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Speaker 1 today. We have until noon. Right. So, uh, folks, I would suggest that we spent the better part of the next hour, hour and 15 minutes in in the next stage of our discussion. But I want to leave some time at the end to talk about scheduling for our next meetings. So let's I'll try to do my best to keep track of time, but, uh, please don't hesitate to remind the chair of what he's not remembering. All right, so it looks like we've we've solved our technical challenge. We have a number of documents that have been combined. So this would be Anne's themes, Joyce's notes, Stephanie's comments, I believe they're editable, not edible. They're editable. Uh, we can write on it. Tracy will help us. We're not wordsmithing. We're we're using this to shape our vision. And hopefully it'll be a document that we can continue to work into and onto. Ashley reminded us twice in session and went out of session that we have the ability this morning, this morning to hear some beginning discussions from our the agencies on data. And I think these two tasks kind of merged together. Ashley, I'll ask you, do you think we should go to the data first?

Speaker 2 I would make the motion, yes.

Speaker 1 We don't have to make a motion. We'll just go to data first.

Speaker 2 We can. This is going to be a living, breathing document. And I think that, you know, it's going to we all are adding in. I'm grateful that Tracey is typing it out, as you know. But I think that, you know, having data can help us really make informed decisions. Yeah.

Speaker 1 So.

Speaker 2 So we thought maybe DOH and then OMH.

Speaker 1 Yeah. So remember the thought was that we were trying to develop broad themes to shape our more specific recommendations. We acknowledge that data is critical to fine tuning this. And if you recall I said earlier, whether you agree or not, no one had said, but my position is that whether we have 4 million or 4 billion, we still have to prioritize our asks. And the themes I think are helpful in terms of putting forth recommendations that will will make change quickly and and and with the most impact. So I think all of these discussions are interconnected. I'll do my best to try to weave them together, but I need you all to participate. So, Joanne, do we speak? Are you prepared to talk a little bit about data that actually get you in that she said you are. I just want to make sure that you are. Yeah. Thank you so much. Yeah. Could we begin with just give us some of your.

Speaker 3 I think I'm on. Are you good?

Speaker 4 Are we able to get a PowerPoint of this or is this just going to be verbal data who were asked to.

Speaker 1 Joanne is on the screen? On the screen? I mean.

Speaker 4 Oh, oh, is there going to be a PowerPoint or is this just verbal data?

Speaker 3 Well, I'm I'm speaking from a PowerPoint to my colleagues, if you'd like.

Speaker 1 Well, we just we just spent 20 minutes getting technologically able to put the three documents out.

Speaker 4 I don't know if I can go out. Can we ask that that PowerPoint be sent to us after the verbal presentation? Of course. Yes, of course. I'm guessing that this includes the data that we asked for yesterday, which is retention rates and visits and Narcan stuff. Right.

Speaker 1 Well, I don't actually know what it is, but I'm hoping that that is.

Speaker 4 Thank you very much.

Speaker 1 Appreciate it. Yeah, we're about to find out.

Speaker 4 Okay. I mean, the other option. If you want me, this goes out and you can do what I do, which is going to zoom and share. I don't know.

Speaker 3 What works best. I'm happy. I'm happy to do that.

Speaker 1 And then we can come back. And then can we come back to this after you're done?

Speaker 3 Yeah. Yeah. Well, why don't we. Should I email you this what I have?

Speaker 4 Okay. So? So I think so. Why don't you email it to me and I'll try to share what you mean?

Speaker 1 Yes, Dr. Lynch.

Speaker 5 We work through dates now.

Speaker 1 That's that. That's a good. That's good. All right, folks, can I have your attention? Let's let's try to do this in a in a joint way, but focus the way we have the scheduling challenges that I'd like to to Dr. Lynch is suggesting, and I agree that we should not leave it to the last minute. So we've already acknowledged that there has to be a report submitted in November. But usually when I'm given deadlines, I always think of the last day close of business as a way to I'm just admitting to you that's the way I roll. I would like to be able to produce something that reflects our work in November, but I think we have the month of November. Do we? So. Okay. I think you're nodding so well. November 1st.

Speaker 4 Okay. All right. Well.

Speaker 1 All right. Thank you for the clarification. Either way, we knew I need the bulk of October to prepare whatever it is we're submitting. So I think we have to get our meetings done in our formal meetings done in August and in September. And given the reminder that we've had that it's important to get information out as quickly as possible. Very hard to do that when we're staggering meetings so close to one another. I think that based on on that, we can't expect to meet on August 2nd. And I'm not even sure any longer whether or not we want to schedule two days, although there is obviously some merit to doing that. So I would like to suggest that we look to the middle of August for our next meeting, then the beginning of September for a meeting after that, and then a meeting at the end of September if possible.

Speaker 6 Steve When, when would peggy O'shea like the the finance? When would that be? mid-August. Right. So.

Speaker 1 That's a good question. Stephanie, thank you. I'm I was very intrigued by council's suggestion that we try to get her to get us a presentation before then through some sort of video conferencing. I would like to explore that, but obviously I can't answer that yet. So absent that, it would have to be the next meeting in the middle of August. I would really not want to wait that long for it. But yes, I think that would be a. Yes. Yes. I'm looking at my calendar as well. I think originally we had talked originally we had talked about this.

Speaker 6 Just a suggestion and we can look it up right now. There's the Jewish holidays and out of respect, we tend to stay away from those dates. And also, just a reminder that the conference is the 11th through the 14th. And I just wanted to make you aware of August, September, September and September, October.

Speaker 1 Your start work on August one.

Speaker 7 Give a date of that.

Speaker 1 Oh, yeah, please.

Speaker 6 Thank you.

Speaker 1 Yes, sir. What? August, August 15th. August 15th.

Speaker 7 That's middle august, a Monday.

Speaker 1 Okay. Yeah, let me just get my.

Speaker 7 Calendar up, okay?

Speaker 6 I can't do that.

Speaker 4 Out of the country. Okay. Oh, God, I'm out of state. Well, you know, I think we need to.

Speaker 7 Do a poll.

Speaker 2 Not for nothing. We do have the capabilities of joining virtually. Right. So let's keep that in mind that even if you're out of state or, you know, you still have the availability to join virtually. That's why we put it in our bylaws.

Speaker 7

Speaker 1 yes. I would love.

Speaker 4 To do that.

Speaker 7 Sure.

Unidentified if Tricia's available.

Speaker 4 Stephen?

Speaker 1 Yes, please.

Speaker 4 We have the 15th on the table.

Speaker 1 We've got the 27th where the 15th doctor Lynch you were going to.

Speaker 5 This may be hard to.

Speaker 7 Talk it out.

Speaker 5 If everyone has access to, you know, we can throw together a full plate with a couple of dates that have already been suggested. And then, well, preservation happens.

Speaker 4 To hammer it out and then try to keep it moving. I agree.

Speaker 1 Is that a offer? Dr. Lynch?

Speaker 7 Yes, it is now? Yes.

Speaker 1 Yeah. I think that would be very helpful.

Speaker 5 I heard the 15, the 27, the 27 seconds. Okay. So that we can. Okay. Which one?

Speaker 4 Okay. Yep.

Speaker 1 I think the question is, are we doing two.

Unidentified Days pretty good.

Speaker 4 You know? Can I make a request that we I think we have this Monday, Tuesday or Tuesday, Wednesday thing going on? Yeah. Do we have to focus on those two days of the week or.

Speaker 1 Yeah, I. I know it's hard for you. I'm not tied to those two. Are you? Are you?

Speaker 4 It's just. I've just always had to do video, which is fine. Could we look at the week of the 29th?

Speaker 7 It's only three days there. We had. So Dr. Lynch suggested to send a Google. We've already ignored him yet and let's do that. Otherwise, we're going to go around in circles over here. Let's just do that and throw a few dates and whoever can make it, make it, whoever can cannot make it. You know, maybe they can join us by video or what have you, but let's just move on.

Speaker 1 Yes, yes, yes, yes.

Speaker 5 My goal is to have a decent idea of where people are instead of wasting time just throwing.

