



**Monroe-Livingston REMAC Minutes
August 18, 2025 at 5pm
Public Safety Training Facility Room 107**

Roll Call Attendance – Ben Sensenbach

Voting Members:

**Dr. Farney
Dr. Dorsett
Dr. Verneti
Dr. Katsetos
Dr. Schueckler (excused)
Dr. Cushman
Dr. Lemay
Dr. LaBarge (excused)
Dr. Rueckmann (excused)
Dr. Klomochko**

Non-Voting Members:

**Scott Johnson
William Comella
Samuel Tinelli (excused)
Robert Breese (excused)
Adam Oplinger (excused)
Karen Dewar
Tim Czapranski
Kevin Gustina
Corey Youells (absent)
Ben Sensenbach
Maverick Greek-Rouse (excused)
Bill Arnold Tim Frost (absent)**

Agenda Review – Aaron Farney, MD

- Additions to the agenda - None
- Minutes Review & Approval
 - June 2025
 - REMAC Minutes: <https://mlrems.org/remac/minuteswebcasts/>



- Motion to Approve by Dr. Verneti, Seconded by Dr. Lemay. Motion passes unanimously.

State Actions – Ben Sensenbach

Amanda Eugui	256221	For violations of a previous stipulation and order	Suspended for one (1) year effective 8/12/2025	8/12/2025
Bensonhurst Volunteer Ambulance Service, Inc.	7193	For violations of 10 NYCRR 800.2(j) and PHL § 3012(1)(b).	Ambulance Service Certificate is revoked effective July 16, 2025.	7/17/2025
Tanner, Steven	430642	For violations of 10 NYCRR § 800.16(a)(13).	Surrendered effective 6/20/2025.	6/24/2025
Sarker, Muntaqa	519343	For violations of 10 NYCRR § 800.16.	Certification is suspended for 3 years effective 6/17/2025. The suspension is stayed pending no further patient abuse violations during the three-year probationary period. Assessed a \$2000 civil penalty.	6/17/2025
Torres, Evan	49862	For violations of 10 NYCRR § 800.16.	Certification is suspended for 3 years effective 6/17/2025. The suspension is stayed pending no further patient abuse violations during the three-year probationary period. Assessed a \$2000 civil penalty.	6/17/2025

New Business – Jeremy Cushman, MD

- Managing Exertional Heat Stroke
- Motion to Approve the Managing Exertional Heat Stroke Policy by Dr. Dorsett, Seconded by Dr. Lemay. Motion passes unanimously.
 - Discussion –
 - Training has been recorded including live training scenarios. The policy release will be held until the final training editing has been completed.
 - Updates to the Collaborative Protocols support the medical management of exertional heat stroke.



- This was crafted with consultation from sports medicine partners.

Old Business – Jeremy Cushman, MD

- Advisory 25-07 New and Updated Policies – Transport of the Mechanically Ventilated Patient, Drug Assisted Airway Management, Prehospital Electronic Monitor Data policies have been released.
- Advisory 25-08 – Drug Assisted Airway Management Credentialing Process has been released.

Regional Medical Director Report – Jeremy Cushman, MD

- Physician team beginning work to improve care in pediatric cardiac arrests
- Working with local EMS leadership to make Rochester a Heart Safe Community
- Pulsara Update

Associate Regional Medical Director for Patient Safety – Jason Farney, MD

- Continuing to collaborate with interested parties based on findings from individual cases.

Associate Regional Medical Director for Education and Quality – Maia Dorsett, MD, PhD

- Pediatric Advisory Council Update
 - Shared Data Regarding improved medication safety.
 - See attached presentation
 - Discussed NYC part 80 equipment changes
 - See attached list
- Airway Collaborative Update
 - Update on NEMSQA airway collaborative
 - Update on DMM and DAAM credentialing

Council (MLREMS) – Sam Tinelli

- No Report

State Council Meetings – Maia Dorsett, MD, PhD

- No Report, next meetings in September

Regional Trauma Advisory Committee – Adam Oplinger

- Excused
- No report

Program Agency Report – Ben Sensenbach



- Pulsara – Continued work with Rochester Regional Healthcare and UR Medicine to foster relationships and provide guidance to EMS agencies and emergency departments

DRAFT



Individual Hospital Reports

Rochester Regional

RGH – Connie Verneti, MD

- Thank you EMS for your efforts with Pulsara

Unity/St. Mary's – Tony Katsetos, DO

- No Report

UR Medicine

SMH/Strong West – Aaron Farney, MD

- No Report

Highland – Jay Schueckler, DO

- Portable CT Scanner will occupy space in EMS parking for the replacement on an internal CT scanner

Noyes – Aaron Farney, MD

- No Report

Motion to adjourn by Dr. Verneti, seconded by Dr. Katsetos. None opposed.

Next Meeting is October 20, 2025 at 7pm at the PSTF 1190 Scottsville Road, Rochester, NY.

Meeting Link: https://youtu.be/1UjMX2d5_e0



MANAGING EXERTIONAL HEAT STROKE

PURPOSE

This policy outlines how EMS clinicians can effectively cool patients on scene with exertional heat stroke consistent with New York State EMS Protocols.

GUIDANCE

The immediate and definitive management of a patient with exertional heat stroke (EHS), defined as one with altered mental status and an elevated skin temperature with a history of heat exposure or exertion, is critical to their clinical management. Cooling should be initiated without delay and transport may be delayed if active cooling can be provided. In most cases, requesting additional resources such as the jurisdictional fire department to the suspected EHS case based off dispatch information or once on scene is prudent given the personnel and resources (water) needed to effectively cool a victim. This document outlines best practices for performing immediate and effective cooling on scene.

WHOLE BODY COOLING

Whole-body cooling strategies for patients with EHS can be performed with resources commonly available on scene. In decreasing order of preference they are:

- Ice water immersion, defined as cold water and ice in a vessel capable of accommodating a supine patient immersed up to their neck to include upper and lower extremities.
- Cold water immersion, defined as cold water alone in a vessel capable of accommodating a supine patient immersed up to their neck to include upper and lower extremities.
- TACO (Tarp-Assisted Cold water with Oscillation) defined as the use of a tarp or mega-mover to contain water around the patient while providing water and, if available, ice, to immerse as much of the torso, groin, and extremities as possible while circulating the water as able.
- Cold water dousing, defined as free-flowing water applied to the whole body – extremities, torso, hands, feet, neck, and head (while maintaining the airway).
- Ice/Cold water-soaked towels with ice packs, defined as the application of towels placed in cold or ice water, subsequently wrung and placed on the limbs (including feet and hands), trunk, and head and exchanged rapidly. Ice packs should simultaneously be placed in the groin, axilla, and neck.

Hydrant water (~40°F) is preferred over tank water (~60°F) when available. In all cases, water should be circulated whenever possible and ice (if available) added as it melts. If hose lays are already charged, they should be run until cool water exits the nozzle. If available, fans will increase the cooling effect of cold water dousing and cold towel methods.



CLINICAL MONITORING

- Continuous clinical monitoring of the mental status of heat emergency patients is essential:
 - Establish dedicated monitoring of the patient by a single individual to monitor their mental status and clinical changes.
 - Improvement in mental status is sufficient to discontinue active cooling using any of the above techniques.
 - Shivering (or the absence thereof) should not be used as a sole indicator to discontinue cooling measures.
- Cardiac and blood pressure monitoring should be used cautiously to prevent submersion of electrodes, blood pressure cuffs, and pulse oximeters; reinforcing the importance of a single clinician to monitor the patient.
- EtCO₂ may be a valuable tool to monitor the respiratory effort for a patient being treated for EHS where direct visualization of their chest for respiratory rate and effort is limited by the means being used to cool them.

TEMPERATURE MONITORING

- The only reliable core temperature monitoring in the field is using a rectal thermometer inserted at least 13cm/6in into the rectum or an esophageal probe in an intubated patient. As the core temperature nears 102°F, crews should prepare to remove the patient from whole-body cooling. If whole-body cooling continues below 102°F, there is an increased risk of hypothermia.
- Tympanic, infrared, or sublingual thermometers are not reliable measures for heat emergency patients, especially when they are receiving whole-body cooling and should not be used.

SPECIAL CONSIDERATIONS

- Sedative or neuromuscular blocker medications may reduce core temperature, so rebound hypothermia is another risk for heat emergency patients.
- If patients are already intubated or had seizure-terminating interventions, monitor vitals and exam findings, with preference for close temperature monitoring with rectal or esophageal probe.

PLANNED EVENTS

- Events where physical activity and/or environmental conditions increase the likelihood of EHS should have in place a plan to provide on-site cooling using any of the techniques noted above, with preference for whole body ice-water immersion through the use of kiddie pools, body bags, tarps, or other device, along with ready access to large amounts of cold water and ice.

REMAC - Pediatric Advisory Council

8/18/25

DRAFT



Purpose:

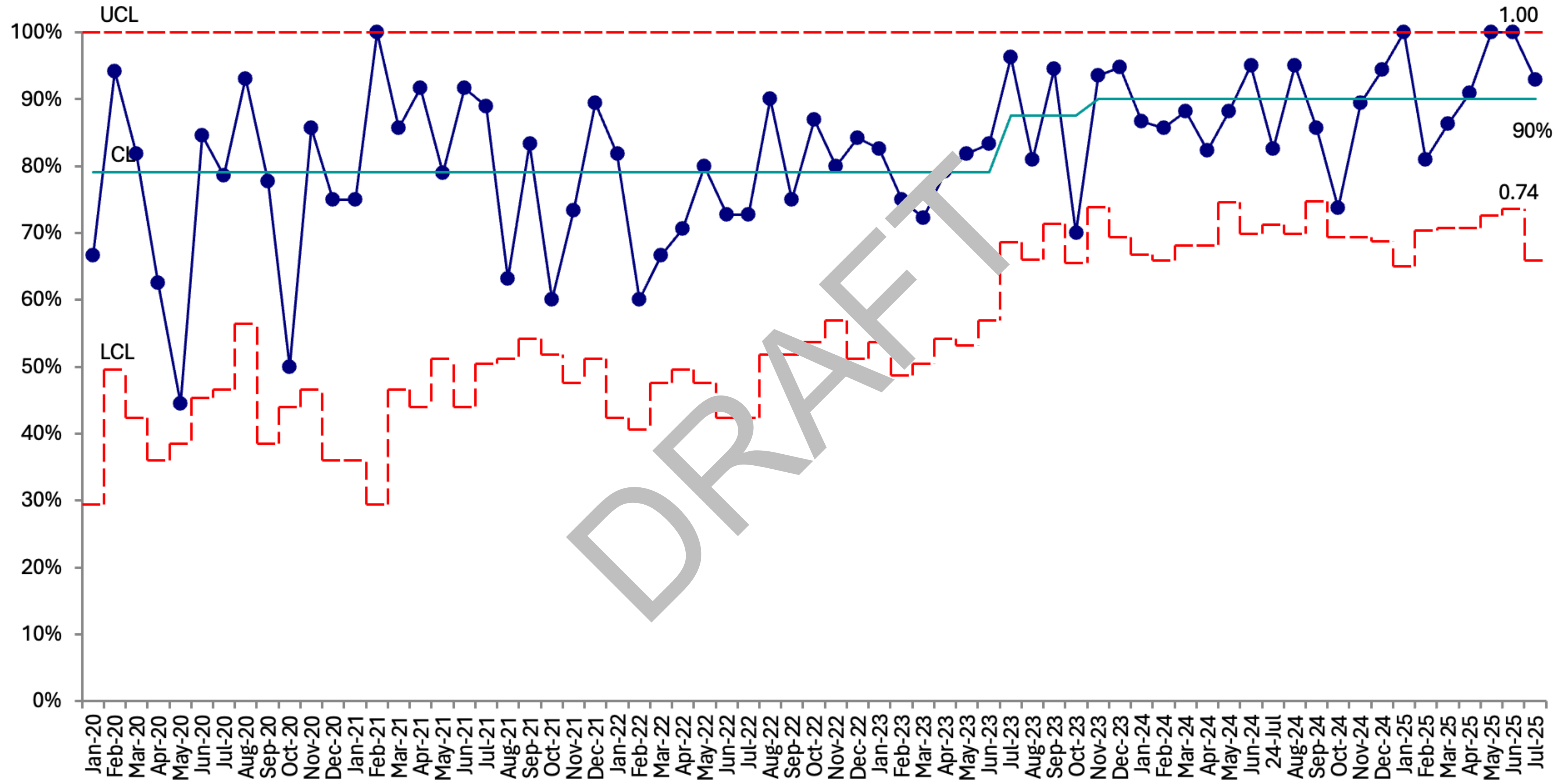
To advance pediatric prehospital care by identifying improvement opportunities and fostering regional collaboration.



Agenda

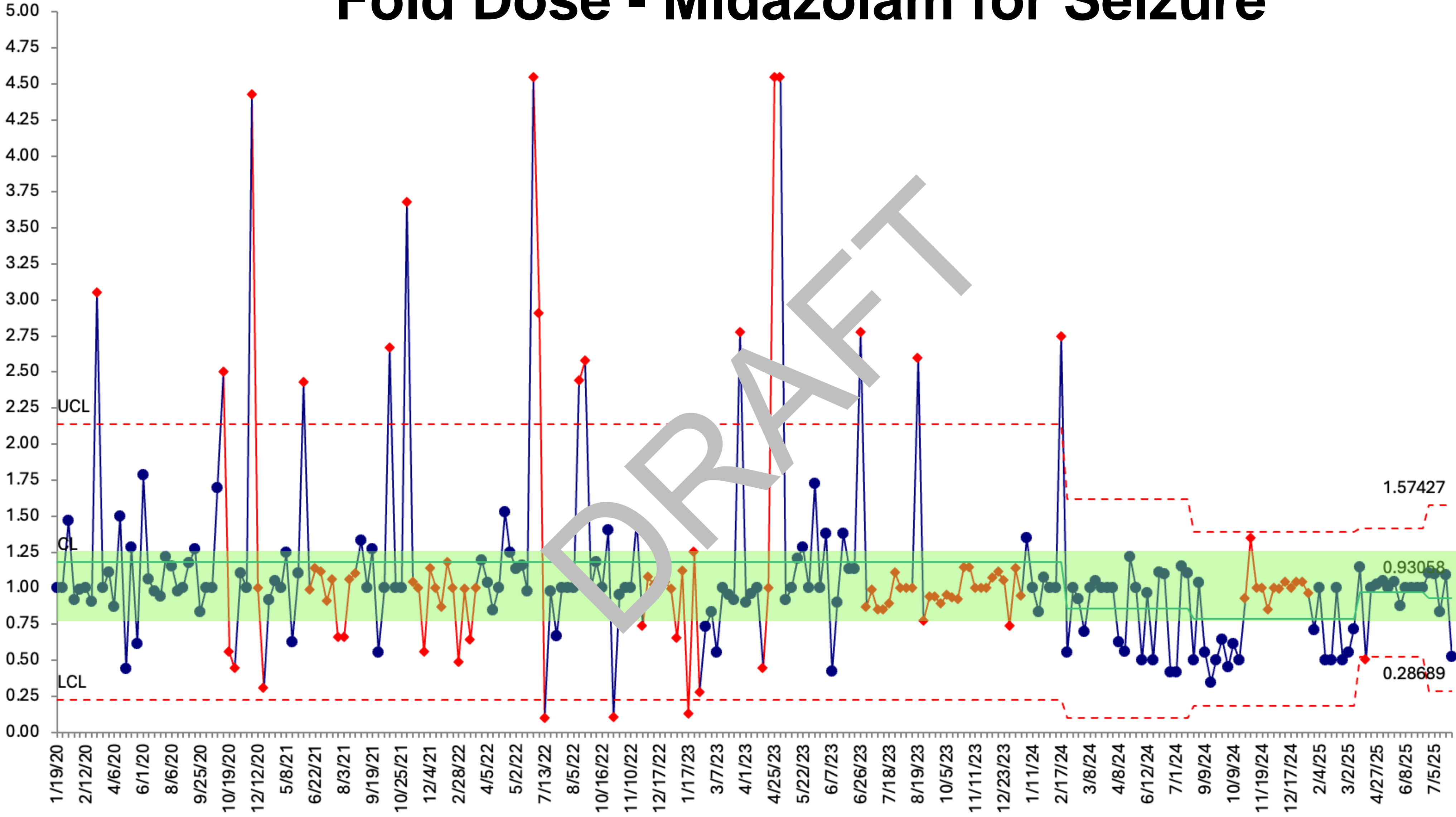
1. Quality Improvement Initiatives
 - Pediatric Medication error
 - Pediatric Pain Assessment & Management
2. Equipment: Part 800 proposed changes
3. Pediatric Continuing Education
4. Pediatric Cardiac arrest Management
5. Other information/Updates

