area. So, what we like to do is we like to encourage people to go to the hospital for two reasons. The first reason they can receive services at the hospital that we can't offer them, social services, referral, rehabilitation, and—and other medical services that they need for general health. The other issue is that if we've just given them Narcan and Naloxone, the half life of the drug may be shorter than the half life of the elicit substance or the prescription substance that they've accidentally abused. So, the Naloxone wears off and the other

drug kicks in again. That's one of the reasons why we want to get somebody to the hospital because they can be observed and medically monitored so we don't have let's say relax, you know, down the road an hour or two later when the half life of a drug is shorter than the drug that you've taken.

CHIEF ASAEDA: And I know you're asking in general, but for this hit that the Chief has mentioned in the instruction sheet, there is some information about rehabilitation resources and such because we are going to provide that. So, in our discussion with the DOHMH, we were able to get that onto the sheet. I know you're asking specifically broadly, but at least for this part we have that.

CHAIRPERSON BORELLI: And how many languages is the flyer translated into?

CHIEF BOOTH: I'd have to look at it and tell you. I see this one is in English, sir the one that I have.

CHIEF ASAEDA: Yes, but we are—with DOHMH we—they've translated it into Spanish. So, we're hoping to get that out, and I believe they said Russian at the moment.

CHAIRPERSON BORELLI: So, there's definitely a plan. Sometimes in this building if you blink there's a new language flyer or legislation that will appear. So, I'll just take your word that you're going to work towards translating into in more languages?

CHIEF BOOTH: We—we are-through DOHMH we are working on having it in different languages.

CHAIRPERSON BORELLI: Okay, and—and I guess I should just ask this question on the record, is there any harm reduction advice given in the kit or by the EMS responders? Needle exchange sites or things like that?

JAMES BOOTH: I mean when we—interact with somebody who—who we've given Naloxone to and—and we—we try to do some education, you know, obviously we try to tell them that the behavior that they're engaging is—is not something that's you know, conducive with, you know, a good lifestyle and that's why we want to get them off to the hospitals so there's a higher level of care where there's social workers who are trained and certified to help manage these individuals at a greater level than the ambulance personnel can do.

CHAIRPERSON BORELLI: Okay, I—I have nothing else to ask. I just want to say thanks for bringing these. I actually—in my neighborhood, I carry these in my car, which is pretty—it's pretty sad to say. I haven't had to use it yet, thankfully, but there's always one in my car. So thank you very much for coming.

CHIEF MCKAVANAGH: Appreciate it. Thank you.

CHIEF CASCIO: Okay. [pause]

CHAIRPERSON BORELLI: So, the next panel will be Van Asher and Carl Gindolfo. If anyone else would like to testify on the bill, you could see the sergeant-at-arms. [pause] So, I guess we'll start from the gentleman to my right, your left.

VAN ASHER: [off mic/difficult to hear] Good afternoon. My name Van Asher, and I'm the Syringe Access Manager as seen on car this after, that Syringe Exchange Program in the South Bronx, and I'm also the new team at this stage I think what is my refresher [on mic] my refresher, which I recently received my refresher EMS course training. We discussed overdose and Naloxone was a half hour. To answer your previous question. That's the extent of

the training. One of the things David Tarantino a Senior Medical Advisor to the U.S. Customs Border Protection just dispelled the myth touching any amount of Fentanyl is likely to cause severe illness, injury or death, which I just wanted to address because there's been a lot of fear about possible death from accidental exposure from touching, and just have worked in syringe exchange for 26 years I've probably been exposed to Fentanyl several times unbeknownst to myself over the last several years, and have no special immunity and I've reversed several overdoses myself with no adverse effects. I think we really need to take a moment and acknowledge that the spike in overdose death rate, but it's also a scary time to be a first responder, and it reminds me of early on in the HIV epidemic when people were afraid to provide CPR, and these were myths that we were both able to dispel. People weren't becoming infected with HIV from performing mouth-to-mouth and people aren't overdosing treating people who are experiencing opioid overdose, but hysteria is an epidemic as well, and that's one that also needs to be quelled so much in the same way. Often times, and—and correct me if I was wrong. It seemed that