Speaker 2 So I would just like to note that August 31st is National Overdose Awareness Day. So that is out there because, you know, we have to give out test strips and Narcan and honor those who we sit here because of

Speaker 4 You think that?

Speaker 1 He's going to I think he's going to throw them all out.

Speaker 7 No.

Speaker 6

Speaker 7 .

Speaker 7

Speaker 1 All right. So the next technological obstacle has been achieved.

Unidentified Overcome? I'm not sure what. Yeah. You know.

Speaker 4 I. Yeah, but I have it and I think I had it opened in, uh, notes, it's. Yes. So I want to make.

Speaker 7 Of course, yes.

Speaker 4 Before I do that for you. Oh. Oh, yeah. Okay. So share my screen first. Yeah, I keep doing that. Yeah. Okay. So do share.

Speaker 1 Okay. By the way, folks, this is Joe. Joe is making this happen. Thank you, Joe.

Speaker 4 There we go. It's up.

Speaker 7 To the next one to look at.

Speaker 4 All of them. Through all of them.

Speaker 3 Still, Joe?

Speaker 4 Yeah. Yeah, we.

Speaker 1 Got their name.

Speaker 7 Right.

Speaker 4 Now he can't go. So that is that. That's what we want to start with. Is that okay? Sure. Okay. I'm sorry. Did I open the. No, no, no, no.

Speaker 3 Not at all.

Speaker 4 Not at all. Right. Right.

Speaker 1 Let's go. Yes, Joanne. And thank you very much.

Speaker 3 All right, let's let's. We're going to test me and see how I can do. So, first of all, good morning, everyone. Yes. Still. Morning. Good morning. Thank you for the opportunity. And I'm grateful that I at least can provide some of the information that has been discussed over the last day and a half. So for anyone who was not here yesterday, my name is Joanne Moore and I am the deputy director for Community Health. I oversee and I am the director for both the AIDS Institute, in which the Office of Drug User Health sits, as well as the Center for Community Health for the purpose of the presentation this morning. I don't know how much time I have, so somebody will stop me when that needs to happen. But what I like to do, I will do you will stop me. I have no doubt about that. But for the purpose of the presentation, I would like to focus on the Naloxone distribution initiative as well as talk a bit about ourselves and our hubs, certainly as we continue in this discussion as a council. Any additional information that's needed, we will be happy to provide. We also recognize that the Office of Drug User Health oversees other initiatives in New York State in partnership with our other state agency agencies. And we'll we'll make sure you have what you need. So just as background, this past April, we reached a 15 year milestone for the state naloxone initiative and 15 years of saving lives. Saving Lives has been the theme of the conversation here at the table today. We have not done this alone within the Department of Health. We work hand in hand with the Oasis Docs SUD the State Education Department as well as OMH. And certainly I want to recognize our continued partnership with the New York City Department of Health and Mental Hygiene to acknowledge the work of New York City. New York City has provided Naloxone for quite a period of time, as well as programmatic support for programs in the five boroughs. And of course, I want to recognize all of our community partners whom without we would not be able to have the expansive program that we have today. We have trained in the time that we have had this program of the 15 years, hundreds of thousands of responders who at this point in time, we estimate, are saving lives at a rate of more than 12 individuals per day. Next slide. So. Opioid Overdose Prevention Initiative. Here on this slide, you see the authority, the mission as well as the model. The model basically is to support a network of community partners so that individuals who are non-medical by training can carry out four basic tasks. And that's first to recognize an overdose has occurred. Take the initiative to dial nine one, one, administer naloxone, and then the last test providing support until EMS or emergency teams arrive. The legal framework for this initiative is through Public Health Law, Section 3309 and regulations that are included in Title ten, Section 8138 of the New York Codes, Rules and Regulations. Next slide. So what we're doing is addressing the ability for community to distribute naloxone. And this goes through two broad access points, that being the registered opioid overdose prevention programs, which for the purpose of efficiency have referred to as opioids as well as pharmacies. So on the right, what you see is a range of who's involved in the ops total totally now of over 900 separate sites. This includes partnership with health care providers, facilities, oasis licensed treatment providers, syringe exchange programs, local health departments, other government agencies, school districts and universities and law enforcement agencies. To the lower left, you'll see reference to pharmacies. There are over 2600 pharmacies across New York State that have a standing order for the dispensing of naloxone. You may recall some time ago New York State put forward the Naloxone Copayment Assistance Program in an attempt to remove one one of the barriers that people reported as far as access. And what this does is that for individuals with prescription drug coverage as part of health insurance, co-payments up to an amount of $40 is paid by the states. Pharmacies do their

naloxone dispensing under both standing orders as well as patient specific prescriptions. And clinicians are increasingly providing scripts to their patients as a routine part of their care. It is now mandatory for clinicians to provide in certain circumstances. Next slide.

Speaker 4 Can you stop for one? Wow. That's slide. Yeah.

Speaker 1 Do you have a question? Just.

Speaker 4 Just incredible. It's just an incredible slide. Items.

Speaker 1 Yes. Ashley, please.

Speaker 2 So I see the drastic increase rate. So state wide programs. And I believe that you did go, you know, answer some questions for me yesterday. So I just I want to ask some more. In terms of the 8 million that's addressed on the scorecard and the 2 million that you're allocated in the budget. Does that mean that that 8 million because you said yesterday that it costs approximately 13.

Speaker 3 13.5.

Speaker 2 13.5. So with that 8 million, does that mean that you will be receiving 21.5 million?

Speaker 3 So the answer to that is no. So the total cost of the program is 13.5 million. I think what I want to point to as it relates to naloxone naloxone funding is that there is not outside of the 2 million, a dedicated funding source. So what we have been able to do through the years, recognizing the need for increased growth as well as the funding that has been provided by Oasis, an additional $1 million is looked at to the opportunities in which we were able to add additional funding to meet the presenting need. So apologies on my colleague and the director for the Office of Drug User Health is also present in the room today. I'm going to ask you to join me at the table so that if there is additional information to make sure your time is used as best as possible, that that can be added. That has the opportunity to add.

Speaker 7 In the slides coming up.

Speaker 1 Thank you, Alan, for sitting with.

Speaker 3 A good Ashley. Yes.

Speaker 2 I would just like the board to keep that in mind. So we have a program that saves lives, that is grossly underfunded. And even with the additional which are not really even additional moneys because we're still leaving them in a deficit. So just let's all keep that in mind when we're thinking about recommendations.

Speaker 3 Thank you. So I know Dr. Walden commented to the seriousness of this slide. And as you can see, there's a dramatic growth in the number of registered opioid programs since 2006. Again, based on the need that is being seen across the state and every region of our state, as I mentioned before, we have 900 or more than 900 registered programs, about 318 of which are located in New York City and over 570 and rest of state. We are finding that additional partners are coming on each week. Next slide.

Speaker 1 I'm sorry

Speaker 3 Of course.

Speaker 1 Ashley, I'm trying to follow your your your reasoning from yesterday and today, and I need you to help me, okay? This we're talking about our concern about the supplanting. But if I'm hearing things correctly, there is no you can only supplant something that is funded. So if there is no hard and fast funding and you're scrounging every year, then the money in the scorecard is not the suplanting.

Speaker 2 It's like a bait and switch.

Speaker 4 Joanne, explain who how you. Give us an outline of like, for example, last year where the bulk of the funding come from if it didn't come from New York State.

Speaker 3 So additional funding dollars are found through some of our federal grants in which the purchase of naloxone distribution would be allowable. Recognizing I know I heard at least one or two mentioned people mention the state's priority to ending the epidemic as it relates to HIV and AIDS. If you were to look at the blueprint for ending the epidemic, you would certainly see reference to harm reduction as well as syringe exchange and other forms of prevention in an effort to.

Speaker 1 Are those budgeted items though?

Speaker 3 So they are they are items that some of which are budgeted in addition to additional state dollars that that we were able to find as well.

Speaker 1 Because all my point is, is that the evidence for supplanting money that had been in the budget and now using settlement funds can only be traced back if there was money in it.

Speaker 7 Could I ask a question?