% Correct Dose



Jan-20 - Jul-25

Fold Dose - Midazolam for Seizure



BLS Expansion Update

DRAFT



Advisory 25-06 Handtevy for BLS Clinicians

To: All EMS Agencies
From: Maia Dorsett, MD, PhD, FACEP, FAEMS *M. Dorsett*
Associate Regional Medical Director for Education and Quality
Jeremy T. Cushman, MD, MS, EMT-P, FACEP, FAEMS *J. Cushman*
Regional Medical Director
Date: June 17, 2025

We are pleased to announce that the Handtevy application is now available to all BLS clinicians in the Monroe-Livingston EMS Region. Originally launched in 2023 for ALS clinicians, the app has proven valuable in improving the safety and accuracy of pediatric medication dosing in the prehospital setting.

With expanded licensing - thanks to the support of the Monroe County EMS Chiefs Association and participating agencies - BLS clinicians now have full access to this resource.

All EMS clinicians (ALS and BLS) in our region should use the Handtevy application as the standard reference for protocols in the field. This will enable all BLS clinicians to view ALS protocols as well, enhancing a team-based approach to care. Basic Life Support First Response agencies are strongly encouraged to place the application on the apparatus/duty phone as the primary means of agency access to Handtevy so that it is available to all personnel and efficiently utilizes a finite number of licenses for use.

We have developed several educational resources for your download and use to support onboarding and clinical integration:

Introduction to Handtevy, including instructions to download the application and demonstration of app functions (14 min):

YouTube Link: <https://youtu.be/4BfaE6m9EaI>

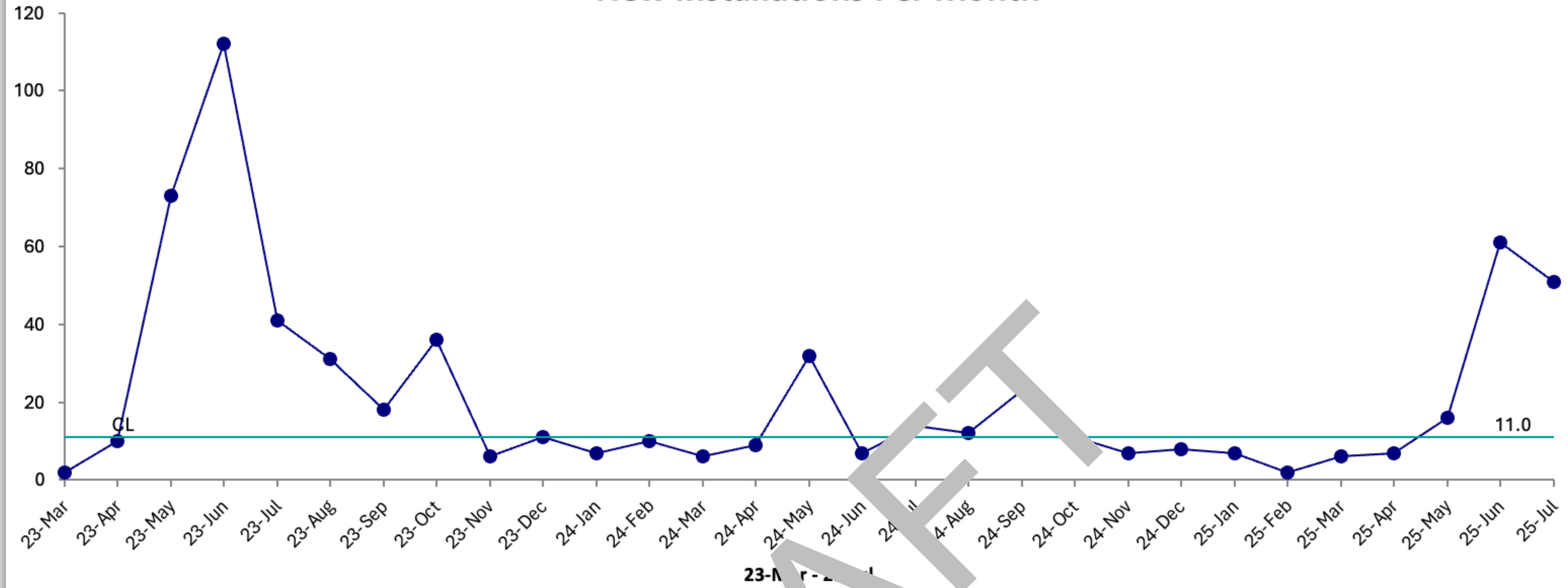
MP4 file for view/download: <https://rochester.box.com/s/5mercmm8mv9x6xy8ek2a9mdx7zx6hcom>

Case scenarios (powerpoint format) to be used by training officers for Hands-On Learning:

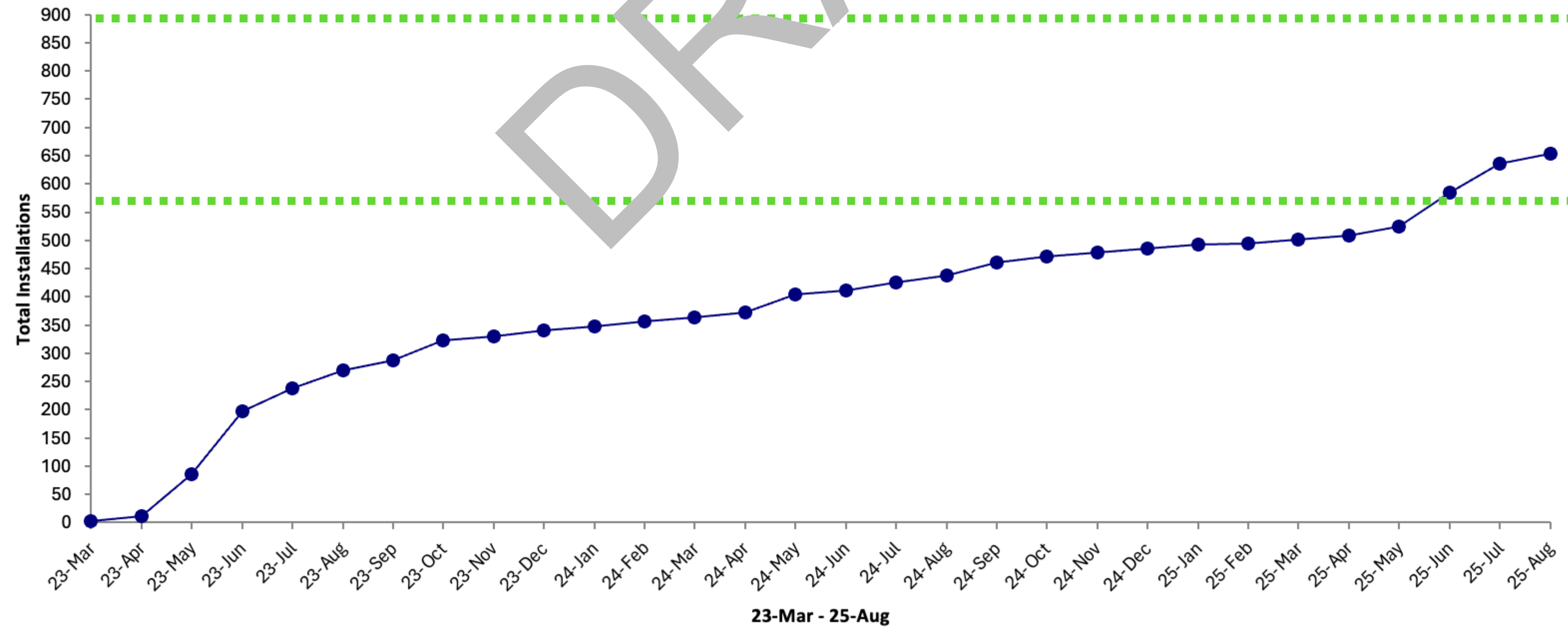
<https://rochester.box.com/s/0bl63xsq6meohn9n5911ysf9c7ktatlv>

We strongly encourage all agencies to ensure that BLS clinicians have an opportunity for hands-on training. As always, we welcome your feedback and suggestions for improvement—please reach out with any questions or comments to handtevy@mlrems.org, or contact this office.

New Installations Per Month



Total Installations - Run Chart



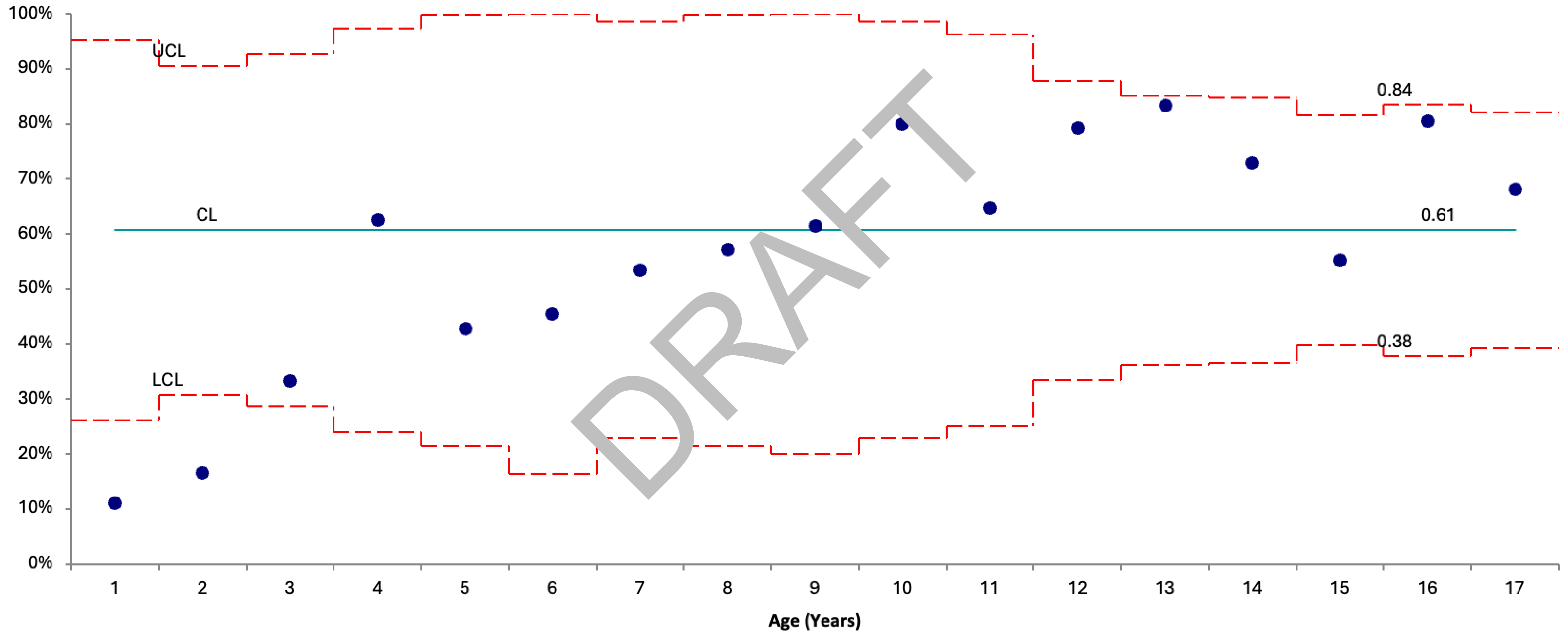
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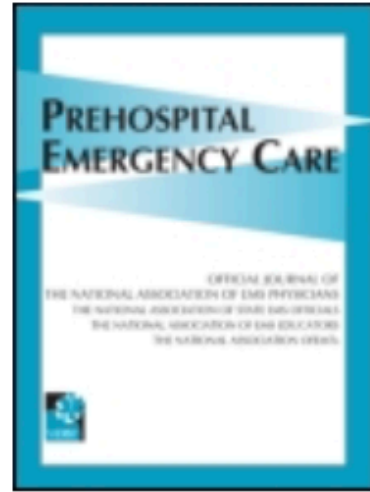
Initial # of licenses

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% Assessed for Pain





Barriers to and Enablers for Prehospital Analgesia for Pediatric Patients

David M. Williams, Kirsten E. Rindal, Jeremy T. Cushman & Manish N. Shah

To cite this article: David M. Williams, Kirsten E. Rindal, Jeremy T. Cushman & Manish N. Shah (2012) Barriers to and Enablers for Prehospital Analgesia for Pediatric Patients, Prehospital Emergency Care, 16:4, 519-526, DOI: [10.3109/10903127.2012.695436](https://doi.org/10.3109/10903127.2012.695436)

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Published online: 23 Jul 2012.

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Barriers and Enablers in Prehospital Pediatric Analgesia

Hoi See Tsao, Tanya Sutcliffe, Charles Wang, Sara E. Vargas, Chelsea Day & Linda L. Brown

To cite this article: Hoi See Tsao, Tanya Sutcliffe, Charles Wang, Sara E. Vargas, Chelsea Day & Linda L. Brown (02 Dec 2024): Barriers and Enablers in Prehospital Pediatric Analgesia, Prehospital Emergency Care, DOI: [10.1080/10903127.2024.2431586](https://doi.org/10.1080/10903127.2024.2431586)

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Published online: 02 Dec 2024.

