NEW YORK STATE

REPORT ON
RURAL AMBULANCE SERVICES

Prepared by:

The New York State Rural Ambulance Services Task Force

FORWARD

When many think of New York State, the bustling streets of New York City often dominate the imagination. However, beneath the urban landscape lies a vast stretch of rural territory. Surprisingly, out of the 62 counties in New York State, a significant 43 - two-thirds of the total - are classified as rural by federal standards. Yet, the challenges faced by these rural communities can be starkly different from their urban counterparts, especially concerning Emergency Medical Services (EMS).

As we embark on the journey to shape the future of EMS in New York State, it is essential to recognize and confront the unique obstacles confronting rural communities. Providing effective EMS services in these areas necessitates a fine understanding of their specific needs and circumstances.

The New York State Rural Ambulance Task Force was established with the mission to research, identify, and recommend solutions to the challenges of EMS in rural communities. This task force represents a pivotal stride towards ensuring equitable access to emergency medical care across the state. Through comprehensive assessment of both immediate hurdles and long-term needs of rural EMS, the task force aims to pave the way for a more resilient and responsive EMS system in our rural communities.

Comprised of subject matter experts hailing from diverse regions across the state, the New York State Rural Ambulance Services Task Force orchestrated a series of strategic initiatives in the development of this paper. These initiatives included extensive task force meetings for the past 12 months, statewide surveys engaging hundreds of EMS providers, interviews with County EMS Coordinators and interactive EMS community Town Hall sessions. These concerted efforts were meticulously undertaken to ensure that the Proposals enclosed in this document resonate authentically with the entirety of the New York State EMS community, embodying a collective vision for enhanced Emergency Medical Services in each rural community statewide.

In presenting these recommendations, we illuminate a path forward toward a future where every community in New York State, no matter how remote or how large a population, can rely on prompt and comforting Emergency Medical Services. Through the collaborative efforts of the New York State Rural Ambulance Task Force, we have not only identified challenges but also forged solutions, underscoring the task force members' commitment to ensuring the well-being of all New Yorkers.

Together, let us embrace this roadmap with optimism and determination, taking one day at a time to advance the system into the future and knowing that by working hand in hand, we can create a brighter, healthier, more equitable tomorrow for our state.

The Proposals presented in this document will serve as a beacon of hope and progress, guiding the way toward creating a reliable and sustainable EMS system in every corner of New York State, including our most venerable rural communities. By leveraging the insights and collective wisdom of the Rural Ambulance Task Force, we have the opportunity to not only address current challenges but also to cultivate a future where every New Yorker can access the timely and quality emergency medical care they deserve.

Sincerely,

The Rural Ambulance Service Task Force Members

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ABBREVIATIONS

AEMT	Advanced Emergency Medical Technician
ALS	Advanced Life Support
BLS	Basic Life Support
CFR	Certified First Responder
CIC	Certified Instructor Coordinator
CMS	The Centers for Medicare & Medicaid Services
DOH	Department of Health
DOL	Department of Labor
EMT	Emergency Medical Technician
EMS	Emergency Medical Services
OFPC	Office of Fire Prevention and Control
PCR	Pre-hospital Care Report
RASTF	Rural Ambulance Services Task Force
REDC	Regional Economic Development Council
REMAC	Regional Emergency Medical Advisory Committee
REMSCO	Regional EMS Council
SED	State Education Department
SEMAC	State Emergency Medical Advisory Committee
SEMSCO	State EMS Council
SOC	Surge Operations Center

BACKGROUND

The New York State Rural Ambulance Services Task Force (RASTF) was formed specifically to "*examine, evaluate, and make Proposals for the functionality and betterment of operations of ambulance services in rural areas of New York State*."[1]

The Task Force represents a wide variety of emergency medical service (EMS) stakeholders, community leaders, professionals, and subject matter experts in New York State, with members appointed by the Governor, the Bureau of Emergency Medical Services and Trauma Systems (Bureau), Office of Fire Prevention and Control (OFPC), Department of Labor (DOL), the Temporary President of the Senate, the Speaker of the Assembly, the Senate Majority Leader, and the Assembly Minority Leader.