Speaker 1 Of course.

Speaker 7 All right, Alan, can you describe to us what do you have to go through every year to get money? Just tell me. Don't go. That's a great talk. Tell us what you think. You know, this is an open forum and we would like to know really how hard is it for you to get the money? It's a struggle. Every single year we get to the point where we don't know if we're going to match the need. We we just struggle to find money, which is above me in terms of like Joanne and people above me scramble to find the money. But we reach a desperate point every year to get the money that we need send out naloxone. . So my next question would be, Ashley, put your hand up. My next question would be why do you think such an important item to save people's life in New York State is so hard for this governor to allocate money to you? I worked to the state for six and a half years. I've asked myself the same question, Governor Hochul, who's only been governor the brief period of time. So certainly the previous administration did not. Did not. There was I cannot understand why there's never been a budget line for naloxone. It's apparent we have a public health crisis. We've had it for so long. There was never the money put into the budget. So I'm listening to what you have to say. And I'm look and I'm listening to the to the budget you have or you've got ADHD. But but and I'm saying that this is an important thing. It seems to me that the New York state government doesn't really care about your department.

Speaker 1 I think we're pretty good. Yeah. If I. If I could just ask that. I think the data speaks for itself. I appreciate your your comments. I don't doubt the truth of anything that just said. But I think we want them to hear the data. We're making the case for the auditor. Yeah, but but but we're. We're making the case for the importance of making sure this kind of program is funded. I don't. What the point I don't know what the point of having to get.

Speaker 7 To the point is. Why is it New York State?

Speaker 1 I can't answer. We can't.

Speaker 7 Well, I'm not asking you to give me the answer. I'm asking New York State to give me the answer.

Speaker 3 And I'd be happy to if I could have the mic.

Unidentified But we everyone here just needs to be able to provide information.

Speaker 4 I'm saying this with the utmost respect. I mean, I'm not trying to disrespect you, but you are disrespecting people who are trying to leave your presentation. And of course, we you know, we get comments at the end. You did request that we are trying our best.

Unidentified To comply with what's being asked.

Speaker 4 Can we please just hear her out and then we get to comments? And I apologize for stepping in. And I know you don't have respect for me to speak.

Speaker 7 Don't don't put words in my mouth. Tracy Okay.

Speaker 4 Harvey And we don't put.

Speaker 7 Words in my mouth. I'm going to listen to her. Okay.

Speaker 2 Back off. I just want to say one, one thing, Steve, because you asked me a question. And so what I was getting at is that there there may not be, you know, a specific amount, but the state does realize how much it costs to run said program. So then for them to only say, oh, 8 million and they're still grossly underfunded, I feel like that's a smack in the face, especially when this money came at the cost. And I'll tell you, this is personal. I'm only here today because of Narcan. But thank you, Joanne, and I'll let you continue.

Speaker 1 I think we're making that point, and I would like to hear the rest of the presentation.

Speaker 3 So I appreciate the comments that are made and I appreciate the advocacy that's being suggested by Avi. What I want to say, though, as as a point of clarification, is that New York State has a long history of dedicated support, both fiscally and in policy and program as it relates to drug user health and wellness. And one clear indication of that are the millions of dollars that are used to support syringe exchange programs at a time where our federal government still to this day does not allow for the purchase of syringes, the main the main prevention technique that's utilized. So that's just one example. The other point that I think is important to make for the advisory council and certainly as you continue

in your deliberations as to where funding should be prioritized, is that I want to refer back again to the comment I made yesterday. In 2006 there was a program in place and the cost was under probably $160,000. In 15 years, we've seen significant growth and we've seen significant risk as well as overdose. So the opportunity to look at the ability to create funding streams for naloxone certainly is present in this discussion. And at the same time, I really have to point to some of the discussion of yesterday to understand that all of that does not only sit with the Naloxone, but to the other social determinants of health that all of you spoke on yesterday, as well as the issues that need to be discussed further discuss and prioritize related to health equity. Naloxone is one intervention of many that is supported by state funding as well as federal funding and fairness. And so what we have to remember is that harm or harm reduction is a continuum within itself, and harm reduction is part of a larger continuum to all treatment options and prevention and supportive options for individuals. So. And continue it.

Speaker 1 Could we I'm sorry, could we go back to the last slide, please? Tracy, can we go back to the last one? I just want to digest this for a moment.

Speaker 3 The number of registered programs.

Speaker 1 I just.

Speaker 4 You know, just ask one quick question and I'm sorry, I don't. Joanne, you mentioned at the end that that there is state funding.

Speaker 3 So so we do.

Speaker 4 Receive how much state funding is there in the end? Because I thought would be good to clarify, because I think you said there was a lot of federal funding, but then there was is it just that 2 million that comes in or. I know that what it sounds like. I think you said did you say what were the words you used? What type of funding and where did it come from?

Speaker 3 So so it's a mix. Our harm reduction services are funded through a mix of both state and federal funding. The question that I was asked was specific to state in which approximately specific to and I'm also looking to, to, to. ALLEN But about $2 million in dedicated funding. Now, that said, as we recognize the growth and the need each year, that gives us the opportunity to engage in conversation not only with our partner state agencies, but also with the DOB about the needs for the state. And while, yes, there are conversations that take place and it is an annual conversation, at the end of the day, we do our best to make sure that the need is funded. Each year, unfortunately, we continue to see a growth. So looking at the number of opioid overdose providers or prevention sites that we have put into place in partnership with community stakeholders, looking at the amount of naloxone that needs to be purchased each year, and then again all the wraparound services recognizing that after the administration of naloxone, there are a number of wraparound services, supportive services that need to be in. Please. Speaking again to that continuum of the interventions available to individuals, both from a harm reduction lens and from a prevention and treatment lens.

Speaker 1 The the category for fire that EMS.

Speaker 3 Yes.

Speaker 1 Interesting. I would have thought that would have been much larger.

Speaker 3 Well, recognizing that multiple emergency response teams will report when there is an incident occurred.

Speaker 1 Okay. If you can move forward.

Speaker 3 Okay. So, Tracy, I'd like to go back to Slide six. Okay.

Speaker 4 Um, and I don't. Oh, I seen the numbers on this one.

Speaker 3 Yes. Okay. So what you see here again, the this slide represents the responders trained in our opioid prevention programs, again, looking at a six year period of 2016 through 21. This goes according to type of agency and is inclusive of numbers as well as percentages. The data come from quarterly reports that are submitted by our registered programs. These numbers do not represent unique individuals in Oasis licensed programs with opioid overdose prevention programs, of which there are 228. At the end of last year, were responsible for training more than one fifth of the responders for the period that I'm speaking of syringe exchange programs. All 25 now are also responsible for more than 18% of trained responders, recognizing that our syringe exchange programs across the state were the first opioid overdose prevention sites and have always sort of been in the vanguard as far as providing input and the framing of how we are training individuals. So the numbers are there. I won't go through each one based on time. Let's go to Slide seven.

Speaker 1 If I if I could, I think in the spirit, that's fine. I appreciate it. No, no, no. It's okay. I'm just thinking, in the spirit of time, just to ask questions as they come up. Please. You know, you're so glad we're doing this. You're making the dramatic case for what I think most of us knew. And so and I'm glad, Allen, you've set the table with a case, either one of you, without putting you on the spot. What would fully funding your program mean to New York State.

Speaker 3 As far as the program or as far as of dollars.

Speaker 1 Either?

Speaker 3 So I'll start. And if Allen wants to add anything, I mean, I think fully funding the program would allow what would look like every region of the state having registered opioid overdose programs, as well as the ability to respond. I think we heard from our member of the community who resides within a rural area, that the challenges are significant as far as looking at these opportunities, whether it be through the prevention programs and or other forms of harm reduction support. And again, pointing to the full continuum as continued by Oasis. As far as funding and as you've seen them, but the expense around naloxone is about 13.5 million. That's in the most recent year. We have continued to see an increase each year. $8 million covers a portion of that. If we wanted to see not only sort of funding for what we've experienced to date, but in addition to in anticipation of increased purchase of naloxone, then we would be looking at increased dollars beyond the 13.5 million.