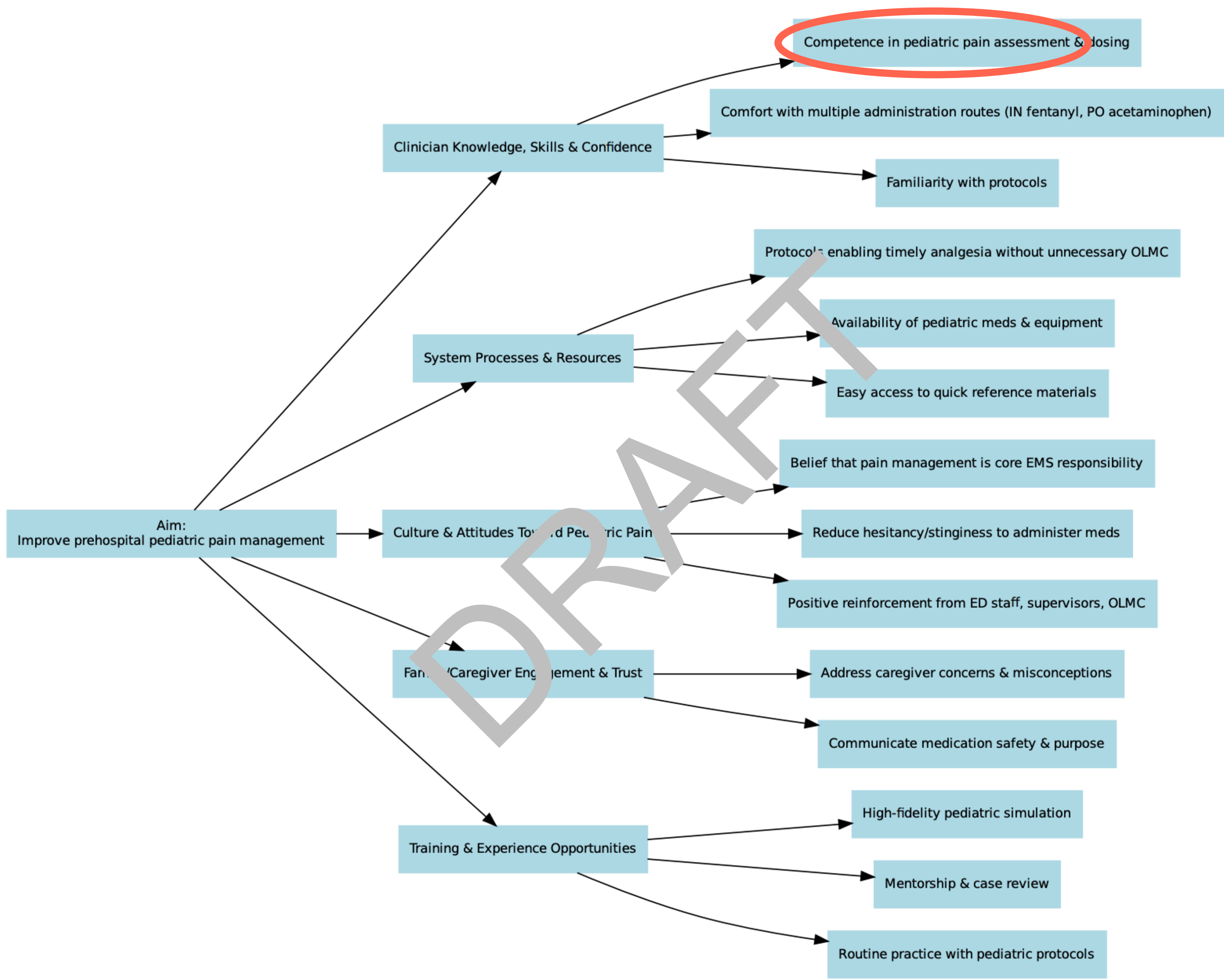
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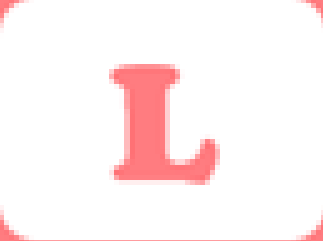



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Scales 	Age group Recommended	Indications				Comments
		Acute pain	Procedural pain	Post op pain	Chronic pain¥	
Self-report measures						
NRS-11	≥ 6 yo	+++	+++	+	+	No paper/hard tool required
FPS-R	≥ 4 yo*	+++	+++	+		Preferred by children
CAS	≥ 8 yo	+++	+++	+		
Observational measures						
NFCS	0-4 months	++	++		++	Acute, procedural and prolonged pain
NIPS	0-1 month	+	+			Some potential bias
FLACC r-FLACC	2 m-7 yo 4-19 yo	+	+/- +/-	+	+	Conflicting recommendations for procedural pain
CHEOPS	1-7 yo		+/-	+		Score on 13, conflicting recommendations for procedural pain
EVENDOL	0-7 yo	+++	+++		+++	Score on 15

Category	0	1	2
 Face	No particular expression or smile	Occasional grimace/frown; Withdrawn or disinterested; <i>appears sad or worried</i>	Consistent grimace or frown; frequent/constant quivering chin, clenched jaw; <i>distressed-looking face; expression of fright or panic</i>
 Legs	Normal position or relaxed; <i>usual tone and motion to limbs</i>	Uneasy, restless, tense; <i>occasional tremors</i>	Kicking, or legs drawn up; <i>marked increase in spasticity, constant tremors or jerking</i>
 Activity	Lying quietly, normal position, moves easily; <i>regular, rhythmic respirations</i>	Squirming, shifting back and forth, tense or guarded movements; <i>mildly agitated (e.g. head back and forth, aggression); shallow, splinting respirations, intermittent sighs</i>	Arched, rigid or jerking; <i>severe agitation; head-banging; shivering (not rigors); breath-holding, gasping or sharp intake of breaths, severe splinting</i>
 Cry	No cry/verbalization	Moans or whimpers; occasional complaint; <i>occasional verbal outburst or grunt</i>	Crying steadily, screams or sobs, frequent complaints; <i>repeated outbursts, constant grunting</i>
 Consolability	Content and relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort, <i>pushing away caregiver, resisting care or comfort measures</i>

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EDUCATION AND PRACTICE

CHILD ABUSE RECOGNITION TRAINING FOR PREHOSPITAL PROVIDERS USING DELIBERATE PRACTICE

Kathleen Adelgais, MD, MPH, Martin Pusic, MD, PhD, Denise Abdo, CPNP, PhD, Sean Caffrey, MBA, NRP, Katherine Snyder, MD, MPH, Michelle Alletag, MD, Ashley Balakas, BSN, CPEN, Timothy Givens, MD, Ian Kane, MD, Maria Mandt, MD, Kelley Roswell, MD, Mary Saunders, MD, Kathy Boutis, MD MSc

ABSTRACT

Background: In most states, prehospital professionals (PHPs) are mandated reporters of suspected abuse but cite a lack of training as a challenge to recognizing and reporting physical abuse. We developed a learning platform for the visual diagnosis of pediatric abusive versus non-abusive burn and bruise injuries and examined the amount and rate of skill acquisition. **Methods:** This was a prospective cross-sectional study of PHPs participating in an online educational intervention containing 114 case vignettes. PHPs indicated whether they believed a case was concerning for abuse and would report a case to child

protection services. Participants received feedback after submitting a response, permitting deliberate practice of the cases. We describe learning curves, overall accuracy, sensitivity (diagnosis of abusive injuries) and specificity (diagnosis of non-abusive injuries) to determine the amount of learning. We performed multivariable regression analysis to identify specific demographic and case variables associated with a correct case interpretation. After completing the educational intervention, PHPs completed a self-efficacy survey on perceived gains in their ability to recognize cutaneous signs of abuse and report to social services. **Results:** We enrolled 253 PHPs who completed all the cases; 158 (63.6%) emergency medical technicians (EMT), 95 (36.4%) advanced EMT and paramedics. Learning curves demonstrated that, with one exception, there was an increase in learning for participants throughout the educational intervention. Mean diagnostic accuracy increased by 4.9% (95% CI 3.2, 6.7), and the mean final diagnostic accuracy, sensitivity, and specificity were 82.1%, 75.4%, and 85.2%, respectively. There was an increased odds of getting a case correct for bruise versus burn cases (OR = 1.4; 95% CI 1.3, 1.5); if the PHP was an Advanced EMT/Paramedic (OR = 1.3; 95% CI 1.1, 1.4); and, if the learner indicated prior training in child abuse (OR = 1.2; 95% CI 1.0, 1.3). Learners indicated increased comfort in knowing which cases should be reported and interpreting exams in children with cutaneous injuries with a median Likert score of 5 out of 6 (IQR 5, 6). **Conclusion:** An online module utilizing deliberate practice led to measurable skill improvement among PHPs for differentiating abusive from non-abusive burn and bruise injuries. **Key words:** child abuse and neglect; emergency medical services; educational programs; deliberate practice

PREHOSPITAL EMERGENCY CARE 2021;25:822-831

INTRODUCTION

Child abuse is a significant problem in the United States (US) with an annual estimated incidence

Received July 29, 2020 from Pediatric Emergency Medicine, School of Medicine, University of Colorado, Aurora, CO (KA, MA, TG, MM, KR, MS); Langone Medical Center, New York University, New York City, NY (MP); School of Medicine, Kempe Center, University of Colorado, Aurora, CO (DA); Crested Butte Fire Protection District, Crested Butte, CO (SC); Dell Children's Medical Center of Central Texas, Austin, TX (KS); EMS Outreach and Education Program, Children's Hospital Colorado, Aurora, CO (AB); Medical University of South Carolina, Charleston, SC (IK); The Hospital for Sick Children, University of Toronto, Toronto ON (KB). Revision received September 22, 2020; accepted for publication September 28, 2020.

There are no interests to declare.

Robert Feltner and Dan Koabel from Creative Elements Group, Inc. Blue Ash, OH. Ashley Balakas BSN and Jason Kotas, EMT from the Children's Hospital EMS Outreach and Education Program, Michelle Loop NRP and Ashley Banks RN from the Children's Hospital Colorado Trauma and Burn Program.

Address correspondence to Kathleen Adelgais, Pediatric Emergency Medicine, School of Medicine, University of Colorado, 13001 E 17th Pl, Aurora, CO 80045, USA. E-mail: Kathleen.Adelgais@childrenscolorado.org

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doi:10.1080/10903127.2020.1831671



Identifying Abuse

These online educational modules are intended to assist healthcare providers in determining the difference between accidental and intentional injuries in children. Considering many clinicians see few cases of child abuse in their daily practice, these case studies will improve assessment skills and build confidence in knowing when to report suspected abuse to appropriate authorities. The cases presented contain real images of injured children. Some learners, including experienced healthcare professionals, may find these images upsetting. You may exit and/or return to this module at any time and completion of this program is voluntary.

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Pediatric Cardiac Arrest Roll Call Training



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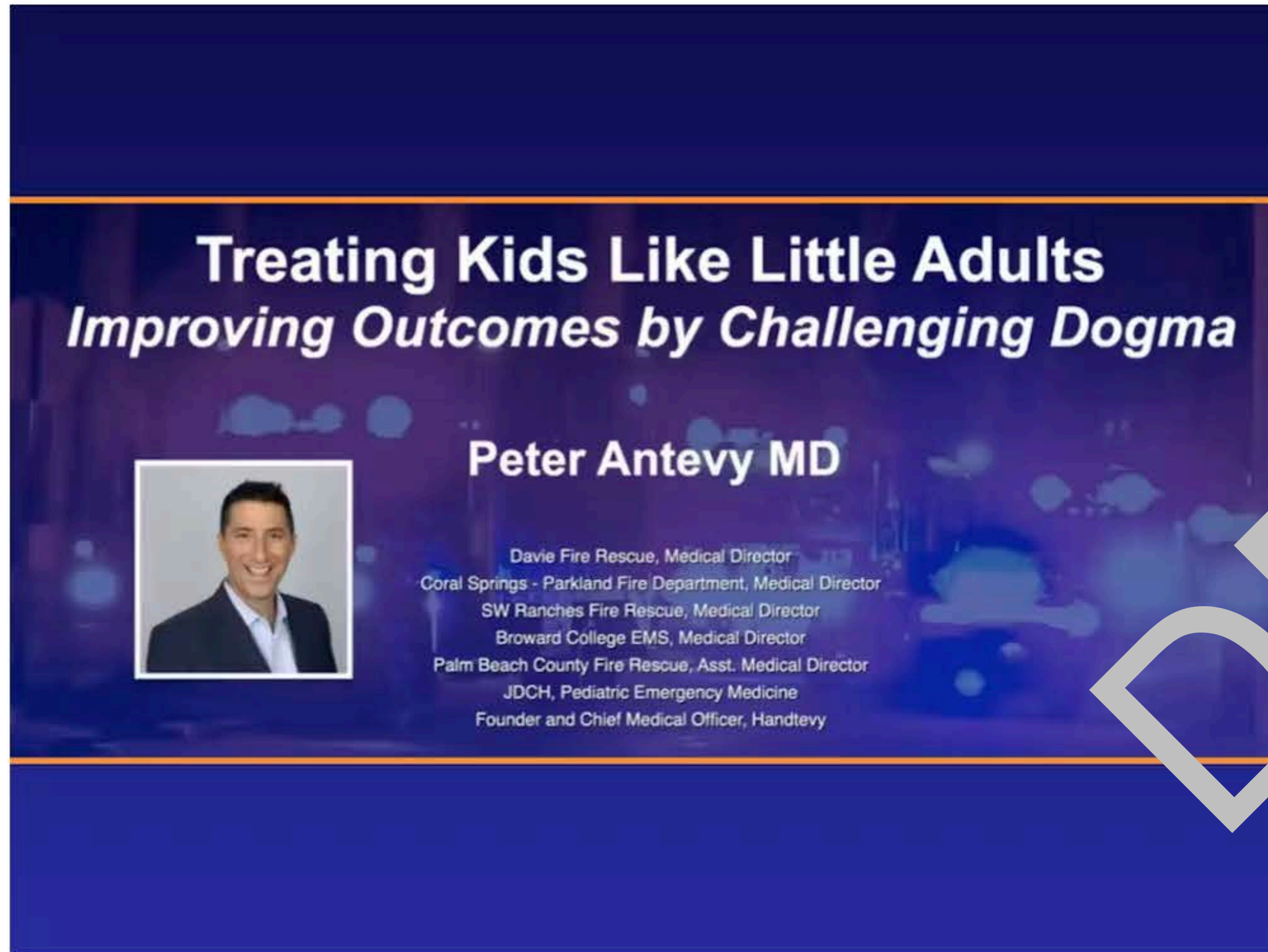
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Treating Kids Like Little Adults



Treating Kids Like Little Adults
Improving Outcomes by Challenging Dogma

Peter Antevy MD

Davie Fire Rescue, Medical Director
Coral Springs - Parkland Fire Department, Medical Director
SW Ranches Fire Rescue, Medical Director
Broward College EMS, Medical Director
Palm Beach County Fire Rescue, Asst. Medical Director
JDCH, Pediatric Emergency Medicine
Founder and Chief Medical Officer, Handtevy

Overview

Materials

Take Types: Distributive Credit Hours: 1.5 Hrs

In this presentation, Peter Antevy discusses why we can improve outcomes for pediatric cardiac arrest patients by changing paradigms and treating them more like "little adults" - by staying on scene, providing good quality compressions, defibrillation when appropriate and good quality ventilations.