they said with the Leave Behind Program, which is so needed and something I've been vying for years that if someone refuses to go to the hospital that they are not given kit, and that is the person that most needs the kit because they're most likely to experience a fatal overdose, and was—was that what was said? Okay, we'll—we'll check, and I know—I know that once someone gets to the hospital, they're met by one of the Department of Health wellness advocates, and it is there that they're given information on harm reduction programs and centers, but there is no reason that that information cannot be given, and put in a kit and I think it is most important that the person that chooses not to go to the hospital, and people don't got to hospitals for several reasons. Historically, if you identify as a drug user, you're treated poorly, and the amount of stigma and shame that we attach to drug users only often increases drug use, and we're seeing new people overdose fatally that we haven't before from the introduction of illicitly manufactured Fentanyl being mixed in with the street drug supply. If we just look statistically in 2015, 10% of Cocaine related fatal overdoses that did not involve Heroin, involved

Fentanyl. In 2016, that number was 37%, which is a 61% increase. So there are people that use Cocaine so infrequently they don't even consider themselves drug users that are at high risk for a massive opioid overdose, and that's staggering. We're a drug using society. There are coffee cups all around us. Coffee used to be illegal. That's how we're taught to think about drugs. It's more about the lack of quality control and 40% of the fatal overdoses that were related to opioids last year were from prescription medication. We also have an over-medicating problem that we're not talking about. So, if someone is refusing to go to the hospital, there's a slew of reasons, their partner and families may not know about their drug use history. So, if let's say I had an overdose and didn't want to go to the hospital, and I was with this gentleman, if you said, Hey, we're going to give you guy a kit because the Naloxone we gave you to reverse your overdose is only going to last 30 to 90 minutes, but the drugs you did are going to last longer, and you may continue to overdose when the Naloxone wears off. So, if you see your friend continue to overdose, you can save the life—their life if you don't call 911 again, and what

that will do is also relieve some of the pressure from EMS returning back to a scene, which I know. I've spoken to many EMS in certain states like Ohio they've been talking about not administering Naloxone to people more than a few times, which is deciding who lives and dies, and that's kind of like saying we're not going to give people insulin more than a couple of times if we see the same people, which I can tell you as an EMT would see people with insulin related situations several times because of their diet, and not eating after taking insulin regularly. I just wanted to say if EMS would leave Naloxone with people that refused to go to the hospital, and in there, there are inserts on harm reduction programs, and they take a moment to say this is how to use the kit. Aside from just having the answer in there, and it only takes about five minutes to do a really quick training especially with someone that is a drug user that knows how to identify an overdose. This will do a couple of things. It's going to cut down on accidental fatal overdose. It's going to change how people who use drugs see EMS. It's going to change how EMS treat people who use drugs because they're going to realize that drug use is ubiquitous in New

York and we're going to see how more of the patient—we're going to see more of the patient rather than the stigma behind drug use, and the long term outcome will be that people will be more likely to access EMS and have less fear. Because people are still afraid that if let's say I overdose and my overdose is fatal and he placed the call, he may be treated as a-- I mean even though the little blue card in there is supposed to exonerate you from prosecution. It's not in other states, and people are still scared to call and report. So, if EMS is working more in kind with people who use drugs, we can shift how people who use drugs see EMS, and if police would also do Leave Behind as well because they see people everyday on their beat they have relationships with that use drugs, that aren't necessarily overdosing, and they could go up to them and say hey I see you everyday. I just am not here to harass you. I just want to make sure. Do you guys have Naloxone kits? Because even though we don't know each other, I don't—I see you everyday, I don't want to see you die, and that will change the conversation, and how people who use drugs see police and how they see other people in uniforms. And the last thing I want to say

additionally, if you want to prevent fatal overdose with opioids, we need to open a more—we need to open opioid prevention sites. There are over 100 worldwide. There has not been one single overdose fatality in any one of them. The Mayor has approved for--last year in the five boroughs we had 1,441 fatal opioid related overdoses, which is up from 1,374 the year before. This isn't going away, and if we want to save our fellow New Yorkers it's just time for change. Thank you.

CHAIRPERSON BORELLI: Thank you, sir. Just to point out that the FDOI does leave the kits with people who refused to go to the hospital

VAN ASHER: Okay.

CHAIRPERSON BORELLI: So, just to—we found that out when you asked.