Speaker 1 Alan, I'd love to hear your thoughts.

Speaker 7 Yeah. And just in terms of I mean, just support what Joanne said to support a fully funded naloxone. And at the growth rate, we're going at probably 17, 20 million just for the naloxone. But then there's all the.

Speaker 1 Yeah, no, I'm sorry. I'm talking, I'm waving down. I continue. Please.

Speaker 7 But then, you know, we create a continuum of care services. I mean, that would be a separate budget item. But just so I.

Speaker 1 Understand, I'm just thinking that we have the luxury here to to ask this question. And, you know, it's psychology. There's there's the primacy effect and the recency effect. Sometimes people are affected by the first thing they heard and disregard everything else. And sometimes people hear the the last thing, and they're only influenced by that. I have to tell you, I'm being affected by the recency effect. I can't see how after hearing just already what you said, reminding us of what most of us probably knew, that we can't elevate what we're talking about to the two part of your top of our list. I'll get you. Actually, I really want to follow up with this. So is there anything more that you would like to say about. Well, just what it would mean for New York State.

Speaker 2 Steve, I have a question and it actually adds on two years. So and it has to do with Continuum because they have both talked about Continuum. So to adequately fund doesn't just mean the naloxone. So I mentioned that I had gotten letters from people that are afflicted. So something that we are lacking in rural communities also is syringe exchange services. So what would it look like if you properly also funded? Those. Right. And that's where we're getting those other models where people are getting support, where they're getting peer services, where they're being connected to other services. Right. And so I would I would question you both like what would that look like to New York, like Steve said? And also, you know, what kind of money and investment would it take? Because I know that people are saying, okay, like we have a mobile one for projects, a point that goes to Troy, but they only come once a month. Even though you can walk down the streets and watch needles float down or they're being told to clean out their needles with bleach. So if we're truly going to invest, I think that that's also important.

Speaker 1 Yeah, I appreciate that. And I guess hidden in my question was the answer. I think the answer to the question is that if we fully invested in what we know works and followed all the tentacles across the continuum, we would radically affect the mortality rate in the state, which is why we're here. So I'm just thinking, you know, I want to hear the rest of the presentation, but, you know, the evidence is quite clear that these are the kinds of things that we have to look to when we prioritize. And we could radically change the health of this state by following the arrow here.

Speaker 6 So I would just like.

Speaker 2 To know what the professionals, money wise, what that would look like.

Speaker 1 Well, actually.

Speaker 6 Can I just ask what? Because you said continuum of care. So I just and to your point as well, when I talk about presentations from OMH, from DOH and from Oasis, you know that I'm looking towards integration of services, meeting people where they are in a strength based system. And so I am also very interested in what we can do for people who are revived using naloxone to to be able to connect to a system that would better meet

their needs. Because I quite frankly, some people are very hung up on, you know, is it the same person ten times? I don't care if we're not giving them the services they need, we're going to keep them alive until we collectively build that continuum of care. So I'm curious how.

Speaker 1 We really have to let Joanne finish. So can we do that? And then we'll come back for Continuum.

Speaker 6 So.

Speaker 7 So I just respond just to Stephanie in context. I mean, there was a conversation yesterday about people going in and out of treatment. The Hamid action programs are the safety net. The people use drugs in New York State. They've been underfunded for a very long time and they can do more. So every every piece of the conversation that we've had in this room yesterday, you can you can slip it into the harm reduction conversation so our programs can provide mental health care to people who are suffering from substance use disorder, can get care and treatment through our harm reduction programs and be referred to OASIS licensed treatment programs. They can get mental health care programs and be supported in a transition to a licensed mental health program. Another place. Or you could do it within that safety net. We know the medical system is not friendly to people use drugs. In fact, it kills them. And when you ask people use drugs, where would they rather go? They say they would rather go to a humdrum program to go to an emergency department or be admitted into care through the medical system. You can ask them about all systems of care that they've been presented with. It's not that they don't conform to the system. The system does not work for people who use drugs in New York State. And you see that in the you see that in the toll that overdose has taken for people use drugs in New York state and how reduction programs start with a baseline of we serve you, you are not conforming to us. We do what you need, whether that's clothing, food, showers, mental health services. There's recognition that people when you walk into a home adoption program, the fact that you use drugs is off the table. You use drugs, what is it that you need? In the old days it used to be HIV and one you accepted that. And then you can deal with the trauma, you can deal with the mental health crisis, you can deal with the basic needs. And as Joanne's mentioned, the social determinants of health underpin our response to that. You go to the programs and you see people sitting in the Drop-In centers and they've got a respite there from the street. They have nowhere else to go, and they turn. To these programs because these programs are willing to to support them. They are the safety net. And if we had if we had the ability to expand that care, that is what we create in our continuum of care. You know, we think of prevention as a way of stopping people use drugs and prevent them. You slow it down. You have treatment at the other end where people who need to stop using drugs, that's they're out if it works for them. But we have so poorly invested in the people most at risk of dying or getting diseases. And that's people use drugs and that's where harm reduction fits in.

Speaker 1 Allen, thank you so much. Thank you. I.

Speaker 3 Joanne Well, that's a hard act to follow.

Speaker 1 Well, but, but, but, but. But you ask them to come to the table.

Speaker 3 I did. Thank you for pointing that out. No, I did. Of course. And, you know, for anyone, I'm sure everyone at the table is familiar with Alan and the work that he's done, but coming from community and working in government, so understanding the bridge and

the necessity for us to have this dialogue. So let me just point to three things as it relates to this conversation. I'm looking at the time. If we could go to slide seven, that's what's up. Yes. Okay. So Slide seven, this looks again. I'm trying to get to the point of what you have asked for, which is the outcomes. Right. So this is looking at reports on the election administration. This is through our registered programs in 2021. If we were to look at through July, we have about 4500 reported administrations for a single year. That equals about 87 administrations per week. If you look at 2020, just look at that with a gentle eye, recognizing that we did see a decrease as far as administration, which we are continuing to analyze, but assume that this is due to COVID and the prevention techniques that were required for that public health crisis. What I do want to know for everyone is our county level data and quarterly reports is available online on the Department of Health website. We can share that link. And that online report includes EMS data, which is not represented within these bars. The next slide I'd like to go to is slide nine. This speaks to, I think, some of the conversation as it relates to the funding, again, showing the 13.5 million as it relates to the 2122 administrations. I want to note that in the dedicated funding, which is the reddish colored bar, that does not include the funding that we receive from support from Oasis, which speaks to where we continue to discuss the actual $2 million. So again, going from 1415, which was at 3.5 to 21, 22, which is that 13.5. And again, this is the purchase of naloxone. The last slide that I'd like to show is on slide 11. And what this is speaks to some of the mapping that has been discussed by this group and understanding exactly where we have the distribution of the registered program sites. Again, this is information that is available online. We can share that as well. And I believe if you actually go online, some of the maps that you'll see, whether it be related to this or a syringe, syringe exchange or other harm reduction work is an interactive map, which I think will provide you with more information, as you've discussed, as opposed to when you look at the visual of what we show above. I'll stop here.

Speaker 1 Thank you very much. I will just, Avi I'll get to you in a second. I'm just struck by how we're getting closer, because yesterday we were talking about broad themes and we talked about integration, co-occurring and harm reduction. We just said in 5 minutes how integrally related those two major themes are when we get to ticking our boxes off for why we prioritize something one over the other. That's the kind of thing that I'm going to be looking at and for. And I'm so grateful that we got to just see this. It's not rocket science. So I'll get to Justine in a moment. I just want to say how grateful and thankful to you both I am on behalf of all of us here. I think this is what will fuel our decisions, these kinds of discussions. Justine. Sorry. I didn't see you up there.

Speaker 4 It's okay. I just have. I really want to stick to this conversation around narcan. So one thing. It's really not a question. It's just I think what I know and I just looking for Joanne to tell me if I'm right or wrong. Those are reported Narcan overdoses. It doesn't include how many didn't report. Is that correct?