Last updated on August 7, 2025 at 6:32 PM EDT

Tags: Cardiac arrest Pediatrics MLREMS Antevy

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SUMMARY OF EXPRESS TERMS

The proposed rulemaking would repeal section 800.23 and repeal and replace sections 800.3(m), 800.24, 800.25 and 800.26 of Title 10 of the New York Codes, Rules and Regulations (10 NYCRR) pertaining to Emergency Medical Services equipment requirements for certified ambulance and emergency ambulance service vehicles.

Subdivision (m) of section 800.3, defining an emergency ambulance service vehicle, is repealed and replaced with an updated definition.

Section 800.23, containing general provisions for certified ambulance services, is repealed and the provisions contained within this section are incorporated into section 800.24.

Section 800.24, pertaining to equipment requirements for certified ambulance services, is repealed and replaced to consolidate minimum equipment requirements contained in current sections 800.24 and 800.26. It also expands minimum equipment standards to current industry best practices, defines the requirements for advanced life support equipment on a basic life support vehicle, clarifies how advanced life support equipment must be stored and addresses the required proficiency of a provider operating or using equipment and provides the guidance for basic life support (BLS) providers who are operating on a vehicle with advanced life support (ALS) equipment standards.

Section 800.25, pertaining to special use vehicles, is repealed and replaced. The new section sets forth the process for emergency medical service agencies to obtain a regulatory waiver from the Department for special circumstances that render compliance with the regulations unreasonable, burdensome, or impractical, or where compliance would result in impediment of emergency

medical services. The section sets forth the limited nature of such waivers and the criteria the Department will use to determine whether to grant a waiver.

Section 800.26, pertaining to equipment requirements for emergency ambulance service vehicles other than an ambulance, is repealed and replaced. The new section sets forth build standards for emergency ambulance service vehicles that reflect current industry standards. It also includes newly required safety equipment such as camera systems that record certain driving events, guidance for securing all equipment in the patient compartment, reverse driving safety mechanisms, and anti-theft devices for when the vehicle is idling.

DRAFT

Pursuant to the authority vested in the New York State Emergency Medical Services Council and subject to the approval of the Commissioner of Health pursuant to section 3002 of the Public Health Law, Part 800 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is hereby amended to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivision (m) of section 800.3 is hereby REPEALED and replaced to read as follows:

(m) Emergency ambulance service vehicle means a vehicle certified by the department for an emergency medical services agency that serves as a first response vehicle and provides prehospital care to a patient by bringing personnel and equipment to sick or injured persons and is equipped at minimum with basic life support medications and adjuncts, as required in Table 1 of section 800.24 of this Part.

Section 800.23 is REPEALED.

Section 800.24 is hereby REPEALED and replaced to read as follows:

§ 800.24 Equipment requirements for certified ambulance services, basic life support first response vehicles and emergency ambulance service vehicles.

(a) All vehicles in a certified ambulance service, basic life support first response service, basic life support emergency ambulance service vehicles, and advanced life support first response service, must be equipped with the following, unless otherwise exempted or pursuant to a waiver obtained in accordance with section 800.25 of this Part. Table 1 outlines the equipment standard

for Ambulance vehicles (Ambulance), Basic Life Support First Response vehicles (BLS FR), Basic Life Support – Emergency Ambulance Service Vehicles (BLS EASV) and Advanced Life Support – First Response vehicles (ALS FR):

Table 1

Items	Minimum Quantity		
	Ambulance	BLS EASV BLSFR	ALS FR
“R” = required equipment “N/A” = not applicable “N/R” = not required			
(a) <u>Patient Transfer Equipment:</u>			
(1) Wheeled ambulance cot capable of supporting patients in the Fowlers position.	1	N/A	N/A
(2) A second rigid device capable of carrying a recumbent patient. Examples include a scoop stretcher, a backboard and flexible stretchers with integrated support.	1	N/A	N/A
(3) A device enabling ambulance personnel to carry a sitting patient over stairways and through narrow spaces where a rigid device (referred to in paragraph (2), above) cannot be used. The requirements of paragraphs (2) and (3) of this subdivision may be satisfied by use of one combination device capable of both operations.	1	N/A	N/A
(4) All devices used to move or transport patients must be secured using crash resistant fasteners in accordance with the requirements contained within section 800.22 of this Part.	1	N/A	N/A

(5) All devices used to move or carry patients must be equipped with safety restraints as recommended by the device manufacturer. In the absence of manufacturer guidance, any device used to move or carry a patient must at least be equipped with three, two-inch wide web straps with fasteners to secure the patient to the device.	1	N/A	N/A
(6) Age and / or size-appropriate restraint systems for patients 10lbs to 400lbs transported in ground ambulances. For pediatric patients, this should be according to the National Association of State EMS Officials “Pediatric Transport Products for Ground Ambulances” Version 2.2 (October, 2020). This document is incorporated by reference in section 800.24(b) of this Part. https://www.cpsboard.org/wp-content/uploads/2016/03/Safe-Transportation-of-Children-in-Ambulances.pdf	1	N/A	N/A
“R” = required equipment “N/A” = not applicable “N/R” = not required	Ambulance	BLS EASV BLSFR	ALS FR
<u>Airway and Oxygen Equipment/ Sudden Cardiac Arrest Resuscitation Equipment:</u>			
(1) A manually operated self-refilling adult-size bag valve mask ventilation device capable of operating with oxygen enrichment and one clear adult-size mask with air cushion.	1	1	1
(2) Oropharyngeal Airways in Size 0 (50mm), Size 1 (60mm), Size 2 (70mm),	1 of each	1 of each	1 of each

	Size 3 (80mm), Size 4 (90mm), Size 5 (100mm), and Size 6 (110mm).			
	(3) Nasopharyngeal Airways in sizes 20 fr, 24 fr, 28 fr, and 32 fr.	1 of each	1 of each	1 of each
	(4) Federal Drug Administration (FDA) Approved Pulse Oximetry device with pediatric and adult sensors.	1	Adult only (1), pediatric optional (1)	1
	(5) Portable oxygen with a minimum 350-liter capacity (medical "D" size) with pressure gauge, regulator and flow meter. The oxygen cylinders must contain a minimum of 1000 PSI pressure, be secured by a commercially produced mount, and in compliance with all federal Department of Transportation (DOT) hydrostatic test expiration dates.	2	2	2
	(6) An in-ambulance oxygen system with a minimum 1200-liter capacity (two medical "E" size) with yoke(s), P-C fitting, pressure gauges, regulators, and flow meters capable of delivering oxygen to two patients at two different flow rates of up to 15 liters per minute simultaneously. If liquid oxygen system is used, manufacturer documentation must be provided that the system has at least a 1,200-liter capacity. The oxygen cylinders must contain a minimum of 500 PSI pressure, be secured by a commercially produced mount, and in compliance with all federal DOT hydrostatic test expiration dates.	1	N/A	N/A
	(7) Adult partial non-rebreather oxygen masks and adult nasal cannulas.	4 of each	1 of each	1 of each
	(8) Battery operated, portable suction equipment capable, according to the manufacturer's specifications, of	1	1	1

	producing a verifiable vacuum of over 300 millimeters of mercury when the suction tube is clamped. This will meet the requirement of paragraph (9) of this subdivision of this Table if equipped to operate off the ambulance electrical system.		May use FDA approved manual device	
	(9) Installed adjustable suction capable of producing a verifiable vacuum of over 300 millimeters of mercury when tube is clamped. A Powered Portable suction unit may serve as an installed unit if it operates on vehicle power, the unit can serve as a portable suction unit as long as it operates on battery power.	R	N/A	N/A
	(10) Rigid plastic wide bore pharyngeal tips individually wrapped. Examples include, but not limited to, Yankauer, DuCanto, and Hi-D.	2	2 Optional if manual device	2
	(11) Soft sterile suction catheters in at least two adult sizes.	1 each	Optional	1 each
	(12) Automated External Defibrillator (AED) with equipment (at least 1 adult and one pediatric set of defibrillator pads OR attenuator OR key) necessary to provide defibrillation for both adult and pediatric patients. An AED is not required if a device compliant with paragraph (7) of subdivision (i) of this Table is present on the vehicle.	1	1	N/A
	<p>“R” = required equipment</p> <p>“N/A” = not applicable</p> <p>“N/R” = not required</p>	Ambulance	BLS EASV BLSFR	ALS FR
(c)	Immobilization and Trauma Patient Management Equipment			

(1) Full size (at least 72 inches long and 16 inches wide) fluid impermeable backboard with necessary straps, as noted in Patient Transfer Equipment paragraph (5), capable of restricting spinal motion of a recumbent patient; may substitute any acceptable device that satisfies the requirements of Patient Transfer Equipment paragraph (2).	1	N/A	N/A
(2) Half-length fluid impermeable spinal immobilization device with necessary straps capable of restricting spinal motion of a sitting patient.	1	Optional	1
(3) Traction splinting device for the lower extremity.	1	Optional	Optional
(4) Devices in at least two sizes capable of securing injured joints or extremities in fixed position. Examples include: padded board splint, cardboard splint, vacuum splint, and commercial immobilizers. May include adjustable devices.	2 of each	2 of each	2 of each
(5) Rigid extrication collars capable of limiting movement of the cervical spine of various size adult and pediatric patients. The devices must permit access to the patient's anterior neck when in place.	2 adult 2 pediatric	1 adult / 1 pediatric	1 adult / 1 pediatric
(6) A device or devices capable of immobilizing the head of a patient who is secured to a long backboard.	1	N/A	N/A
(7) Flexible litter. Examples include but are not limited to: MegaMover and poleless litters.	1	Optional	1
“R” = required equipment “N/A” = not applicable	Ambulance	BLS EASV BLSFR	ALS FR

	“N/R” = not required			
(d)	<u>Infant and Pediatric Airway, Oxygen and resuscitation equipment and other Infant and Pediatric related equipment:</u>			
	(1) Pediatric bag valve mask, equipped with oxygen reservoir system.	1	1	1
	(2) Clear face masks in newborn, infant and child sizes, inflatable rim (or mask with minimal under-mask volume) to fit pediatric bag valve mask, equipped with oxygen reservoir system.	1 of each size	1 of each size	1 of each size
	(3) Pediatric nasal cannula and pediatric non-rebreather oxygen mask.	2 of each	1 of each	1 of each
	(4) Sterile suction catheters in at least two pediatric sizes.	2 of each	2 of each Optional if manual device	2 of each
	(5) Child and infant size blood pressure cuffs with gauge.	1 each	1 each	1 each
	(6) Pediatric stethoscope (interchangeable type acceptable). May be satisfied by any stethoscope with pediatric adapter diaphragm.	1	1	1
	(7) One commercially prepared infant swaddler.	1	1	1
	(8) Emergency childbirth (OB) supplies in a kit, consisting of the following sterile supplies: disposable gloves; scissors or scalpel; umbilical clamps or tape; bulb syringe; drapes.	1	1	1
	(9) A length-based resuscitation tape OR a reference material that provides appropriate guidance for pediatric drug dosing and equipment sizing based on patient length.	1	Optional	1

	“R” = required equipment “N/A” = not applicable “N/R” = not required	Ambulance	BLS EASV BLSFR	ALS FR
(e)	<u>Bleeding and Hemorrhage Control Equipment</u>			
	(1) Sterile gauze pads 4 inches by 4 inches.	12	6	6
	(2) Rolls of adhesive tape in varying sizes.	4 rolls total	4 rolls total	4 rolls total
	(3) Rolls of conforming gauze bandages in two or more sizes.	3 of each	1 of each	1 of each
	(4) Sterile multi-trauma dressings.		2	2
	(5) Sterile gauze pads, minimum size 5 inches by 9 inches.	6	3	3
	(6) Trauma shears.	1	1	1
	(7) Sterile bed-size burn sheet	2	1	1
	(8) Triangular bandages.	6	3	3
	(9) Minimum of 500ml sterile normal saline in plastic container(s). May be in more than one container to comply.	1	1	1
	(10) Commercial chest seal.	2	2	2
	(11) Commercial windlass tourniquet at least 1-inch in width. Examples include, but are not limited to: CAT, SOFT-T, SOFT-T Wide, and SAM XT.	4	2	2
	“R” = required equipment “N/A” = not applicable “N/R” = not required	Ambulance	BLS EASV BLSFR	ALS FR

(f)	<u>Miscellaneous and Special EMS Equipment in clean and sanitary condition:</u>			
	(1) Linen on wheeled ambulance cot.	R	N/A	N/A
	(2) Cloth towels.	4	N/R	N/R
	(3) Pillow (covered or disposable).	1	N/R	N/R
	(4) Cloth or disposable pillowcase.	2	N/R	N/R
	(5) Cloth or disposable sheet.	4	N/R	N/R
	(6) Cloth or disposable blanket.	2	1	1
	(7) Facial tissues.	1 box	N/R	N/R
	(8) Emesis containers, emesis bag, or equivalent.	2	1	1
	(9) Adult and large adult size blood pressure cuff with gauge.	1 each	1 each	1 each
	(10) Adult stethoscope.		1	1
	(11) A thermometer capable of measuring a reasonable temperature range of non-hypothermic patients.	1	1	1
	(12) Carrying case or bag for essential emergency care equipment and supplies.	1	1	1
	(13) Chemical cold pack.	2 of each	1 of each	1 of each
	(14) Chemical hot pack.	Optional, 2 if present	Optional, 1 if present	Optional, 1 if present
	(15) Single-use, water based lubricating jelly.	4	2	2
	(16) Eye protections for droplet / splash exposure. Examples include goggles and face shields.	2 pairs	1 pair	1 pair
	(17) Latex-free, disposable exam gloves in sizes small, medium, and large.	10 pairs each	4 pairs each	4 pairs each
	(18) Flashlight with batteries.	1	1	1

	(19) Triage tags, or equivalent, for at least 20 patients.	R	R	R
	<p>“R” = required equipment</p> <p>“N/A” = not applicable</p> <p>“N/R” = not required</p>	Ambulance	BLS EASV BLSFR	ALS FR
(g)	<u>Safety Equipment</u>			
	(1) Six flares or three Federal DOT approved reflective road triangles or equivalent.	R	R	R
	(2) One Underwriters' Laboratory rated five-pound U.L.-rated ABC chemical fire extinguisher or any extinguisher having a U.L. rating of 10BC.	1	1	1
	(3) Portable, passive monitoring CO detector with real-time visual and audible alerts for the presence of high level CO.		1	1
	(4) High visibility/retroreflective traffic vests.	4	2	2
	<p>“R” = required equipment</p> <p>“N/A” = not applicable</p> <p>“N/R” = not required</p>	Ambulance	BLS EASV BLSFR	ALS FR
(h)	<u>Required BLS Medications and adjuncts:</u>			
	(1) Adult auto-inject epinephrine device or Syringe Epinephrine Kit.	2 doses	1 dose	1 dose
	(2) Pediatric auto-inject epinephrine device or Syringe Epinephrine Kit.	2 doses	2 doses	2 doses
	(3) Aspirin.	2 doses	2 doses	2 doses
	(4) Naloxone (or equivalent opioid antagonist).	2 doses	2 doses	2 doses