This report is the result of research, strategic workgroups, town hall events with EMS stakeholders, and creative critical thinking examining and evaluating the New York State EMS system to make Proposals to develop and promulgate a plan for improvement of the services in rural areas the state.

The phrase "*EMS in Crisis*" has been commonly used to characterize the destabilized situation of EMS systems in counties, regions, and states across the United States as well as here in New York State. To identify key issues, facilitate valuable discussion, and formulate constructive suggestions for improvement, the Rural Ambulance Services Task Force focused on four topic-specific subgroups: funding, staffing, standards, and systems. Detailed discussions and proposals from each subgroup are included in the substance of this report.

[1] NY State Senate Bill 2021-S3503C (nysenate.gov)

EXECUTIVE SUMMARY

Emergency Medical Services (EMS) play a vital role in rural areas across the United States, providing crucial care to nearly 10 million Americans annually. Despite the presence of 23,272 EMS agencies nationwide, with 73 percent serving rural communities, universal access to emergency medical care is under threat, especially in rural areas across America.

In New York State, the reliability of the EMS system has significantly declined in recent years due to various challenges. These challenges include a decrease in volunteerism, insufficient and lack of public funding to cover readiness costs, staffing shortages, escalating operational expenses, inadequate insurance reimbursement, increased call volumes, absence of performance standards, limited awareness of the EMS system among elected officials and the public, the influence of NYS home rule, and a lack of transparency and accountability for EMS agencies. In some instances, these systems receive public funding, but in many communities, they are not financially supported. This results in a patchwork system with local municipalities or fire districts throughout the state opting for different approaches to provide EMS coverage. These options include but are not limited to, for-profit commercial companies or not-for-profit organizations that staff with career or volunteer employees. Some municipalities have contracted with these types of EMS organizations to supply or supplement EMS coverage, other municipalities have no formal coverage.

EMS response is often at the mercy of time of day, day of week, proximity of an ambulance within a geopolitical boundary, and the availability of staff. Response times vary from minutes to more than an hour in many locations. Multiple dispatch centers and agencies may be involved in a single EMS call when the initial dispatched agency does not have adequate staffing (career staffed or volunteers) to respond to the call. There are no standard performance metrics for agencies or dispatch centers to report the percentage of calls answered within an agency's primary coverage area. EMS agency leaders are reluctant to endorse centralized collection and publication of performance statistics. When looking at EMS responses, it is difficult to determine how many different agencies were requested to answer a call prior to one responding. As a result, measuring time from the receipt of an EMS call until an ambulance arrives on scene is challenging in most of New York State. Some EMS agencies measure themselves, however these measurements are inconsistent across agencies as there is no specific standard or requirement for this data to be collected. Thus, the ability to report is hampered by these inconsistencies and lack of standards. These variables result in a fragmented, inconsistent, and non-standardized service delivery of emergency medical services with a wide range of costs, coverage ability and response times. New York State's EMS system is currently in crisis and demands immediate and substantial action. Measures are necessary to ensure universal access to high-quality emergency medical care in a timely manner for the rural population, where people live, work, and engage in recreational activities. Over the past few years, numerous ambulance services have been forced to close due to insufficient staff or inadequate income to cover growing expenses, and those that are still operational struggle to consistently respond to emergency calls.

While attempting to determine EMS system response performance, the Task Force encountered a multitude of challenges. Counties, towns, villages, and individual EMS agencies often operate their own non-interoperable 9-1-1 dispatch centers. These centers collect data using different

Computer Aided Dispatch (CAD) systems, standards, and dispatch protocols, resulting in a fragmented system that makes it impossible to measure agency response, performance, and outcomes. The fragmentation extends to EMS response plans, which rely on geopolitical boundaries to assign ambulances to calls, often overlooking the availability of a closer, more appropriately staffed ambulance. Without mandated call for service reporting, the task force was unable to determine individual EMS agency performance and more comprehensively understand the impact of EMS unit availability on the larger EMS system.