Speaker 3 Absolutely. So we always make an assumption with these types of reports where they're self-reporting that it's an underrepresentation of what's actually happening in the community. You can imagine all the reasons why we would show underreporting.

Speaker 1 Well, there's also the whole issue of of administrations that are not even tied to overdoses. So the data and then just a second, just in. I'm just in Albany County, we try very hard to understand this because Narcan is given by default, oftentimes on the on the road with EMS regs. And we're trying to, you know, so suddenly where we need to discern what were actual overdose events, what were lives actually saved by the administration and what were administrations that were done just because there was an unresponsive

patient that they had no idea what's going on. So in some ways, the numbers are under representative of overdose, but they might be overrepresented of the youth sometimes the administration.

Speaker 4 But I think the EMS is also. Never mind. Okay. Okay. So my follow up question and I'm sorry to be sticking very heavily to the budgetary question, but what I'm hearing is 2.7 million is coming, 2 million from Oasis, 0.7 from the state. And then there's been an undisclosed amount coming from somewhere in the state at the end. When you ask for what has that amount been every year that it does because it's not a line budgeted item, is it still an amount coming from the state that's meaningful here? And then my next question is, I saw on a slide that and I'm not sure if it's just a training tap in there or are there how many Article 30 or how many Oasis treatment providers are oops sites and what percentage of the funding covers that is it? The 2 million that Oasis gives you is to cover the Article 30 to cover the Oasis sites.

Speaker 1 You know, I think it's.

Speaker 4 Important.

Speaker 1 I do believe it's an important question. Um, I was hoping that we wouldn't be talking about budget and we would allow the presenters to talk about the importance of the programmatic aspects to inform us when we get to talking about budget. We can go there if you must, but I don't know that we're going to solve or resolve. You have three or four questions in a row there. I don't know. So, Joanne, do you have any comments or thoughts?

Speaker 3 So I'm looking at. And different slides. One moment, Alan. In the meantime, did you have comment as I will look for that slide.

Speaker 7 I wish Joyce wasn't whispering to me at the time.

Speaker 4 Ha ha ha ha ha ha. Well, there's three of them for you. It's about in the end, above the two points.

Speaker 7 Where does the where does the money come from?

Speaker 4 No, no, no. How much is how much and who within which organizations within the state are funding you at the end of the year, even though it's not outlet, it's not it's not been dedicated funding. And then the next question is, what percentage is the 2 million that Oasis is giving you? Is that to cover the Oasis oops? Or are you not covering Oasis oops? But I saw a slide about Oasis doing trainings, or you're doing training basis.

Speaker 3 So I have to be like, okay, so what I can say is this is that no, not specifically. As it relates to your question as to whether or not the funding that's provided by Oasis is for only Oasis treatment sites, the money is for the collective need as far as the purchasing of naloxone. Now, that said, as far as report of community naloxone administrations by agency type oasis licensed programs represented just over 10%. So clearly the work that we've done in partnership with Oasis related to the availability of naloxone, both within treatment sites as well as across New York State, is seen through the oasis providers, health care providers, housing providers, and as one may expect, primarily through syringe exchange programs in the surrounding areas of those syringe exchange sites.

Speaker 7 Avi, Well, I would just like to make a comment which I wanted to kind of follow up before I was rudely interrupted. I'm kind of following up with what Justine was saying, and it seems to be a terrific program. And I really want to acknowledge Cheryl Moore from western New York, who does a fantastic job in all eight counties of western New York providing Naloxone. You know, maybe without her, there would be a lot of people. So the question and you said, Steve, you said you don't want to talk about budget, but I think maybe we need to know a little bit of something because it's such an important program. So, Allen or I'm sorry, I forgot your name. Joanne, what would you think will be an adequate amount that you will need to make sure that that, you know, you're you're providing you're providing safety for the for the rest of the state.

Speaker 3 So I'll follow up on the comment I believe Allen made earlier that recognizing the purchase of naloxone is one part. The surrounding services that assist individuals following the overdoses is an additional and significant part of the cost. In the last year was 13.5 for the product. Only Alan, I believe, made reference to between 16 and $18 million to provide additional supports.

Speaker 7 That's just naloxone Joanna.

Speaker 3 Oh, that was just from the naloxone. Okay. So the reason why I think that giving a definite number is a bit challenging is because so much of the work that we do, for example, if someone were to experience an overdose and there was a a drug user health hub within that community, the health hub, which is also funded by New York State, would be part of that person's support system following the overdose. So the dollars are all linked, right? And it's a continuum. I think it's challenging to say a specific dollar amount, but what I can point to with with complete confidence is that we know we spent 13.5 million on naloxone alone within the last budget year.

Speaker 7 But there's a lot that goes into it besides the naloxone. And we all know that, that, you know, there's the treatment, there's the counseling, there's all that stuff.

Speaker 1 And.

Speaker 4 Um, okay, so, you know, I sent everyone just as a point of information, that article that my colleague and I published and the peer reviewed journal, the Journal of Substance Abuse Treatment. I would really recommend that you all read it because it goes into depth into what a harm reduction agency provides. So and that article was written quite some time ago for the price, what I think for a fully funded harm reduction agency that would work 24, seven, seven days a week where we provide a full continuum and we are not Medicaid funded. Just to just tell you, we work we scrape by every every year. It's really hard for our agencies. Our budgets are just really we we are just perennially, chronically underfunded. But if we really wanted to support the harm reduction agency throughout the state and want them to work 24 hours a day, seven days a week, and you would need a minimum of about $4 million to $5 million for those agencies dividing that by three, that would be something like one point something per year for each shift. Understanding that the later shifts would require more money. So I think that that's a pretty that wouldn't that would sort of help us build the type of capacity to provide all of our communities, you know, 24 hour support. A lot of our people, you know, we if we can only work from 9 to 5 or four and our agency closes at 8 p.m., what happens between eight and 12 midnight? What happens between 12 midnight and 2:00 in the morning or between 2:00 in morning, 6:00 in the morning? And, you know, if people are waiting at our doors so that they can get in and get at our age and say, you get everything, you get breakfast,

lunch, and then you get everything. Read my article. I think it's important for you to understand what a continuum of care looks like and how hard it's been for us to patch it. And I know the DOH has been patching up. Just to answer you, Justine, I'm sure that there's a lot of patching up in that budget that it's just really hard to get to.

Speaker 1 And if I could just respond and again, thank you, Joanne and Allen very, very much. I never said budget wasn't important. I said we weren't talking about budget now. I think that everything we've just said, we've. I'm hoping that we're preaching to the choir. You've impressed me enormously. I'm ready to vote on funding a whole state wide program in harm reduction. I don't need to continue to talk about the money. We asked that. OMH also talk today a little bit about that data presentation and I'd like to do that. We want to come back to this and in detail answer these questions. I don't have a checkbook now, but I've already I'm ready to sign the check.

Speaker 6 But Steve, the one thing that I don't want to lose sight of is I want some integration in the presentations. So we've now heard from DOH. We've heard about the hubs themselves, how they operate. But then in order to bring in to an is Anne still sitting here and she's listening the two bring into the equation and I now what's my thought of what it is that she keeps saying but it's it's promising practices and best practices. What is it that collectively can be used to build the system that we're looking for?

Speaker 1 All I'm saying is there are stages to our work here. Right now we're eating, we're absorbing. And this is enormously helpful. We have to do this work and then we have to do what Justine pointed out in terms of balancing fiscal and budget recommendations. I just don't want to not give our other partner an opportunity.

Speaker 6 I just want to make sure that we circle back to everybody together.

Speaker 1 I think that yes.

Speaker 6 I think one of the things we need to spend a little time on before we leave today is setting an agenda for our next meeting, because we know that there are a number of presentations that we have yet to hear and need to hear. But one of the things that I would ask of our colleagues from DOH could you create an ideal continuum of care in your eyes with your expertise? What do you believe that full continuum would look like? And then we can begin to look at next steps or next phases, because I too agree with Steve and the rest of my colleagues here. This is where our supports are at and what we need to do. So let's let's dig into that continuum and what you believe it to be.