(5) Bronchodilator as indicated by current collaborative protocol.	4 doses	3 doses Optional- BLSFR	3 doses
(6) Nebulizer capable of delivering medication to adult and pediatric patients.	2 doses	1 dose Optional- BLSFR	1 dose
(7) CPAP and at least two different adult size masks.	Optional BLS 1 each size ALS	Optional	1 each size
(8) Blood Glucose monitoring equipment.	R	R	R
(9) Liquid Glucose or equivalent.	1 dose	1 dose	1 dose
"R" = required equipment "N/A" = not applicable "N/R" = not required	ambulance	BLS EASV BLSFR	ALS FR
<u>Required ALS Medications and adjuncts if vehicle is operating as ALS vehicle:</u>			
(1) Direct and / or video laryngoscopy equipment.	R	N/A	R
(2) Adult and pediatric endotracheal tubes.	R	N/A	R
(3) Magill forceps, adult and pediatric.	R	N/A	R
(4) Supraglottic airways in appropriate sizes for adult and pediatric patients.	1 of each size	N/A	1 of each size
(5) Adult chest decompression needle - minimum size 14ga x 3.25 inch.	2	N/A	2
(6) Pediatric chest decompression needle - minimum size 14ga x 1.5 inch.	R	N/A	R

(7) A device capable of performing automatic or manual defibrillation, cardiac rhythm monitoring (at least three leads), 12-lead ECG acquisition, and transcutaneous pacing.	R	N/A	R
(8) A device capable of continuous waveform capnography.	R	N/A	R
(9) Medications required to perform care as directed by approved protocols.	R	N/A	R
(10) All devices and supplies necessary to administer medications required by protocol in sizes to fit neonate, infant, child, and adult patients.	R	N/A	R
(11) Isotonic crystalloid fluids and administration tubing capable of adjustable fluid delivery rate.	R	N/A	R
(12) A device to provide pressure infusion of IV fluids.	R	N/A	R
(13) A device that limits risk of inadvertent fluid over-administration for pediatric patients.	R	N/A	R

(b) Table 1(a)(6) references the National State EMS Officials “Pediatric Transport Products for Ground Ambulances” Version 2.2 (October 2020) which provides guidelines for the selection of pediatric restraint systems. The guidelines set forth in National State EMS Officials “Pediatric Transport Products for Ground Ambulances” Version 2.2 (October 2020) are hereby incorporated by reference with the same force and effect as if fully set forth herein. A copy of National State EMS Officials “Pediatric Transport Products for Ground Ambulances” Version 2.2 (October 2020) is available for inspection and copying at the Regulatory Affairs Unit, New

York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237.

(c) All equipment, supplies, medications, and vehicles mentioned in this section must be clean, sanitary, and operable as defined.

(1) Clean means vehicles and equipment shall be free from visible dirt, blood, other fluids, or stains. No visible rips, tears or other damage to seating surfaces in the vehicle may be present.

(2) Sanitary means all packaging for equipment, supplies, and medications must be intact, within expiration date, and cannot be discolored.

(3) Operable means the equipment, supplies, or vehicle is able to be used according to manufacturer instructions, guidelines, and any applicable laws, rules or statutes.

(d) An ambulance operating at the Basic Life Support (BLS) level is not required to carry the items listed under “required ALS Medications and adjuncts” in Table 1 of this section.

(e) Any certified vehicle equipped to operate at an Advance Life Support (ALS) level, must be kept in such a manner that a lower level of certified provider is not able to access or use equipment outside their scope of practice when not in service as an ALS vehicle.

(f) Basic Life Support First Response (BLSFR) agencies are not required to comply with the equipment requirements in this section unless they voluntarily participate in an educational program, pilot program or demonstration project as approved or defined by the department. A minimum of one vehicle must be registered with the department in order to participate in an educational program, pilot program or demonstration project. Any equipment, medications, or

adjuncts that are optional for BLS providers in protocol (if trained and equipped) will also be optional for BLSFR agencies.

(g) All certified first responders, emergency medical technicians, and advanced emergency medical technicians operating on a certified vehicle must be able to operate all equipment and systems onboard the vehicle for their level of certification and must be able to demonstrate competency of equipment at any time to ensure the appropriate care and treatment of a patient.

(h) When not occupied, all certified vehicles are required to be secured to prevent entry, theft, or unauthorized use of the vehicle or equipment.

(i) Any volume of liquid in excess of 249 milliliters stored in a certified vehicle must be in plastic containers.

(j) The equipment standards set forth in this section will go into effect six months after the regulations are adopted. All current equipment standards shall remain in effect until such time as this section becomes effective.

Section 800.25 is hereby ~~PEPEAL~~ED and replaced to read as follows:

§ 800.25 General regulatory waivers.

(a) The department may waive regulatory requirements of this Part if the department finds that compliance with the requirement or requirements is:

(1) unreasonable, impractical, or burdensome because of special circumstances that exist; or

(2) compliance would result in impediment of emergency medical services delivery in operations, education, or other circumstance as determined by the department.

- (b) Waivers granted under this section may be limited in time or may be conditioned as the department considers necessary to protect the public welfare.
- (c) A waiver may be approved by the department in full, in part, for limited use, or for agency wide application.
- (d) In determining whether a waiver may be granted, the department shall weigh the equities involved and the advantages and disadvantages to the welfare of patients and emergency medical services system. The department may consult regional emergency medical services councils on waiver requests.
- (e) Applications for a waiver must be submitted in writing to the department and must include, at minimum, the following:
- (1) the specific regulation for which a waiver is sought;
 - (2) the reason the waiver is necessary; and
 - (3) a description of what steps will be taken to achieve or maintain the purpose of the regulation to be waived and to protect the health, safety, and well-being of the public.
- (f) Approvals for waivers under this Part must be kept in any locations specified by the department and be available upon request by the department during any scheduled or unscheduled inspection or review until they are expired or no longer apply.
- (g) Waivers that have been granted by the department will be applicable for a specific period determined by the department and their effect must not exceed the period beyond any regular renewal or recertification period.

(h) Failure to adhere to the terms of the approved waiver will result in rescission of the waiver and may result in a regulatory citation and imposition of penalties for violation of the applicable regulation.

Section 800.26 is hereby REPEALED and replaced to read as follows:

§ 800.26 Equipment requirements for emergency ambulance service vehicles other than an ambulance.

(a) The governing authority of any certified agency which, as a part of its response system, utilizes emergency ambulance service vehicles other than an ambulance, must have policies in effect regarding:

- (1) equipment;
- (2) staffing;
- (3) individual authorization;
- (4) dispatch;
- (5) response criteria; and
- (6) proof of appropriate insurance coverage.

The department may define additional policies or requirements as deemed necessary.

(b) All emergency ambulance service vehicles in a certified ambulance service must be equipped pursuant to section 800.24 of this Part, unless otherwise exempted or pursuant a waiver obtained pursuant to section 800.25 of this Part.

(c) Any emergency ambulance service vehicle other than an ambulance must be equipped and supplied with emergency care and safety equipment, including the following:

(1) Have seat belts on all seats and seating areas in the driver and all passenger seating that meets or exceeds the standards set forth in chapter 301 of title 49 of the United States Code, “Motor Vehicle Safety” (May 2008). The standards set forth in chapter 301 of title 49 of the United States Code, “Motor Vehicle Safety” (May 2008) are hereby incorporated by reference with the same force and effect as if fully set forth herein. A copy of chapter 301 of title 49 of the United States Code, “Motor Vehicle Safety” (May 2008) is available for inspection and copying at the Regulatory Affairs Unit, New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237.

(2) Have two-way voice communications capability to provide communication with dispatch and medical control at all times. Alternative communication systems are subject to approval of the department as being equivalent in capability.

(3) Have a system in place to provide visual and audible alerts when the vehicle is in reverse motion, and a camera system capable of providing the vehicle operator with view to the rear of the vehicle in reverse motion.

(4) Have at a minimum, a camera or camera system with the following capabilities:

(i) records from the driver’s perspective at least towards the front of the vehicle;

(ii) is activated by “g” force change;

(iii) is capable of recording pre and post activation; and

(iv) is capable of recording sounds and video and retain such recording for a period no less than 10 days.

(5) Have any equipment or materials always secured within the vehicle using a commercially manufactured barrier. Any equipment secured using cabinets, straps, drawers, brackets, or any other type of securing method must also be commercially manufactured.

(6) Equipment that is mounted in a vehicle should not interfere with the functions of safety features such as airbags, seatbelts, or other standard, manufacturer installed safety equipment.

(7) Have an anti-theft device, other than the ignition key or keyless ignition fob, that disables the vehicle from being operated by anyone other than an authorized user.

(d) Vehicle construction standards will go into effect 12 months after the regulations are adopted and will apply to new and used emergency ambulance service vehicles acquired after such date. Any emergency ambulance service vehicle in service at the time this regulation takes effect will be exempted from this section until such time as existing vehicles are replaced. Vehicles that were ordered prior to the date this section takes effect will be exempt from this section.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law (PHL) § 3002 authorizes the State Emergency Medical Services Council (SEMSCO), subject to approval by the Commissioner of Health, to enact, and from time to time, amend and repeal, rules and regulations establishing minimum standards for ambulance services, ambulance service certification, advanced life support first response services, the provision of prehospital emergency medical care, public education, the development of a statewide emergency medical services system, the provision of ambulance services outside the primary territory specified in the ambulance services' certification, and the training, examination, and certification of certified first responders, emergency medical technicians, and advanced emergency medical technicians.

Legislative Objectives:

The legislative objective of PHL § 3005 is to protect the public health, safety and welfare by establishing rules and regulations relative to the standardized equipment and construction of ambulance vehicles.

Needs and Benefits:

The current regulations regarding equipment requirements for certified ambulance services are outdated and fail to address industry advances with available equipment and supplies in the commercial market. The industry has been requesting these changes due to changing equipment standards and the current regulations being outdated. This includes the technology developments for in-vehicle camera systems that record and store videos and the restraint systems that are available for equipment and stretchers. Recent protocol updates also include new equipment and

medications which affect the standard of care for EMS providers and should be encompassed in regulation.

In addition, the applicable regulations are located in multiple sections of regulation, making it difficult for regulated entities to utilize. The proposed regulations set forth a list of required vehicle equipment for emergency medical services vehicles based on the type of vehicle and level of service and place these requirements in an easy to use table for ease of compliance. In addition, the regulations update the equipment standards to reflect more current equipment, which includes automatic external defibrillators, child safety restraint systems, and the standardization of certain medical equipment that must be carried on a vehicle. The required equipment list was developed by the SEMSCO Safety Committee and approved by SEMSCO and the Commissioner of Health.

Current regulatory language for requesting a waiver from the department is vague and does not provide clear guidance on the types of waivers that may be requested, the length of time a waiver may be in effect, and where an agency is required to maintain any waiver(s) received from the department. Additionally, the requirement that an agency re-apply for an existing waiver upon its expiration ensures that waivers are in line with current regulatory requirements and best practices. The new general waiver section will provide clear guidance for any agency requesting any type of waiver from the department.

Costs:

Costs for the Implementation of, and Continuing Compliance with the Regulation to the Regulated Entity:

Initial capital costs associated with the proposed rule change related to equipment requirements for certified ambulance agencies will be minimal. The only piece of equipment that may be

considered a significant cost is the addition of an automated external defibrillator and the required accessories. These devices are approximately \$2,000 per unit; however, in keeping with best practice, most ambulance services affected by this rule already possess these devices.

Additional capital costs associated with the proposed rule change to section 800.26 – Equipment Requirements for emergency ambulance service vehicles other than an ambulance vehicle – are estimated to be as high as \$4,000.00 for the addition of the equipment outlined in the proposed rule and will be incorporated into the initial build or re-fit of an emergency ambulance service vehicle. There may be additional cost for the installation of the proposed equipment, but those costs are difficult to estimate as emergency ambulance service vehicle manufacturers bid on vehicle specifications and costs will vary from vendor to vendor. Additionally, as emergency ambulance service vehicles differ from manufacturer to manufacturer, some equipment may be installed either at the manufacturer factory or by the vendor prior to delivery, which could impact the cost of the vehicle.

The required equipment in many instances is already incorporated into new vehicles and is included in estimated vehicle replacement costs. All equipment will be available through approved vendors utilizing pricing set forth in the State Contract System. The proposed equipment may be re-installed on a new ambulance or re-chassis of an existing emergency ambulance service vehicle in accordance with manufacturer recommendations.

There may be funding opportunities in the form of grants at either the State or Federal level to offset the purchase and implementation of the required items. Additionally, there is no specific manufacturer required and agencies can use bulk purchasing, state contract vendors, and put out requests for proposals and bids from vendors and manufacturers to obtain the best pricing.

Costs to State and Local Governments:

The costs to local governments that operate certified ambulance services or advanced life support first response agencies will be significant when new ambulances or other response vehicles are purchased. The costs are outlined above under the cost for implementing and complying with these proposed regulations. There are approximately 1,770 certified ambulance agencies and advanced life support first response agencies in New York State, of those approximately 376 of those are municipal at either the village, town, city, or county level.

Costs to the Department of Health:

This regulation imposes no new costs to the Department of Health.

Local Government Mandates:

These regulations will impose new mandates on local governments that operate ambulance services in the form of new equipment requirements for ambulances and emergency response vehicles. The new safety requirements will bring regulations of vehicle construction in line with national safety standards and will ensure the greatest protection of the life and safety of the public.

Paperwork:

These regulatory changes will impose new paperwork and record keeping requirements on agencies. They will need to follow the provisions contained within the proposed section 800.25 to obtain a waiver for equipment or vehicle construction requirements. Additionally, any waivers will need to be reissued at the time of an agency's recertification. Waivers will need to be accessible during both agency recertifications and during any unannounced inspections by department staff. Agencies will need to ensure that all vehicle equipment is maintained and

recalibrated according to manufacturer's instructions to ensure it is functioning properly and that records of same are kept on file.

Duplication:

This regulation does not duplicate, overlap, or conflict with any existing State or Federal rules or other legal requirements.

Alternatives:

The alternative to the proposed new regulation would be to keep the current regulation as-is. However, this alternative is not viable because it is necessary to update the regulations to keep with current industry standards and to provide a more accessible and comprehensive point of reference in regulation for required equipment. The compliance schedule that is contained within the regulation for equipment included the consideration for implementation of any training programs and the acquisition of the equipment and supplies. The compliance schedule contained within section 800.26 considered the vehicles that an agency may have ordered but not yet delivered and the burden of adding equipment that was not included in the original specifications or bid package. The equipment requirements were the product of SEMSCO and represents the industry's request.

During the proposal's public comment period, the Department received comments around various equipment, adjuncts, and medication requirements. Some of the comments resulted in modifications to quantities, locations, and more specificity to the level of provider or type of vehicle. Commenters also expressed concern over certain requirements for emergency ambulance service vehicles, including, but not limited to, camera systems that record certain g-force events, back up cameras, audible alerts while the vehicle is backing, and requirements to secure equipment in the vehicle. The Department considered these comments and made

adjustments to the regulation to ensure compliance and enforcement would not be frustrated by the new regulatory requirements because they are too obscure or restrictive.

Federal Standards:

The regulations are consistent with applicable Federal requirements and national standards.