VAN ASHER: Thanks.

CHAIRPERSON BORELLI: We—we—we had somebody dig. Next Carl or Oren to you want to speak?

OREN BARZILAY: I was running a little behind so Carl is going to cover for me. So, I'll go. Good afternoon. My name is Oren Barzilay, and I serve as President of Local 2507, which represents 4,200 uniformed Emergency Medical Technicians,

Paramedics and Fire Inspectors. Thank you for the opportunity to testify today. As you all are no doubt—as you are well aware, EMS is on the front line of the ever-growing opioid crisis. Every seven hours someone dies of a drug overdose in our city. More New Yorkers die of drug overdose than homicides, suicides and motor vehicle crashes combined. Overdose deaths in New York City have increased for six consecutive years. The desired long-term, long-term goal for opioid addicted patients should be providing them with an opportunity to engage with Mental Health and substance abuse professionals who may be able to use addiction interaction techniques to help the patient agree to a drug treatment program. Stroke, heart attack and trauma patient benefits—benefit from designated facilities and specialized treatment teams. Yet our only option for overdose treatment in traditional EMS model is to transport the patient to an emergency department that is unlikely to offer the type of recovery services the patient needs. The reality in EMS of treating an overdose is to provide initial resuscitation to a non-breathing victim. Narcan is a resuscitation drug, not a treatment modality. Undoubtedly, Narcan

administration is critical intervention to a non-breathing patient. However, Narcan—Narcan has a life—has a half life of 60 to 90 minutes. So, therefore, Narcan is in reality a very short-term solution to a long-term epidemic problem. Patients who are—arrived or revived via Narcan, often refuse transportation or further intervention. A patient can often—can often become violent as they experience withdrawal symptoms. That combined with the never-ending volume of other requests for EMS response mitigates the ability of pre-hospital care providers to meaningful engage the patient. If the goal of the Council is to affect long-term solutions, not by a pocket full of posies on a modern plague, I strongly suggest establishing opioid response teams. After compiling and analyzing firmographic and geographic data, these things could be deployed to neighborhoods with the highest incidents of reported overdoses. They team could consist of a police officer, an EMT who is trained in addiction counseling. This would allow a healthcare professional under the protection of a police officer to not only mitigate the medical—the immediate medical emergency that allow an adequate time to interact with the patient, relieving

the time consistent to allow for an attempt to navigate patients with treatment programs in designated emergency departments, discuss harm reduction strategies and at least referrals for medical assistant treatment programs. This thing could also engage in longer of follow-up interventions on a community based level. In closing, I look forward to--with working with the Council in combat—in combatting this crisis.

CHAIRPERSON BORELLI: And just—just explain the-the idea for—for opioid response teams. Do any other municipalities do anything similar for that?

OREN BARZILAY: There are other municipalities across the country that have opioid response teams.

CHAIRPERSON BORELLI: Is there—is there like one that would come to mind as like the—the example?

OREN BARZILAY: San Francisco would come to mind.

CHAIRPERSON BORELLI: And it's the same thing where the police or healthcare professionals--

OREN BARZILAY: Yes.

CHAIRPERSON BORELLI: Same thing. Is there any way you can forward us some information on it--

OREN BARZILAY: Okay.

CHAIRPERSON BORELLI: --just on San Francisco?

OREN BARZILAY: Yeah, we'll—we'll do some research and get it to you.

CHAIRPERSON BORELLI: But I—I think that's something the committee would be interested in—in—in looking into in the future especially where—where you have on Staten Island you have the Richmond County District Attorney's Office already trying to bring the law enforcement aspect into the—into the overdose response and—and they—they've built some cases, and they just took down some—some suppliers which is a good things.

OREN BARZILAY: Yeah.

CHAIRPERSON BORELLI: Thank, thank you guys. Appreciate it.

OREN BARZILAY: Okay. That's it? Okay. My colleague is pointing to me. (sic)

FEMALE SPEAKER: I apologize. I apologize.