Speaker 1 Yeah, I appreciate that. I, I think almost, almost like a wish list. Yeah. And that's why I ask, what would a fully funded system mean for the state of New York? My goodness.

Speaker 6 Steve, I also don't want to leave the LGU's out of the the budget conversation because I think that it's important that as we're thinking pie in the sky and what we're truly looking to build out, I think that even though we as a board cannot control certain parts of money, they're going to the LGU's recommendations, I believe would be heard because there is some funding that we recommend on and then there's other funding. So I'm I'm kind of a macro and micro thinker, but in the macro level, I think we need to be really mindful and optimistic about the potential that happens. So I would almost like I don't know if it would be nice if it would be specific. LG Representatives that sit on this board to talk

more about after we get the DOB presentation, what it looks like on your end to be budgeting and planning so that this can be included.

Speaker 1 Yeah. Thank you very much for thinking of the LG. I appreciate that. I do. I will tell you that many are looking to this body for some guidance, and I think what we come up with will be influential in that regard. Maybe the conference might be able to sit with us and talk a little bit about. All right. Yes. Actually, you want to point out that we were going to go to OMH. That was your did you talk to Dr. Smith as well?

Speaker 4 Yeah.

Speaker 2 That's right. Yeah, that's actually I was just great.

Speaker 1 Oh, I thought. I thought you were directing me across the table.

Speaker 8 Is there a way I can connect my MacBook to present and show some slides?

Speaker 1 Well, we seem to have done that before. Can we joe can we

Speaker 7 No. Okay.

Speaker 6 Of the zoom link.

Speaker 8 You join the online?

Speaker 6 Yeah. Let me send.

Unidentified You. Me too.

Speaker 7 Joanne, is it possible for you to send us those maybe ten slides that you use a reference today so that we can have for our records? That would be great.

Speaker 8 She said.

Speaker 7 And I just want to say you did an excellent presentation for us today, and I notice that you indicated local health departments and in one of their slides, and I like to see how we are integrated in some of those preventive programs as well, where the funneling of either dollars or even the narcans are seen.

Speaker 3 We're happy to do that. All right. So there are definitely points to some of the slides, one or two that I actually skipped for the purpose of time that may speak to that. And so I will look to our partners other ways, just as far as the distribution of the slides. But Tracey, I'll touch base with you for after the meeting. Thank you.

Speaker 4 Ah, I think that we interrupted so much that we didn't hear the syringe service program talk. Can we get that on as well? As you mentioned that there weren't around.

Speaker 1 That for that today.

Speaker 2 No, she's asking that it be sent.

Speaker 1 Okay.

Speaker 4 And any other programs that you have? I think there was an overdose, one with high data that I at least know about from a talk.

Speaker 5 Well, we have a minute. We only have eight responses on that, dude. Apologies if you have a minute. If you could do that. So we can.

Speaker 1 Take this moment to look at our schedule.

Speaker 7 I'm not getting my email.

Speaker 8 I'm on. I'm on.

Speaker 1 So get.

Unidentified You want to be the one to.

Speaker 5 I if you just respond with the dates you can, I don't know that it's been 100% determine what the agenda what the time frames look like each day.

Speaker 7 Or two days.

Speaker 5 I would defer to the leadership on that.

Speaker 1 What was the question.

Speaker 7 As to what we're going to do in the next few days?

Speaker 1 Well, I expressed my preference earlier for one day, but I'll leave it open for discussion, if you like.

Speaker 7 Oh, okay.

Speaker 1 Yeah.

Speaker 2 In our partner at oh, OMH. I think it's ready.

Speaker 8 Okay, I'm ready. Yeah.

Speaker 1 Dr. Thomas Smith.

Speaker 8 How much time do we have?

Speaker 1 I would like to ask you to try to limit it to a half hour.

Speaker 8 Okay. I can do that.

Speaker 1 We can always come back to you.

Speaker 8 And I just thought I pulled out a presentation that we've used in other settings. And I think I just going to do a very broad overview of of services and systems that OMH operates. Pretty high level stuff. I'll do that with slides. And then I have two brief word

documents, one that has a summary of a recent analysis where we're looking at rates of co-occurring substance use disorders amongst people treated in the mental health system. So that'll be important. And then another brief document that outlines three initiatives, quality improvement initiatives that OMH is sponsoring currently designed to help improve integrated care within, again, the OMH system. And there'll be another document. So I'll try to go through all this quickly. The first one is just a broad introduction to the OMH system, right, is the agency that oversees mental health services. We do three things we regulate, right? Set the regulations and rules and licensed and and survey licensed providers. We fund we organise obviously a fair amount of the funding for services and we also operate we operate the psychiatric centres. We have a state operated system of care, 23 state psychiatric centres across around the state that have inpatient, outpatient settings. The types of services statewide that we regulate, fund or operate are listed here. Crisis, inpatient, outpatient, residential care, coordination and other. It's a big public mental health system. If you look at the entire system, you know what we operate, but what also we regulate. It's over 8000 inpatient psychiatric beds. The great majority of those are in, you know, in Article 28 hospitals. Right. We licensed if you look at all types of outpatient programs, we license almost 800 programs around the state. The great majority of those are clinic programs. We'll go through all those in more detail as about 220 emergency room emergency programs. The majority of those are emergency departments in Article 28 hospitals. But there's also CPEP, 22 CPEP around the state. We funded license and support over 46,000 now beds, housing beds across the state in the various types listed there, the treatment, support and unlicensed programs. And then we have a whole range of support programs, whether it's health, home care coordination, core services, vocational programs, home and community based services. It's a wide smattering of other support services, many of which have been funded in the past ten years through the Affordable Care Act, provisions that are designed to help make care more person centered, community based, home based, those kinds of programs. So in any given year, over 800,000, we estimate now currently people use the public mental health system. You know, any any of these services, especially the outpatient services of the great majority of them, are people with a serious mental illness or youth with a serious emotional disturbance. So those are the more major psychiatric illnesses, if you will, depression, bipolar, schizophrenia, etc.. In terms of what proportion of New Yorkers just sort of population health estimates who have a mental illness in any given year, you know, close to 20%, those are similar national averages, 20% of people seeking treatment for a mental illness during the year. Serious mental illness prevalence, 5% sed 12%. That's less relevant to us. And of these, you know, almost a million people using the public mental health system every year, the great majority of them use a clinic services. We have a core clinic program. There's the Article 31. Article 31 is the state regs that authorizes us to over oversee clinic programs. So that's your bread and butter, your doc therapists, what have you. So this slide shows the the proportions of people served in these various settings, whether it's residential clinic, etc., but clinic. And when you get to integrated care and co-occurring disorders, I think clinic, outpatient clinic, here is where we want to start. That's where we really have the best opportunities, I think, Ashley.

Speaker 1 Dr. Smith, just one second. Ashley.

Speaker 2 So when? Yesterday it was mentioned that Oasis and OMH are doing integrated care. Does that mean that you're providing mental health and substance use in the outpatient settings only? So are there no vetted programs that treat co-occurring?

Speaker 8 So let's come. We'll get to that. Hold that. I think I want to talk about that when we get to a slide on clinical care. Yeah. Yeah. You can interrupt that. In terms of crisis

services. Most emergency departments are overseen by the Department of Health, right under the Article 28 licenses. I can't remember 110 or well more than that. Well, Joanne on know how many hospitals have emergency departments that see psych patients? We generally think about 100 to 100 and 2030 statewide. There's we have CPEP comprehensive psychiatric emergency programs that are overseen jointly by the age and over. There's 22 of those. Those are dedicated spaces for people with psychiatric problems that include observation beds. You can stay there for up to 72 hours and and there's requirements for staffing 24, seven, etc.. But 22 CPEP'S, I think statewide, I think six of them, only six or seven are outside of New York City. Right. So in some of the big cities like Buffalo, Rochester. Right. Syracuse, I think Binghamton has one, but they're not in any rural areas. We directly regulate those CPEPS. We're going online now with Crisis Stabilization Center. Some of you may have seen the RFP that's out there now with some of the funds made available in the past year through federal funding, state funding. We're going to roll out the nine, eight, eight crisis line program and we're going to hopefully set up crisis stabilization centers in communities across the state. These would be stabilization centers integrated. We're doing this with Oasis or Oasis integrated settings where people can go instead of emergency departments when they're in a crisis. And the goal here is to try to have places to to divert and offer better opportunities for people in crisis. There's two kinds that we're funding a supportive and intensive crisis stabilization centers, both both types both types will have to provide a triage and assessment, counseling, psychoeducation, crisis intervention, peer services, care, collaboration, etc.. In addition, the intensive centers will will provide psychiatric assessment and treatment care so that that RFP is out now. We're hoping to make some decisions and start getting online with those centers.