Compliance Schedule:

The equipment standards set forth in section 800.24 will go into effect six (6) months after the regulatory amendments are adopted.

The vehicle standards set forth in section 800.26 will go into effect twelve (12) months after the regulatory amendments are adopted.

The new regulations contained within section 800.25 will become effective upon publication of a Notice of Adoption in the New York State Register.

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REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

The proposed rule changes will affect all 1,780 active emergency medical services certified by the department, approximately 376 of which are municipal at either the village, town, city, or county level. Additionally, 988 of these are certified ambulance agencies, 81 are advanced life support services, and 711 are basic life support services.

Compliance Requirements:

Section 800.24 of the proposed rule, concerning equipment requirements of ambulances and emergency ambulance services vehicles, condenses the required equipment standards from several locations within the current regulations. Much of the equipment that will be required in the new regulations is already being carried by certified agencies on their vehicles and so this will not impose a significant burden on these entities. The proposed regulation also includes required medications for basic life support and advanced life support vehicles, which is not contained in current equipment regulations. However, most certified agencies already carry these medications and therefore the regulatory amendments are not expected to create an undue burden. All emergency medical services agencies will be required to have policies and procedures in place for the maintenance of equipment, and for the tracking of medications and other equipment that has an expiration date.

Section 800.25 of the proposed rule sets forth the requirements and process for requesting a regulatory waiver. Applicants will be required to maintain records of approved waivers and be able to produce them for inspection by the department.

Section 800.26 of the proposed rule relates to emergency ambulance services vehicles and will require agencies to ensure that when they purchase new vehicles, they include the required safety equipment, which will impact the bidding process as they will contain specifications for equipment that they may not currently have in place on agency vehicles. Emergency medical services agencies will be required to provide any paperwork relative to the periodic recalibration of equipment or in service policies and procedures during a certification inspection.

Professional Services:

In order to comply with the proposed rules, regulated entities may be required to engage with professionals to install and maintain the video and audio equipment they will be required to have installed. Additionally, regulated entities will need to contract with these same professionals to install this equipment when purchasing vehicles. Lastly, equipment should be installed by a professional so as not to void any manufacturer warranty and to ensure proper and safe installation.

Compliance Costs:

The estimated capital costs for the proposed equipment required by section 800.24 is approximately \$2,000, with the bulk of the cost being applied to the purchase of automated external defibrillators. The ongoing cost of compliance for the proposed equipment regulations will involve the purchase of defibrillator pads and medication replacement for expired stock. It is difficult to estimate this cost as regulated entities are free to purchase from any vendor for these items and they are also free to purchase medications and other supplies in bulk with other emergency medical services agencies for cost savings.

Section 800.25 does impose new requirements on regulated entities in that a more formal process for applying for and maintaining waivers is set forth. However, it is not anticipated to impose any significant compliance costs. Instead, section 800.25 would allow regulated entities to request regulatory waivers, so it may in fact help to reduce compliance costs on regulated entities.

The estimated capital costs for the proposed vehicle specifications in section 800.26 of the proposed regulation is approximately \$4,000 for the equipment that is required. This cost would be factored into the purchase of a new or used vehicle. It should be noted that many agencies currently incorporate these requirements voluntarily into vehicle purchases. Additionally, it is difficult to estimate the cost of compliance as there are many manufacturers of the required safety items in this proposed regulation and their pricing can vary greatly in terms of maintenance or replacement equipment. Agencies will be able to take advantage of bulk purchasing with other agencies, State contract pricing, or put out a request for proposals for the required equipment, including installation, to attempt to contain costs.

Certified Ambulance agencies will need to provide proof of compliance during periodic vehicle inspections and when agency certifications are renewed every two (2) years. Additionally, waivers will need to be requested to continue at the end of an agency certification period. This will impose some additional time for an agency in preparing for an inspection however, it is not anticipated to cause any additional significant costs to the agency.

Economic and Technological Feasibility:

Since many of the regulated entities already have the equipment that will be required by the proposed rule changes in sections 800.24 and 800.26, the economic feasibility of compliance

should already be factored into their budget. For agencies that will need to incorporate the new equipment requirements, there is a six-month grace period for the requirements contained in section 800.24 and a twelve-month grace period for the requirements contained in the proposed 800.26. These grace periods will allow agencies to plan for the estimated costs of compliance.

Technology for the proposed regulations should not be difficult for agencies to implement. The vehicle equipment contained in section 800.26 is usually installed by the manufacturer and tested prior to the delivery of the vehicle and for vehicles that are retrofitted there are ambulance service companies that are qualified to install the technology contained in the proposed regulations.

Minimizing Adverse Impact:

The adverse impact on small businesses and local governments of the proposed rule can be mitigated in several ways. Agencies are not restricted from ordering their equipment in bulk to obtain the greatest savings, they are allowed to seek out State contract pricing wherever applicable, and they are not required to use certain manufacturers or suppliers of equipment. They are also allowed to create bid specification packages and request as many bids as they wish to ensure they are receiving the best service for the least amount of cost.

In addition, section 800.25 will allow regulated entities to apply to the department for a regulatory waiver, which could minimize the cost of compliance. In addition, delaying implementation of sections 800.24 and 800.26 will provide regulated entities with additional time to come into compliance, further minimizing any adverse impact the regulations may have.

Small Business and Local Government Participation:

The proposed rules for sections 800.24, 800.25, and 800.26 were a result of the collaboration of the SEMSCO which has representatives from a wide swath of EMS agencies, including municipal entities and agencies that are small in size and budget. The department created these proposed regulations based on their recommendations and input.

The department will share information with the regional EMS Program Agencies and the State Emergency Medical Services Council which has representation from each regional EMS council and several State EMS trade organizations, including but not limited to, FASNY, NYSVARA and UNYAN members to ensure that the new regulatory requirements are widely circulated among those affected.

For Rules That Either Establish or Modify Violations or Penalties Associated with a Violation:

The proposed equipment regulations contained in section 800.24 allow for a six-month grace period to comply which would prevent the imposition of any fines or other action for noncompliance.

The proposed vehicle construction regulations contained in section 800.26 allow for a twelve-month grace period to avoid the imposition of unbudgeted for equipment on vehicles that have already been ordered by an agency. Additionally, the existing agency vehicles will be grandfathered and not required to comply on existing vehicles until they are replaced by another vehicle. This allows for agencies to budget the capital and maintenance costs.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

Rural areas as defined by Executive Law § 418(7) are counties with a population less than 200,000 and towns with a population density less than 150 people per square mile. There are 654 certified agencies that qualify as rural who may be impacted by the proposed changes.

Reporting, Recordkeeping, and Other Compliance Requirements; and Professional Services:

Section 800.24 of the proposed rule, concerning equipment requirements of ambulances and emergency ambulance services vehicles, condenses the required equipment standards from several locations within the current regulations. Much of the equipment that will be required in the new regulations is already being carried by certified agencies on their vehicles and so this will not impose a significant burden on these entities. The proposed regulation also includes required medications for basic life support and advanced life support vehicles, which is not contained in current equipment regulations. However, the majority of certified agencies already carry these medications and therefore the regulatory amendments are not expected to create an undue burden. All emergency medical services agencies will be required to have policies and procedures in place for the maintenance of equipment, and for the tracking of medications and other equipment that has an expiration date.

Section 800.25 of the proposed rule sets forth the requirements and process for requesting a regulatory waiver. Applicants will be required to maintain records of approved waivers and be able to produce them for inspection by the department.

Section 800.26 of the proposed rule relates to emergency ambulance services vehicles and will require agencies to ensure that when they purchase new vehicles, they include the required safety equipment, which will impact the bidding process as they will contain specifications for equipment that they may not currently have in place on agency vehicles.

In order to comply with the proposed rules, regulated entities may be required to engage with professionals to install and maintain the video and audio equipment they will be required to have installed. Additionally, regulated entities will need to contract with these same professionals to install this equipment when purchasing vehicles. Lastly, equipment should be installed by a professional so as not to void any manufacturer warranty and to ensure proper and safe installation.

Certified Ambulance Agencies will need to provide proof of compliance during periodic vehicle inspections and when agency certifications are renewed every two (2) years. They will also be required to maintain any manufacturer related calibration and maintenance recommendations to ensure the equipment remains in good working order.

Costs:

The estimated capital costs for the proposed equipment required by section 800.24 is approximately \$2,000, with the bulk of the cost being applied to the purchase of automated external defibrillators. The ongoing cost of compliance for the proposed equipment regulations will involve the purchase of defibrillator pads and medication replacement for expired stock. It is difficult to estimate this cost as regulated entities are free to purchase from a particular vendor for these items and they are also free to purchase medications and other supplies in bulk with other emergency medical services agencies for cost savings.

Section 800.25 does not impose any new requirements on regulated entities and therefore it is not anticipated to impose any compliance costs. Instead, section 800.25 would allow regulated entities to request regulatory waivers, so it may in fact help to reduce compliance costs on regulated entities.

The estimated capital costs for the proposed vehicle specifications in the section 800.26 of the proposed regulation are approximately \$4,000 for the equipment that is required. This cost would be factored into the purchase of a new vehicle. It should be noted that many agencies currently incorporate these requirements voluntarily into vehicle purchases. Additionally, it is difficult to estimate the cost of compliance as there are many manufacturers of the required safety items in this proposed regulation and their pricing can vary greatly in terms of maintenance or replacement equipment. Agencies will be able to take advantage of bulk purchasing with other agencies or State contract pricing to attempt to contain costs.

Certified Ambulance Agencies will need to provide proof of compliance during periodic vehicle inspections and when agency certifications are renewed every two (2) years.

Minimizing Adverse Impact:

The adverse impact of the proposed regulation on those emergency medical services agencies classified as rural can be mitigated in several ways. Agencies are not restricted from ordering their equipment in bulk to obtain the greatest savings, they are allowed to seek out State contract pricing wherever applicable, and they are not required to use certain manufacturers or suppliers of equipment. They are also allowed to create bid specification packages and request as many bids as they wish to ensure they are receiving the best service for the least amount of cost.

In addition, section 800.25 will allow regulated entities to apply to the department for a regulatory waiver, which could minimize the cost of compliance. In addition, delaying implementation of section 800.24 for six (6) months after enactment and section 800.26 for twelve (12) months after enactment will provide regulated entities with additional time to come into compliance, further minimizing any adverse impact the regulations may have.

Rural Area Participation:

These proposed regulations will be subject to a 60-day public comment period, and subject to review and approval by a subcommittee of the State Emergency Medical Services Council, as well as the approval of the full State Emergency Medical Services Council. All certified ambulance agencies, including those from rural areas within the state, will have an opportunity to comment during the public comment period and through their representatives on their respective Regional Emergency Services Medical Committee, Regional Emergency Medical Services Council and the State Emergency Medical Services Council.

**STATEMENT IN LIEU OF
JOB IMPACT STATEMENT**

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

DRAFT

SUMMARY OF ASSESSMENT OF PUBLIC COMMENT

The New York State Department of Health (the “Department”) received several comments from emergency medical services agencies (“EMS agencies”), professional groups representing emergency medical services, and individual emergency medical services providers. Several commenters requested clarification on the inclusion of Basic Life Support First Response agency vehicles as a category in equipment requirements, and whether the Department has the authority to regulate these entities. The Department included Basic Life Support First Response agency vehicles as optional to be able to participate in certain programs as defined by the Department. These vehicles are included in the equipment requirements section to ensure clarity and consistency for EMS agencies and the Department.

The Department also received comments around various equipment, adjuncts, and medication requirements. Some of the comments resulted in modifications to quantities, locations, and the addition of greater specificity to the level of provider or type of vehicle. Commenters also expressed concern over certain requirements for emergency ambulance service vehicles, including, but not limited to, camera systems that record certain g-force events, back up cameras, audible alerts when the vehicle is backing, and requirements to secure equipment in the vehicle. The Department considered these comments and adjusted the regulation to ensure compliance and enforcement would not be frustrated by the new regulatory requirements because they are too obscure or restrictive.

In response to public comments, clarification has been provided on the equipment requirements in section 800.24 which include the required quantities, making certain equipment optional for the lower levels of provider, and certain vehicle types. Additionally, section 800.23

has been repealed in full as the requirements in that section have been incorporated into section 800.24. The definition of emergency services ambulance vehicle has been updated to a clearer definition in subdivision (m) of section 800.3. Justification for certain safety equipment such as camera systems, immobilization devices, and devices that secure equipment have been clarified in the proposed regulations.

Lastly, comments were received about the securing of equipment on a vehicle that is above the scope of practice for the highest level of provider in a crew. In some situations, a vehicle equipped as an advanced life support vehicle may have a crew that is certified at a lower level. The Department clarified the regulatory language to ensure that EMS agencies can comply with this requirement.

DRAFT

ASSESSMENT OF PUBLIC COMMENT

The New York State Department of Health (the “Department”) published a Notice of Proposed Rulemaking in the State Register on July 10, 2024, regarding amendments to Part 800 of 10 New York Codes, Rules and Regulations (NYCRR) pertaining to vehicle and equipment regulations for ambulances, emergency ambulance services vehicles, and advanced life support first response services. The Department received 115 public comments from individuals, professional organizations, and members of both regional and state emergency medical services councils. These comments and the Department’s responses are summarized below.

Comment: A commenter requested a copy of “Society of Automotive Engineers Ground Vehicle Standard J3043_201407 Ambulance Equipment Mount Device or Systems”.

Response: Upon the Department’s further review, the “Society of Automotive Engineers Ground Vehicle Standard J3043_201407” has been removed from the text of the regulation as it was too narrow and restrictive for regulatory compliance. Also, the standard is not available through open sources; agencies would be required to purchase the standard. Lastly, the standards are updated periodically which would cause the regulatory requirement to be outdated. The standard is specific to the mounting and securing equipment for an ambulance patient compartment; this section of regulation pertains to emergency ambulance service vehicles (EASV). The mounting or securing systems that the standard would apply to are generally not used in an EASV and as such, could frustrate compliance for an agency. Lastly, from an enforcement perspective, there is not a clear and concise way for the Department to ensure an agency has complied with the standard.

Comment: A commenter requested a changelog of the proposed regulations for review.

Response: When the regulations are fully enacted, a changelog, policy statements, and guidance documents will be published. No amendments were made as a result of this comment.

Comment: A commenter suggested adding “required to perform care” language to the required Basic Life Support (BLS) medications under § 800.24, Table 1(h) to provide consistency in regulatory language.

Response: Adding the suggested language to § 800.24, Table 1(h) “Required BLS medications and adjuncts” has the potential to cause confusion for agencies attempting to comply with BLS requirements. Not all BLS adjuncts and medications are required to be present and available; some are optional if trained and equipped. No amendments were made as a result of these comments.

Comment: Two commenters suggested that the word “Kit” be added to the term “Syringe Epinephrine” and eliminate the use of brand items such as “Epi Pen” in § 800.24, Table 1(h)(1) and (2). One commenter also stated that epinephrine to treat anaphylaxis is not available as a nasal spray.