MALE SPEAKER: Sorry, that, yeah, just to thank you for your time to day. I just want to rebut some of the things that the city actually got up here and testified about or spoke about. I mean there is a great difference between the ALS and BLS care that is given for overdose and I know Chief Booth spoke a little bit about the training that goes into it, and- and being, you know, paramedics being trained a little bit more, but the difference in New York City Protocols and you can reference it via the New York City RAMSCA website that [coughs] excuse me, at the CFR BLS level, you're instructed to administer one milligram either of or via inter day's route, which is a little bit more than what the medics administer whether it's giving IV and it's giving IN or—or I—or intermuscular, which brings upon a host of problems, an I know that Oren had referenced it in his testimony as well about the violence and the—the patient actually coming out of a withdrawal and becoming violent, which is a problem for us. So, you know, I—I think going forward with this we're also just to speak about the ALSK, you're—we're also able to intubate patients, which is we put a breathing tube basically down their throat into their lungs.

We're able to monitor their oxygen saturation level, which is—isn't available for all the BLS crews that are out there. So, there's definitely things that the department or steps that the department can take. You know, we look forward to working with them, and—and—and, of course, with your committee as well in—in getting some of us the technology that might be necessary for it, but the education is the most important thing that I think we need to do going forward. Being an instructor myself, you see the very limited amount of time that we're given even to do the—the—the CME or the Continuing Medical Education on the Leave Behind kits, which is important and it's a vital thing to—to have out there obviously. And just to touch on that very quickly anybody that overdoses get in Our Camp Kit,(sic) whether they are left on scene and they refuse to go to the hospital or if they're transported to the hospital. The thing that we're not giving them are the services that they need, which would be in the Exchange Program information, counseling, short-term rehab. Even as Oren testified that there are very few hospitals that offer outpatient or rehab facilities or even a detox facility. I know most of

the city hospitals, and I don't want to speak out of turn here for HHC, but they offer them, but what we need to do is we need to educate our EMTs and our paramedics on the aftercare that we don't really get to do. I just stopped the—the Councilwoman out in the hall because the facility she was referring to is very well know to me and, you know, my colleagues from, you know, my career days when I was on the street working Brooklyn. It's 599 Ralph. It's a men's shelter, and very often we're not given the opportunity because we don't have the proper education. I think the department can go—go forward a little bit more in training us, and giving us the information that we need to give to the patients that are on the street. You know, I can tell you all the stroke centers in New York. I can tell you all the trauma centers, the replant, the burn centers, the cardiac catheterization centers, but I can't tell you where all the rehabs are and—and that's a problem. I mean treatment obviously is something that needs to be done. The aftercare when they get out of the hospital I understand that they connect them with social workers, but it's the aftercare when they get out of the hospital, and from my studies with

addiction, it's when the—the addict quote/unquote if you want to call them that, when they're ready to get treated, they're going to get treated. So, we have to continue to plant that seed and give them the information that they need, and give them all the resources that are available, you know, that the city has to provide for them. Thank you.

CHAIRPERSON BORELLI: Thank you. Thank you very much.

OREN BARZILAY: [interposing] and just one other thing. I'm sorry, and it's now one person every six hours instead of every seven.

CHAIRPERSON BORELLI: Okay. So, it's one person every six hours?

OREN BARZILAY: Yeah, one fatality every six hours now.

CHAIRPERSON BORELLI: I see.

OREN BARZILAY: Yeah.

CHAIRPERSON BORELLI: Thank you, thank you. The last panel is Mr. Dave Samuels.

DAVID SAMUELS: Thank you. Yes. [pause]

CHAIRPERSON BORELLI: And we're switching gears I believe to 1054. Good to see you again. You can begin.

DAVID SAMUELS: Good afternoon. I'm David Samuels. I'm an electrical contractor. [background comments] I'm sorry?

CHAIRPERSON BORELLI: Just speak into it a bit more.

DAVID SAMUELS: Sure.

CHAIRPERSON BORELLI: Thank you.