Speaker 5 This specific question has the understanding that that EMS engages with a lot of patients that are ultimately taken to the hospital for both substance use and or mental health acute issues, or sometimes not acute issues. So accessing the EMS system, has there been talk in the establishment of the crisis stabilization center model of looking to the bureau of EMS so that ambulances would have the authority to triage and bring patients to the crisis stabilization center? Right now, an ambulance can only take a patient to the hospital. Yeah.

Speaker 8 I don't know how much we've had a discussion with the Bureau and it's a it's a different team that that I'm not directly involved in that at OMH. So that that's a great state agency answer. Very. I don't know. I do know that.

Speaker 5 Well, I'd be happy to help.

Speaker 8 Yeah. In Rochester, for example, we have already tested that arrangement where we've gotten we do have a I think the University of Rochester has a crisis program that they set up. And we work with the the hospital there and the bureau, the county, and have a pilot, if you will, a pilot program underway where the EMS can do that and it's working quite well. So we will have to do that. I don't know to what extent the team has already started, but I appreciate your offer there.

Speaker 7 Interrupt for a second regarding this with crisis services. So I think you're just like, Oh my God, he can hear me. So the crisis services that the opening up with Oasis and stuff of that. Okay. You explain me to two different ones.

Speaker 8 Yep. One is more is supportive versus intensive. They're both supportive. The difference is that the intensive really offers more psychiatric assessment and treatment.

Speaker 7 Okay. How many of those are going to open up?

Speaker 8 I don't know. We have RFP's out I think in the first wave not I don't want to guess.

Speaker 1 Got Smith I think it was one in every in.

Speaker 8 You know.

Speaker 1 In.

Speaker 8 Or one in each of the of the of the ten. Economic development. Right.

Speaker 7 Right. So I think that's our goal is to uncover this one of them. There's one that's that's my understanding is or supportive or whatever you want to call it that that's only allowed for 23 hours and 59 minutes.

Speaker 1 That's the intensive. The intensive crisis stabilization is up to 24, up to.

Speaker 7 23, 23 hours and 59 minutes as a doctor. Okay. And what do you think can be done in 23 hours and 59 minutes if a person really need help or to get a bed or whatever it is? I mean, if you come in and and what happened at 23 hours and 59 minutes. Are you getting kicked out or what?

Speaker 8 I think a lot more can be done than what currently happens in the first 23 hours of a crisis, whether you're in an emergency room or in the community. So I think it's a great start. But you make an important point. It's the beginning. It's a footprint, if you will. We have to build in the structures around it to do the linkages, the collaboration, and get what the person needs at the 24th hour. Yeah, that's going to be a key element of the success of these programmes is whether we can make sure those linkages are there and people get what they need beyond that.

Speaker 7 I asked one more question. Okay.

Speaker 1 So I want to help answer that, though.

Speaker 7 Oh, go ahead.

Speaker 1 I was just going to say that we've been working hard on this in Albany County. The issue is that our emergency departments are overflowing and overwhelmed. Yes. And no one's getting any service. Right. So the hope is with with something like this is that if we can discern who might not need to go to the emergency department, they might be able to get in 23 hours. A de-escalation and immediate stabilization and then a linkage to something else in the community. But I think the point that you make, Ivey, I think, is that that's not going to work for everyone. And some people may still need to go back to the hospital, but at least what's going on in the emergency rooms, which can get so hectic, at least in Albany, this is an attempt to try to divert at the front door.

Speaker 7 Okay. So this is what I'm trying to get to, because in so many cases, people need a little more than just, you know, a strip of Suboxone and a slip of paper and say, go meet so-and-so on Tuesday. Okay. There are some people with different situation that

may need a little more of a treatment. So if you're going to send them to the hospital, I'm going to give you an example. What happened on Sunday at Erie County Medical Center. Okay. Where we referred 11 people into Erie County Medical Center because the influx of people going in and the lack of nurses and support, there were only three beds available. So you have nine people that ended up sitting in the hallway for about 24 hours. That's not really a good service. You know, the point that I'm trying to say is why not keeping longer than 23 hours and 59 minutes, maybe we can work something out. So it's you know, whoever came up with that idea of 23 hours and 59 minutes obviously doesn't know what it looks like or what it feels like out in the field of.

Speaker 1 Avi. Again, I don't mean to. Dr. Smith, interrupt you. This is near and dear to my heart. This is what I spend most of my days working on. I will tell you that that's largely a reimbursement issue that was conceived that way. But the the crisis services that I mean, that's a whole other theme that we might focus on is so under serving the state of New York. Yeah. It's overwhelming us in Albany County. We have just as an example, God bless them. They're working hard. But we have emergency departments where there are psychiatric patients in the EMS rig in the parking lot, waiting hours to be seen in the emergency room where they might spend days before they will get service. So you're really preaching to the choir here, but that that the systemic change that, you know, we can do a part maybe, but we can't cure that problem. But we can do something.

Speaker 6 Well, can I.

Speaker 1 Well, just finish. Maybe I'm interested to hear what you have to say.

Speaker 7 I'm sorry. I'm sorry, Stephanie. But what I'm trying to say is, I mean, this is the point where this board is here and this is the point where we're trying to help people. Okay. We want to create something that's going to help people get the help that they need. They may not need to go to the hospital or whatever it is. Okay. And it's all fine and dandy because I think hospitals are overwhelmed. CPEP unit at the erie county medical center will call save the. Michael, and say, by the way, I got this guy who needs a bed, but we just let him go at 4:00 and we get to call at 5:00. Okay. Which is really horrible because you cannot get hold of the person. What I'm trying to say is this if we can work out something where a person is attended to until we can get him into a bed, that would work a lot better than pushing somebody out in the street. The CPEP unit, you know, I took my son to a CPEP unit. I wouldn't take my dog in there, you know. Well, I.

Speaker 8 Think that's part of the work this committee should do. Let's think about where we want where we would want these individuals to be during that period of crisis. I'd propose that most of them we would not want to be in emergency department. We want to be in some community setting, but with services and and support. So let's see if we can define that and direct the money towards.

Speaker 7 Like of my mind. And that's exactly what I'm getting.

Speaker 6 And that was, I guess, my. All roads lead back to understanding the crisis and the and the waiting time and everything that's going on. But also looking at the fact that a lot of these people are duplicated. Right. You have the same people that will often come back. And so the this is an exercise in futility. If we don't do things like workforce development, because the people who are manning crisis stabilization centers are burning out at a rapid rate because they have people they try to navigate people, they're trying to coordinate care that should really be delivered in an integrated, single setting, single

person, perhaps on the clinical side. So supporting staff, but then also supporting the community providers so that when people are being navigated to services, they are actually getting the services they need in the least restrictive setting using a person centered, evidence based, promising practices, integrated model. And that I think ultimately is why at the first meeting when we were maybe with the second meeting where we were talking early on about the buckets, I keep saying like co-occurring integration should be oh, it should not be a separate bucket, it should be part of every bucket. And I think it's two obvious point because when Abbie and I first spoke several years ago, it was because Dr. Manzo connected us, because we had the navigator grant. And what he was finding was that individuals were coming through again and again because they had integrated needs that were not being met. And so I think that as we kind of like are now really drilling down on the key buckets Naloxone, the hubs, the crisis stabilization centers. We have to use a lot of attention and time on the model of care within the community. And so I think that we're kind of like now we're really like feeling it all out and feeling where the gaps are. But I think that when we look at workforce development, I think that that's another place in the community. We need to kind of keep our eye.