Response: The suggested route of administration for medications is not included in these regulations but rather are more properly found in the collaborative protocols established by the State Emergency Medical Services Council (SEMSCO). Additionally, the reference to the brand of auto-injectable epinephrine “EpiPen” was removed as the Department does not endorse any one brand of medication over another. Lastly, while there are some drug manufacturers beginning to offer epinephrine as a nasal spray, that route of administration has not been

approved by the State Emergency Medical Services Medical Advisory Committee for this medication and thus is not included in the regulations.

Comment: A commenter suggested the incorporation of specific quantities for “Supraglottic Airways, Various Sizes” in Table 1(b) which pertains to airway and oxygen equipment and sudden cardiac arrest resuscitation equipment, in § 800.24.

Response: The Department has updated the equipment requirements to clarify the required sizes for supraglottic airways.

Comment: A commenter suggested that computers, laptops, or other devices and equipment be mounted so they do not interfere with standard safety equipment in a vehicle.

Response: Revisions were made to the regulation to reflect a requirement that all equipment must be mounted so it does not interfere with standard vehicle safety measures, such as airbags.

Comment: Several commenters requested clarification surrounding the addition of equipment requirements for Basic Life Support First Response (BLS FR) agencies to the regulation. Commenters would like to see the definition of a BLS FR and language about when the requirements are applied to a BLS FR. They also requested clarification on the differentiation between equipment requirements for BLS FR agencies and Basic Life Support Emergency Ambulance Service Vehicles (BLS EASV). It was suggested equipment requirements between the two classifications be kept consistent with protocol for BLS providers. Lastly, the Department does not inspect, regulate, or inquire on operations for BLSFR services pursuant to § 3011(1) of the Public Health Law (PHL).

Response: The proposed regulation has been revised to clarify that the equipment requirements for a BLS FR are optional unless the agency wishes to participate in Department programs, such as the continuing medical education program. Currently, BLS FR are required in policy to register at least one vehicle with the Department to be able to participate in this program. There is no standardized equipment requirement for BLS FR, making it difficult to ensure that an agency is meeting a consistent standard for required equipment. The addition of the BLS FR requirements closely mirrors the requirements for BLS EASV, with some exceptions. The medications, equipment and adjuncts that are optional in the New York State BLS protocols are also optional for BLS FR.

Comment: A commenter expressed concern that the \$200 Limited-Service Laboratory Registration fee required for operation of blood glucose monitoring equipment would pose a challenge for agencies that do not qualify for the fee exemption. The commenter requested a fee exemption for volunteer BLS FR agencies.

Response: This comment is outside the scope of the proposed rulemaking. No amendments were made as a result of these comments.

Comment: Several commenters requested clarification on the necessity of battery-operated portable suction equipment, referenced in Table 1(b)(8), set forth in § 800.24. It was suggested that manual portable suction devices should be allowed in place of battery-operated devices for § 800.24 (a) Table 1 (b)(8) for BLS EASV, in line with BLS FR requirements. Clarification was requested on why manually operated portable suction equipment is not acceptable for BLS EASV. A commenter cited cost as a barrier with this item.

Response: The Department has determined that BLS FRs and BLS EASVs may be permitted to carry FDA approved manual suction devices as a minimum requirement. An agency may choose to carry a portable, battery-operated suction unit at the BLS level of care. The proposed regulation has been updated accordingly.

Comment: A commenter suggested that requirements for equipment related to portable suction units under Table 1(b)(10), set forth in § 800.24, rigid plastic wide bore pharyngeal tips, should not be necessary for Advanced Life Support First Response (ALSFR) or BLS EASV if a manual device is permissible.

Response: While the Department acknowledges the commenter's opinion, the Department has determined it is acceptable to make the requirement for soft suction catheters optional for BLSFR and BLS EASVs, but the requirement for ALSFR is not modified. Due to the more invasive airway interventions performed by the ALSFR agencies, they must also have the rigid plastic wide bore pharyngeal catheter tips.

Comment: Several commenters suggested that requirements for half-length, fluid spinal immobilization devices under Table 1(c)(2), set forth in § 800.24, should be optional for ALSFR or BLS EASV. Furthermore, a commenter suggested the removal of this item, citing that for appropriate usage, multiple providers are needed and that the item will be used upon arrival of an ambulance.

Response: Upon further review, the Department has revised the requirement for half-length, fluid spinal immobilization devices. This requirement has been made optional for BLS FR and BLS EASV vehicles but is still required for ALS FR.

Comment: A commenter suggested that pediatric suction supplies under Table 1(d)(4), set forth in § 800.24 under “sterile suction supplies,” should be required in BLS FR vehicles.

Response: The Department considered these comments and revised the equipment requirements to reflect these items as optional for BLS FR if relying upon manual suction devices to meet minimum requirements. If a BLS FR has a battery-operated portable suction, then they would be required to have pediatric suction supplies.

Comment: Two commenters recommended that the number of required sterile or modified suction trap or small bulb syringe in Table 1(d), set forth in § 800.24, be reduced to be consistent across all classes of vehicle, citing storage and lack of use as barriers.

Response: Upon further review by the Department in response to this comment, the requirement for bulb syringes or other suction traps has been removed as the bulb syringe is contained within an obstetrical kit.

Comment: Several commenters recommended that the required number and volume of sterile normal saline in plastic containers in Table 1(e)(9), set forth in § 800.24, should be consistent across all classes of vehicle. The commenter recommended that language referencing the utilization of all items with the manufacturer’s expiration date be incorporated in the regulation.

Response: The Department revised the required volume of sterile normal saline to 500ml minimum but kept the BLS FR requirement for this item as optional. Additionally, the Department also added language requiring all equipment to be within its expiration date.

Comment: A commenter suggested relocating where single-use, water-based lubricating jelly is located within Table 1(f), set forth in § 800.24.

Response: The Department recognizes this item is used for airway management; however, its location in § 800.24, Table 1, will remain under “Miscellaneous and Special EMS Equipment in clean and sanitary condition”. The Department acknowledges and appreciates the comment but did not implement the change. No amendments were made as a result of these comments.

Comment: A commenter suggested that fire extinguishers should be required on BLS FR vehicles.

Response: The Department has reviewed and considered the commenters’ suggestion and changed the minimum requirement to include one fire extinguisher for a vehicle registered by a BLS FR. This change is not considered cumbersome as it would not be applicable to all vehicles in a BLS FR, only the single vehicle required to be registered.

Comment: Commenters suggested all requirements for BLS medications and adjuncts, specifically the requirement for albuterol, in Table 1(h)(5) and (6), set forth in § 800.24, should be applied to BLS FR vehicles.

Response: The Department acknowledges and appreciates the comment; however, BLS FR will only be required to carry equipment, medications and adjuncts that are required by protocol. At this time, albuterol and nebulizers are an optional medication and adjunct as they are only required to be present if trained and equipped. No amendments were made as a result of this comment.

Comment: Two commenters were not in support of requiring anti-theft devices for EMS vehicles, specifically fire department vehicles. The commenters requested clarification on the definition of “anti-theft device” and opined that fire vehicle theft does not occur frequently enough to justify this regulation.

Response: The Department acknowledges this comment; however, agencies may apply for a waiver of any equipment required. The definition of “anti-theft device” is intentionally broad to allow for not one specific type of device over another. Further guidance will be provided in policy statements. No amendments were made as a result of these comments.

Comment: A commenter stated there are minimum quantity chart errors. The commenter questioned the need for a separate column for BLS FR vehicles when they are not regulated or inspected by the Department.

Response: The Department acknowledges receipt of the comment. However, the commenter was not specific to which errors were identified. The Department has modified the equipment table to combine the BLS FR and BLS E SV into one category for ease of compliance and to mitigate any confusion.

Comment: A commenter suggested language in Table 1(b)(7) and Table 1(d)(3), set forth in § 800.24, be changed to “non-rebreather oxygen masks” and remove the word “partial.”

Response: The Department acknowledges and appreciates the suggestion and has modified language under Table 1(b)(7), set forth in § 800.24, to “non-rebreather oxygen masks.”

Furthermore, the Department recognizes that the use of the word “partial” to describe a non-

rebreather oxygen mask is outdated and no longer the common term for this piece of equipment and has removed the word from the proposed regulation.

Comment: A commenter questioned requirements in § 800.24, Table 1(d), for a length-based resuscitation tape or reference-based material for pediatric drug dosing and equipment sizing based on patient length.

Response: EMS agencies may choose from either a length-based tape or an equivalent reference material based on patient length. The language intentionally avoids the appearance of favoring one system over another. Additionally, most pediatric reference materials also have length-based reference material, and an agency would be considered in compliance with the regulation as long as the reference material contained a length-based component. No amendments were made as a result of these comments.

Comment: A commenter stated that items in § 800.24, Table 1(d), pediatric medication dosages and equipment sizing devices, should not be required for all ambulances as this item can only be utilized by advanced life support providers. The commenter suggested moving these items to Table 1(i), required ALS medications and adjuncts.

Response: The Department acknowledges and appreciates this comment. However, this equipment is optional for BLS FR and BLS EASV. No amendments were made as a result of these comments.

Comment: Two commenters requested clarification on the language “fully secured when not in use” in reference to § 800.24(e), securing of agency vehicles when not in use.

Response: The Department considered the comments and has revised the language in the proposed regulation to provide more clarity on the requirements that a vehicle be secured. Further guidance may be provided after regulations are enacted within a policy statement.

Comment: Commenters stated that they believed the requirement of systems that provide the operator with video and audio alerts in reference to § 800.26(d)(3) are limiting. They state that they have searched for a 12-volt battery operated system that can be mounted in the vehicle to meet this requirement. In the commenter's opinion, audible mechanisms while the vehicle is in reverse gear is excessive. Several commenters voiced opposition to the requirement that EASV's have a system that provides visual and audible alerts when the vehicle is in reverse and a camera system that provides a view of the rear of the vehicle. Comments also suggested that this requirement be optional.

Response: There is no specific recommendation or requirement for voltage for video and audio alerts for EASVs. Agencies are free to choose equipment in any voltage that is appropriate for their specific vehicle. The requirement for an audible mechanism to be engaged while the vehicle is in reverse gear is part of scene safety. Vehicles may need to be moved in many different situations where visibility is poor or there are no personnel available to spot a driver and an audible mechanism warning bystanders, first responders, or patients that a vehicle is backing up is an added layer of safety. Additionally, agencies may request a waiver for any equipment required by these regulations. Lastly, further guidance will be provided in policy statement once the regulations are enacted. No amendments were made as a result of these comments.

Comment: A commenter stated that individually wrapped sanitary napkins, as required in § 800.24, Table 1(d), are not typically included in obstetrical kits. Additionally, the commenter stated that this requirement is redundant of Table 1(e)(5), 5 inches by 9 inches sterile gauze pads. The commenter suggested removing the requirement of an individually wrapped sanitary napkin.

Response: The Department revised the regulation to remove the requirement for sanitary napkins in required equipment for the reasons stated by the commenter.

Comment: Several commenters suggested that the requirements for specific sizes of tape in § 800.24, Table 1(e)(2), are too narrow and restrictive. Two commenters cited cost and availability as a barrier for implementation.

Response: Upon further review by the Department based on the comments, the Department recognizes that specifying the size of tape is not efficient or necessary. The required equipment specific to the size of roll of tape has been modified to require at least four rolls of tape in varying sizes.

Comment: Several commenters stated the cloth or disposable blanket required in § 800.24, Table 1(f)(6) is duplicative of Table 1(f)(17) and suggested removing this redundancy.

Response: The Department recognizes that this requirement is redundant and removed the requirement for a blanket from Table 1(f)(17) based on this comment.

Comment: Several commenters suggested that Table 1(i)(13) set forth in § 800.24, devices relative to the administration of fluids to pediatric patients, be removed. The commenters stated that they believed this regulation implies a burette IV set is the preferred equipment, which

presents barriers to usage such as complexity, safety, and cost. The commenters shared that current best practices utilize IV pumps for administration for pediatric safety purposes, as opposed to those that operate on gravity such as the burette IV.

Response: The Department recognizes that certain methods of regulating fluid administration in pediatrics may be outdated and/or expensive. However, best practice recommends that fluid administration in pediatric patients needs to be closely monitored and calculated. The Department does not endorse or recommend any brand or type of device within regulation and may provide further guidance in a policy statement. No amendments were made as a result of these comments.

Comment: Several commenters suggested a change to the language in § 800.24(c) and § 800.26(d) regarding Advanced Life Support (ALS) equipment. The commenters believe that the language in the proposed regulation is too broad and requested the language be changed to include only ALS medications and intravascular access devices stored so that BLS providers cannot access them.

Response: The Department changed the language to state that if a vehicle is equipped, but not functioning as an ALS vehicle, the equipment that is over the scope of practice for providers must be secured when the vehicle is not functioning at an ALS level of care. The specificity of equipment such as medications, intravascular access devices, and cardiac monitors has been removed and language has been modified to refer to the equipment must be secured within scope of practice.

Comment: Two commenters suggested that § 800.26(f) be removed from the regulatory package, citing that training requirements are regulated under Article 30 of the PHL and citing duplication of § 800.24(f).

Response: The specific reference to training in § 800.24(f) has been removed and reworded to only require proficiency and competency in required equipment operation. Section 800.26(f) has been removed entirely as it is duplicative.

Comment: Two commenters addressed what they perceived to be a typographical error in § 800.26(d) and suggested a language change to state “ambulance” as opposed to the current language of “any emergency ambulance service vehicle other than an ambulance.”

Response: While the Department notes this comment, § 800.26(d) refers to emergency ambulance service vehicles other than an ambulance – EASV, which were previously named as such in Part 800 of Title 10 of the N.Y.C.R.R. No amendments were made as a result of these comments.

Comment: Several commenters objected to the implementation of camera systems that will record certain events with a recommended retention of at least ten days. Commenters stated audio recordings may have privacy, legal, and contractual ramifications and that cost and other privacy concerns are a barrier for agencies. The commenters recommended that this requirement only be applicable to ambulances. Additionally, a commenter stated their support for a camera system to provide the vehicle operator with a view of the rear of the vehicle while in reverse motion but also cited limited production of such camera systems as a barrier for implementation. Lastly, a commenter stated that camera systems should not be required for BLS EASV.

Response: The proposed vehicle requirements in § 800.26 apply only to emergency ambulance vehicles other than an ambulance. BLS FR agencies are only required, under the proposed regulation, to have a minimum of one vehicle registered with the Department to comply so that they may participate in Department initiatives, and educational programs, amongst others. Agencies with EASV's may apply for a waiver pursuant to § 800.25 to any equipment requirements. No amendments were made as a result of these comments.

Comment: Several commenters voiced concern regarding adequate storage space for spare oxygen tanks for BLS FR, BLS EASV, and ALSFR vehicles. Commenters stated that these vehicles are supported by an ambulance, which carries additional oxygen supplies and that the minimum PSI requirement for 1,000 PSI on a "D" sized oxygen tank is excessive. Also, one commenter stated that 1,000 PSI cylinders are still not full and carrying a spare cylinder would be onerous, costly, and possibly unsafe.