DAVID SAMUELS: My name is David Samuels. I'm an electrical contractor. I represent the New York Electrical Contractors Association, and some affiliated associations. As a contractor we're concerned with the installation of those plans that have been approved by the Fire Department, and our concerns are not in terms of design or a filing for plan examination. Our business is primarily with the Bureau of Fire Prevention, and what we have to do is install the work that is specified on those plans that are examined and approved, and then we must be inspected to see that have, in fact, conformed to the plans and specifications. And what I'm here today to request is that this legislation be expanded so that we can be part of this online process. It's—it's very important to us that we conform to our contracts with our buildings and—and customers, and at the same time

comply with FDNY's planned specs and requirements. Every contract of any magnitude has clauses in it that that says "time is of essence" and it's very important to us to be able to complete our work on time, accurately and to be able to demonstrate that those fire alarm systems that we have installed are, in fact, operational, and conform to the plans and specifications and are done in time for the customer of our contractors to utilize their space. Heretofore, we have had the ability to file inspections online, but unknown to us, it was—it—it-it stopped. Presently, in order for an electrical—a license electrical contractor to apply for an inspection date requires that a person travel to Metrotech in Brooklyn on—on four or five days a week (coughs) and—and make application for up to three inspections on one day. If there's five inspections, you must come back the second day to—to—to file for two more applications. This process is—is—it's old. We have public safety issues here that we've addressed with the Department of Buildings in—in an online situation, [door bangs] which has worked very smoothly and we've had the ability to meet with the Bureau of Fire Prevention and discuss many issues

this included. The Bureau has attempted to-to do this, but some reason there has never been a follow-through. So, we're—we're imploring the city to incorporate the inspection aspect of filing in this new computerization. The—the situation for contractors has been that every year the backlog of uninspected work continues to increase, and that's very concerning to us. My particular firm is operating in New York City for 90 years. Our aspect of the electrical construction industry is interior alterations, and most of our work is in Manhattan and our staff is in the neighborhood of 200 people, and it's not uncommon for us to perform between 1,200 and 1,500 installations a year, and a very high percentage of these require inspections. Included in the hand-out today on the last page is an application showing those components that must be presented to Fire Department. If I could make an analogy of a chain holding a heavy weight, every link in that chain is necessary to sustain the—the load, and we have a multi-faceted process in terms of being inspected. We must submit seven different kinds of documentation. We—we require assigned as-built drawing from the engineer of record. Many times our

installation—our inspection takes place on overtime, and it's necessary to assemble associated contractors whether they're H-V-A-C, equipment manufacturers, kitchen equipment and so forth, the building personnel, the contractor's representative and—and, in fact, if anything goes askance, any document is wrong or it's missing or—or the inspector can't make a visit, there's a—there's a hugely expensive situation that occurs and it has to be redone so that we believe that with the instant—incorporation. Excuse me. Incorporation of this on-line process that we can expedite errors, omissions and—and make sure that the communication is—is excellent. It would be very important to all of us in the electrical contracting industry to have this modernization in incorporated and we—we would hope in the future that we can continue to have the dialogue that we've had with the Bureau of Prevention and the Fire Department and are thankful that we can have these—these conversations. The-the handout that I will not read to you because it doesn't have that much appeal, frankly. It's factual. Some of the facts are a little bit hyperbolic, but nonetheless they're accurate, and, um, I—I would remind the Council that

the Inspection Department is fee-driven. It has the ability to have significant income, and it can have a great, great modernity from the—the use of those funds to expedite the process. If there's any questions, I'd be glad to address them.

CHAIRPERSON BORELLI: No, I mean. Were you encouraged at all with—with what they said today about seeking to—to—were you encouraged at all by what they said in terms of seeking to put as much stuff online as possible?

DAVID SAMUELS: Well, I—I think that the emphasis has been plan examination, and that's a—that's a function of—of design professions whether they're architects or engineers, and—and we're in a different place in the Fire Department. We're in the Bureau of Fire Protection. Tech—Technical Services is a different group. The—the process of—of fire alarm installation actually starts with the Building Department, and when they provide approval of the concept, then the drawings that are designed by the fire professional, the engineer or architect are sent to the Fire Department for review, and when those plans are reviewed, they're then able to be disseminated for estimation and then award and

installation. After the installation is completed, we request an inspection so that, in fact, the—the inspector comes and sees that that design has been conformed with, and it functions properly.

CHAIRPERSON BORELLI: Well, thank you, Mr. Samuels and thank you for your honest assessment of your prepared remarks.

DAVID SAMUELS: Thank you, sir.

CHAIRPERSON BORELLI: It's most appreciated. Thank you. Is there any other individuals willing to testify? Seeing none, thank you. [gavel] the meeting is adjourned.

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 September 28, 2018