Speaker 1 For the reason that we spoke and identified the themes that we felt were important yesterday. I think we're starting to see how they connect to the specifics. And I agree with you, Stephanie. I'd like to ask Dr. Smith to try to.

Speaker 8 Yeah, I.

Speaker 1 Want to turn you and just we have about five more minutes, unfortunately. Okay.

Speaker 8 So let's talk about the clinic, the outpatient clinic system, mental health clinic system. It's about 450 clinics that are licensed across the state treat over 700,000 people per year. I'm going to switch over to this other document, and we can we can share these documents so people will get this. This is an analysis from 2020 date Medicaid claims data. So it's the Medicaid population, but Medicaid is far and away the chief payer for these programs. Right. So this is looking at how many people who had a visit were served by the public mental health system, had a co-occurring substance use disorder and broken out into opioid versus other substance use disorders and folks and it's broken up by age group and gender and diagnosis, etc. But the long and short of it is for the entire population. It's upwards of 35% of people presenting for mental health care have a co-occurring disorder. If you get into the more major disorders like bipolar, PTSD, you know, psychosis, it's upwards of 50, 60%. And these may these are probably even underestimates because this is only looking at Medicaid claims data. That's for all substance use disorders. The rates of active opioid use disorder are 10% across the board of people in the mental health system and again, higher 14 15% for the more serious. A disorder. So and this is a mental health system that largely does not want to have people with active opioid use disorder, for all those reasons we've talked about. And still upwards of 15% are in that system. So very significant rates of co-occurring disorders. And just for the sake of time, I'll run through one more. We're aware of this and we've been working over this, had a couple of quality improvement initiatives over the past four or five years to try to address these issues. One is the building capacity initiative. This is one where we said we have a learning health care system team, if you will, in in our chief medical officers office that has the Psyche's platform, that uses administrative data to create a platform for providers to go in and get quality measures and data related to their work so they can do secure continuous quality improvement. So we went out in 2018, 2019 and said and said to our licensed providers, the clinic providers, we we need to do a better job identifying and

treating opioid use disorders in the mental health system. And we we this is one where we put a lot of pressure on our clinics to participate and we got 485 of them. So well over half of these clinics to participate. Oh, let me. Let me go backwards, take a time out. We have integrated care initiatives and we have integrated licensure initiatives, right, that we've worked on with Department of Health and Oasis. So out of those 500 or so OMH licensed Article 31 clinics, it's about 80 of them have pursued a licensure for integrated care. There's two ways you can do it. You can being Article 31 clinic and get an Article 32 license. Right. Oftentimes you end up in this funny situation where the 30 ones are on one side, the 32 are on the other side. And sometimes there's separate medical records. There's those kind of stuff. But you can have both licenses at the same physical place. Got about 40. That's only 10% of our clinics have have that. And then another 40 same amount, another 10% have pursued the integrated licensure that we created with Doc and Oasis, which under one license allows you to to treat provide all the services that the agencies support. So that's 20% total, 10% integrated licensure, 10% Article 3132. So adds up to 20%. So it's still a small minority of our clinic providers.

Speaker 6 I don't want to go too far into the weeds, but the IOS license is really more about physical plant and less about common assessments and billing and and treatment. Am I correct about. I just want because because and I'm asking because when we build the system the same way, we asked Doe what the pie in the sky was. In my opinion, an integrated license should actually serve the purpose of almost matching what the CCPHC model does at the at the federal level. And so it becomes more than a plant or a logistics and more about quality improvement as far as service delivery and integration.

Speaker 1 I would I think you're you're correct. Albany is proud to say we were the first integrated licensed non pilot in the state and it essentially is an integrated physical plant where we have we have an oasis clinic and a mental health clinic with the same staff, the same medical record. But but it's we're not doing. Ken MINKOFF integrated treatment at the one last comment, then we're going to have to wrap it up, please.

Speaker 2 I know that you said that you guys are trying to do better, but we have been talking about individuals who use substances also. And I know in my community a lot of the mental health providers will be like, oh, you need X amount of time or you need to work on your substance use issue first. So I guess like as a doctor, right, would you agree that we need to do it because that's co-occurring truly being able to understand both issues, not denying someone access because of another issue. I know. I mean, I think that it really needs to be self-directed. Right. So would you say that we need to do better in terms of truly having a co-occurring lens as opposed to just looking at it like we're in the same building?

Speaker 8 Well, yeah, I think yes, the provider system has has a way to go. There's still a lot of providers who even to this day are being trained that this is substance use, this is mental health, and they're apples and oranges and pick which one you want to do. And a lot of providers come out with these sort of biases, if you will, saying, I can do this, but I can't do that. So we have to work on everything from training programs to a ongoing training for current staff to learn new models to licensure regulatory actions. There's a lot we have to do.

Speaker 1 There are there are many still archaic practices. But I think, you know, I have seen I've come a long way, but we have a long way to go. And I appreciate the discussion. Patricia, do you have something to say? You are signaling me there.

Speaker 6 You know, I have to bring in prevention. So I just wanted to mention that prior to her retirement, Donna Bradbury and I have been working closely together to talk about the prevention lens or AMH. I think within the past year establish a division of prevention services. So we are really talking about how can we reach young people in schools, in communities, how we can work together in terms of things like suicide prevention, and look at our model for prevention and the model for prevention work hand in hand so we can better identify young people early on and refer them to the appropriate level of care. So I just wanted to add that because of the presentation.

Speaker 1 Thank you very much. Did you want to say something?

Speaker 6 I just want to thank both Dr. Smith and Joanne for their contribution today and the presentation around what their department, you know, are currently doing and where the potential gaps are and where, you know, this board could consider areas for contribution. I think it's a really great, great conversation and I think I just want to thank you guys. I would also like to recommend that this is not the beginning of an end. It is the beginning of a continuation that, you know, from time to time you would both come to the board with things that you think might be important for us to hear or, you know, things that as we come upon that we would like to hear more from. We don't have enough time, Stephen, but I think probably Oasis can think about a similar type of data presentation that they would like to give to us around, you know, needs and gaps. And, and, you know, you guys did a really intense sort of go around couple of years ago where you gathered information from the field. I mean, you know, I think a similar type of presentation would be helpful, I think, to the support by Oasis. That would only be fair. Steven Come. Steve, come September, would it be possible to have sort of a joint like, kind of like wish list, integrated conversation with DOH etc?

Speaker 1 Which Oasis do we not leave yet? Are you leaving?

Speaker 7 I have a TV interview, but.

Speaker 1 So if you'll give me 2 minutes, please.

Speaker 7 Okay, you got it.

Speaker 1 This is this is a hard thing to pull off. I want to recognize the fact, first of all, that we're in a beautiful space. We're going to try to stay in this space. And I'm grateful for the SUNY assistance and for our newly found IT friend Joe. Thank you very much.

Speaker 7 I want to say.

Speaker 1 Yeah. I'll do my I'll do my best. I'll do my notice that the water machine says Oasis, though I wasn't sure why that was. But listen, speaking of Oasis, my job is made a lot easier by my work with Oasis. I need to give props where they're due. Tracy, thank you so much for your assistance. Tricia Thank you for your counsel. Jennifer Thank you very much for letting us in this morning and yesterday morning. And Debra is still here and I keep forgetting your name. Greg, thank you so much. It literally is taking a village here. And I'm grateful to have come to meet you, to work with you. And I just urge you to stay optimistic. And if you remember what I said yesterday, try to give the benefit of the doubt. To everyone all the time. Surprising things. I'm just talking about my perspective, but. I urge you to consider it. We'll get some. Josh, are we ready? Dr. Lynch, are we ready to say anything about date for next meeting where we will do email it to you. I'll get that out.

We're also trying to get something together, perhaps video conferencing with our budget presentation. So more to come on all of that. Um. Very grateful to you all. Oh, I. I have to make a motion to adjourn. But then that motion was seconded by Bill McGoldrick.