Response: The Department has reviewed and considered these comments. While an ambulance would ideally be enroute immediately following the BLS FR or EASV to transport a patient and would also carry oxygen for a patient requiring hi-flow oxygen or continuous positive airway pressure (CPAP) prior to the ambulance arrival will require a sufficient oxygen supply to continuously treat the patient prior to the ambulance's arrival. The Department does not consider it unreasonable to require two oxygen tanks with a minimum of 1,000 PSI to ensure that there is an adequate supply. No amendments were made as a result of these comments.

Comment: Two commenters questioned why an Automated External Defibrillator (AED) would be required for an ALSFR vehicle if a manual defibrillator is also required. The commenters

requested quantities be defined for number of adult and pediatric pads required in § 800.24(b)(12). It was also commented that an AED is cost-prohibitive for a BLS EASV.

Response: The Department revised the regulatory language to reflect that an AED is not required for ALS vehicles when they have a device that is capable of automatic or manual defibrillation, cardiac rhythm monitoring, 12-lead ECG acquisition and transcutaneous pacing. Additionally, the equipment requirements were revised to reflect the recommended minimum number of adult and pediatric defibrillation pads to two of each type. Lastly, the current recommended standard of care for treatment in cardiac arrest is early defibrillation of the patient. BLS EASV may be the first vehicle on the scene of a cardiac arrest and as such, the requirement for an AED on these vehicles is not an excessive requirement.

Comment: A commenter requested clarification on whether the adult minimum size needle, 14ga x 3.25-inch, could also qualify as the pediatric needle. The commenter recommended the requirement of two needles in keeping with collaborative protocol for chest trauma.

Response: The Department acknowledges this comment and has changed the required quantity for the 14ga x 3.25-inch needle to two to comply with protocols. § 800.24, Table 1(i)(6), provides the correct size for a pediatric decompression needle.

Comment: Two commenters requested that § 800.23, general requirements related to equipment, be reviewed to avoid conflicts in new regulations.

Response: Section 800.23 was reviewed by the Department and is now proposed to be repealed.

Comment: Two commenters requested clarification on what would qualify as two sizes under § 800.24, Table 1(c)(4) for securing injured joints or extremities. The commenters asked if carrying two structural aluminum malleable (SAM) splints would satisfy the minimum requirement.

Response: The Department considered the comments and revised the regulation to include “may include adjustable devices” to provide clarity on the specific equipment requirement.

Comment: Two commenters stated that § 800.24, Table 1(c)(6) devices capable of immobilizing the head of a patient, are typically no longer used and this requirement should be removed.

Response: While the Department acknowledges receipt of this comment, there are situations in which head immobilization is a benefit to patient care, such as when intubated via endotracheal tube or another type of advanced airway. Head immobilization in this instance could help avoid displacement of the advanced airway while moving the patient. Additionally, when immobilizing a patient suspected of spinal injury, the head and cervical spine must be immobilized as well. The Department recognizes that the occurrences of using a long board and spinal immobilization devices on patients suspected of spinal injury has decreased, but it is not entirely removed from the standard of care. No amendments were made as a result of these comments.

Comment: A commenter requested clarification on quantity for child and infant size blood pressure cuffs required in § 800.24, Table 1(d)(5).

Response: The Department has clarified the equipment requirement by specifying the number of child and infant sized blood pressure cuffs. Amendments have been made as a result of these comments.

Comment: A commenter suggested expanding § 800.24, Table 1(f)(8), emesis containers, to include an emesis bag as an option. Another commenter suggested the removal of emesis containers, specifically for BLS FR without further explanation of the comment.

Response: The Department has added “emesis bags or equivalent” as an option for agencies to meet the equipment requirements.

Comment: Two commenters suggested that chemical hot packs be removed from § 800.24, Table 1(f)(14).

Response: The Department has reviewed the comments and has revised the regulation to separate and make optional chemical hot packs. The Department has also included the required quantity, if an agency decides to carry chemical hot packs.

Comment: A commenter requested that the necessity of certain equipment, including pediatric pulse oximeters, battery operated portable suction equipment, flexible litters, passive monitoring CO detectors, camera systems, and backup alarms be reviewed. The commenter cited barriers for implementation including cost, space, and maintenance.

Response: The Department has reviewed and considered the commenter’s concerns. The requirements for a pediatric pulse oximeter, flexible litter, and battery-operated suction unit were

changed to optional for BLS FR and BLS EASV. The passive monitoring CO detectors, camera systems, and backup alarms have remained in equipment requirements as they are equipment and devices that ensure the safety of providers while on scene and responding to and from emergency calls. Agencies may also apply for a waiver for any equipment required by the regulation.

Comment: A commenter stated cost as a barrier for compliance with § 800.24, Table 1(b)(4), FDA approved pulse oximetry device with pediatric and adult sensors for EASVs.

Response: Upon further review and analysis, the Department has changed the requirement to optional for the pediatric pulse oximeter for BLS FR and BLS EASV.

Comment: A commenter requested clarification on § 800.24, Table 1(b)(11), regarding the use of soft sterile suction catheters in the EMT scope of practice. The commenter suggested that if this is an ALS skill, this item should be limited to ALS vehicles.

Response: The Department has reviewed this comment; however, no amendments have been made as a result of the comment because as long as an EMT stays within the guidelines for upper airway suctioning techniques, a soft suction catheter may be used within their scope of practice.

Comment: A commenter shared concerns with the requirement of an AED and all ancillary equipment in § 800.24, Table 1(b)(12), for BLS EASVs as cost prohibitive for privately owned vehicles.

Response: The standard of care for cardiac arrests includes the application of an AED as soon as possible to increase survivability. The Department recognizes there can be significant cost to the

purchase and maintenance of these devices, however AEDs drive positive patient outcomes in cardiac arrest when there is early defibrillation. No changes have been made as a result of these comments.

Comment: Two commenters suggested that items in § 800.24, Table 1(c)(7), flexible litter, should not be required for BLS EASV because these vehicles do not transport patients. The commenter believes that a device such as a Mega Mover should be classified as a bariatric device.

Response: The Department has reviewed and considered the commenters' concerns. The requirement for BLS FR and BLS EASV to carry flexible litters has been made optional.

Comment: A commenter suggested a modification of the language in § 800.24, Table 1(d)(6), related to wording for requirements for stethoscopes acceptable for pediatric patients from "Pediatric stethoscope (interchangeable type acceptable). May be satisfied by any stethoscope with pediatric adapter diaphragm" to "stethoscope acceptable for pediatric use." .

Response: The Department has reviewed and considered the commenters suggestion; upon further review and analysis, the language contained within the proposed regulation is determined to be sufficient. No amendments were made as a result of these comments.

Comment: A commenter suggested modifying the language in § 800.24, Table 1 (e)(4), to "sterile multi-trauma dressings" so it is consistent with FDA labeling.

Response: The Department recognizes that the use of "abdominal pad" to describe the required equipment is outdated and has amended the language to be in concert with FDA labeling.

Comment: A commenter stated that items in § 800.24, Table 1(f)(11), thermometers, are not medically imperative.

Response: The Department acknowledges this comment; however, recent protocol changes include the ability to administer medications for patients with a temperature over 100.4 degrees Fahrenheit. As such, a thermometer is necessary in order to determine an accurate body temperature and provide appropriate treatment to patients. No amendments were made as a result of these comments.

Comment: A commenter requested clarification on the use of items required in § 800.24, Table 1(g)(3), carbon monoxide detectors, for event staffing and inter-facility transport. The commenter cited cost and calibration requirements as barriers for implementation.

Response: The Department has considered the comments received concerning the requirement for carbon monoxide detectors. Due to the colorless and odorless nature of carbon monoxide and how symptoms for carbon monoxide poisoning can be mirrored by other illnesses, this piece of equipment is important to keeping providers safe. Without this equipment, providers could be quickly overcome by otherwise undetectable high levels of carbon monoxide, requiring this device as a front-line manner of protection. Of note, agencies may request a waiver for any equipment required by these regulations. No amendments were made as a result of this comment.

Comment: A commenter suggested language ensuring the inclusion of regional emergency medical services councils for waiver approval in § 800.25. The commenter recommended that a

standardized form be utilized for waiver requests under § 800.25(e). Additionally, the commenter stated that waivers should not be required to be kept in the vehicle.

Response: The Department has added language that allows for the consideration of waivers by the regional emergency services councils. Additionally, the process for requesting a waiver and any related forms pursuant to § 800.25 will be disseminated in a guidance document after enactment of the proposed regulation. The location where a waiver must be kept will be defined further in Department guidance documents.

Comment: A commenter suggested a modification to exclude the date of publication for the requirement to meet or exceed certain federal vehicle requirements and crash testing standards contained within § 800.26(d), to reduce the need for future revision.

Response: Any incorporation of specific reference material must reflect the year and date of the material. The Department has reviewed the crash test standards included in § 800.26 and has removed reference to the Society of Automotive Engineers standards contained within § 800.26 since these standards do not apply to EMSV's as they are designed for ambulances that transport patients.

Comment: A commenter questioned the requirement in § 800.26 which states, in part, “have any equipment or materials over three pounds mounted or secured to the vehicle.” The commenter stated that this conflicts with § 800.23(d) which states “[i]nsofar as practical, all equipment in every vehicle shall be secured to the vehicle whenever the vehicle is in motion.”

Response: The Department has considered the comment and has modified the language in the referenced section to be broader with the removal of the specific Society of Automotive

Engineers Ground Vehicle Standard J3043_201407: Ambulance Equipment Mount Device or Systems (July 14, 2014) crash test standard, and still achieve the intent of ensuring passenger and driver safety in an EASV by requiring all equipment to be secured. Additionally, § 800.23 will be repealed as part of the revised regulatory change.

Comment: A commenter stated that requirements under § 800.24, Table 1(a)(4), that all devices used to transport to move patients be secured using crash resistant fasteners, is not supported by a state or federal standard. The commenter also requested clarification regarding whether this regulation is applicable to litter retention devices. In addition, two commenters stated that it is unclear what qualifies as a crash resistant fastener and what patient movement equipment should meet this requirement.

Response: Section 800.22 contains guidance on fasteners and other retention devices for patient movement equipment. In light of these comments, the Department has added “in accordance with section 800.22” to clarify the intent of this requirement.

Comment: A commenter suggested removing the term “albuterol” in Table 1(h)(5) set forth in § 800.24, and replacing the term with language indicating a bronchodilator to encompass future medications with the same mechanism.

Response: The Department recognizes that there may be changes to the medications that providers are able to administer and has changed the wording from “albuterol” to “bronchodilator” to accommodate future changes.

Comment: A commenter suggested modifying the language in § 800.24 requiring all providers be able to operate all the equipment on their ambulance, to only apply to the provider’s agency vehicles.

Response: The Department has modified the proposed regulation language to provide clarity on equipment proficiency by providers.

Comment: A commenter stated that only Department of Transportation (DOT) highway approved vehicles can comply with chapter 301 of title 49 of the United States Code (USC), “Motor Vehicle Safety” (May 2008) and they stated that certain vehicles that respond and extract patients to ambulances do not fall into this category and as such, should be exempted from this requirement.

Response: The Department has considered the comment and the concerns raised. The referenced section of chapter 301 of title 49 of the USC, “Motor Vehicle Safety” refers to the federal requirement that a vehicle cannot be modified after purchase to remove or reconfigure the seat belts in the driver or passenger configurations. No amendments were made as a result of this comment.

Comment: A commenter stated that anticipated barriers for implementation of the proposed regulations for used emergency ambulance service vehicles include cost and warranty compliance.

Response: The Department acknowledges and appreciate this comment. However, the proposed regulations contain a minimum safety standard that is not unreasonable, even in a used EASV. It

should be noted that pursuant to § 800.25, agencies may apply for a waiver for any required equipment. Therefore, no amendments were made as a result of these comments.

Comment: A commenter suggested that the regulations should not apply to vehicles ordered before the date of adoption to reflect ordering and fulfillment time for emergency vehicles.

Response: The proposed regulations for EASV's will not take effect until twelve months after adoption of the regulation. This provides a grace period for vehicles ordered that did not have the new requirements included in the vehicle specifications and purchase cost. Existing vehicles will be grandfathered in until they are replaced, regardless of how long after the regulations take effect. As a result of these comments, the regulation has been amended to clarify the regulatory requirements.

Comment: A commenter suggested that ambulances that are remounted electively or as the result of a collision should be exempt from the waiver process.

Response: The Department acknowledges the receipt of this comment; however, the proposed regulatory package does not include construction standards for ambulances, only emergency ambulance service vehicles (EASV). Therefore, no amendments were made as a result of these comments.

Comment: A commenter requested clarification on the regulatory requirements for agencies utilizing alternative methods of transportation for providers such as bicycle, Segway, motorbikes, ATV or other alternative methods.

Response: The Department has not previously regulated these specific types of transportation.

The Department does not seek to regulate specifically to these vehicles due to the specialized and individualized nature and agency specifications when ordering. No amendments were made as a result of these comments.

Comment: A commenter requested clarification on the appropriate equipment for infants under 10 pounds.

Response: The National Association of State Emergency Medical Services Officials (NASEMSO) document incorporated by reference in § 800.24(b) provides guidance on securing of children under 10 pounds. The Department intends to update policies and guidance documents once the regulations take effect. No changes were made as a result of these comments.

Comment: A commenter requested clarification on whether a single size pulse oximeter would satisfy the requirements of § 800.24, Table 1(b)(1).

Response: The Department has considered the comment and has modified the regulation to reflect that only an adult pulse oximeter is required on a BLS FR or BLS EASV, and a pediatric pulse oximeter has been made optional.

Comment: A commenter suggested adding a minimum quantity of one urinal and one bedpan under required ambulance equipment.

Response: The vehicle and equipment requirements contained within § 800.24 are the minimum requirements for an agency. Any certified agency may add equipment in keeping with scope of practice, or via regional or medical director approval when applicable. There is nothing that

would preclude an agency from adding a urinal or bedpan to their vehicles. Therefore, no amendments were made as a result of these comments.

Comment: A commenter requested clarification on the necessity for BLS FR to possess items under § 800.24, Table 1(g)(1), traffic flares or triangles and further stated that these items should not be required for BLS FR.

Response: The Department acknowledges this comment; however, emergency vehicles of all types are often parked on roadways or in areas where the safety of providers on a scene is in question. The requirement for this equipment is part of ensuring that emergency vehicles and providers are highly visible under all weather and lighting conditions. No amendments were made as a result of these comments.

Comment: A commenter suggested high-visibility vests be required for all vehicles under Safety Equipment in § 800.24, Table 1(g).

Response: Upon further review by the Department, the suggested equipment has been added to the table along with required quantities for each type of vehicle.

Comment: A commenter suggested that the column labeled “Ambulance” under “Required ALS Medications and adjuncts if vehicle is operating as an ALS vehicle” in § 800.24, Table 1(i) should read “ALS only” for all requirements.

Response: The types of medications and adjuncts required for ALS vehicles may apply to either ALSFR or an ambulance. The separation of equipment between BLS and ALS is for clarity in applying the equipment requirements. No amendments were made as a result of these comments.

Comment: A commenter suggested the inclusion of paper bags as required items in the regulation.

Response: The proposed regulations encompass the minimum equipment standard for vehicles of all types. Agencies may add other equipment as approved either by their medical director, region, or the Department over and above the minimum requirements. No amendments were made as a result of these comments.

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