Multiple Counties have conducted their own EMS system studies. These County EMS reports often provide more detailed system performance data of individual EMS agencies. All the County reports that were reviewed by the RASTF clearly indicated that the existing way of providing EMS is just not working. A quote from the 2021 annual report on the St Lawrence County EMS system summarized some of the staffing issues in this manner, "*EMS agencies are struggling to stay afloat and provide medical care to their community in need. Agencies having primary jurisdiction are struggling to respond to emergency calls due to the inability to staff an ambulance with the required driver and credentialed EMS provider. Response times and turnover percentages have increased to record numbers*"[2].

Beyond these immediate issues, the crisis represents a deeper need for substantial reform in how rural EMS is designed, funded, governed, managed, understood, envisioned, and valued in New York State.

The approach taken by the Rural Ambulance Services Task Force to fully understand the numerous challenges in rural EMS was comprehensive. It involved a multi-faceted strategy, incorporating the collection of relevant data, gathering information and direct input from various sources within the EMS sector. This inclusive approach included Town Hall meetings, surveys, and literature reviews of EMS studies conducted in New York and other states. The insights gained from this extensive strategy serve as the cornerstone for the Proposals put forth. Through thorough data analysis, the task force identified several critical deficiencies and overarching themes that demand prompt and focused attention.

The Task Force focused on four large categories and the various proposed Proposals were derived from those categories. While collecting information, the Task Force was made aware of many issues facing rural EMS agencies and practitioners including, but not limited to:

Funding Mechanism Inadequacies: Insurance reimbursement for EMS services is based on an antiquated transportation-based funding model and is falling short in adequately supporting EMS systems. Many rural EMS agencies express immediate operational jeopardy due to their inability to cover costs, primarily stemming from insufficient insurance reimbursements and a lack of public financial support.

[2] St. Lawrence County 2021 Annual EMS Report

Readiness Funding Need: There is a crucial need for EMS services to be funded based on their state of readiness. Readiness being the time between calls, when no revenue is generated, but resources are ready to respond when needed. EMS agencies must maintain a constant state of readiness, with personnel and ambulances available to respond to emergencies at any moment.

Workforce Issues: There has been a significant decline in the number of EMS practitioners who are using their EMS certifications in the state over the past decade, thus impacting individual EMS agencies as well as the overall EMS system. The reasons for this include, but are not limited to, job stress, low job satisfaction, poor management/leadership, and insufficient pay (resulting in the need to work more than one job to make ends meet.)

Increasing System Demands: EMS agencies and personnel are facing escalating demands, marked by a rise in call volume. Contributing factors include an aging population, longer patient transport to definitive care, being called to cover other jurisdictions, increased turn-around times and additional training requirements.

Education: The current EMS educational system is simply not accommodating to students, or Instructor candidates, and needs change. Areas such as increasing overall awareness of courses, course funding, a lack of Certified Instructor Coordinators (CICs) and availability of courses are all in need of review. In addition, out of the box thinking regarding the use of prior learning assessments (PLA) and the creation of micro-credentialing programs will assist EMS practitioners.

System Fragmentation: The current EMS system is fragmented with many different service methodologies being employed and little to no coordination on a regular basis. This can impact EMS agency operations and potentially negatively impact patients. There is a need for a coordination mechanism (i.e. County EMS systems) to bring the disparate entities making up the system into concert and allow for operational efficiencies.

The rural EMS system in New York State is teetering on the brink of collapse. To safeguard access to quality prehospital care and prevent the potential closure of additional rural ambulance agencies, urgent government intervention is imperative. Immediate action is needed, focusing on investing in the cost of readiness and establishing a critical access ambulance designation to ensure equitable access to emergency medical services throughout the state.

Several pressing factors contribute to the impending crisis, including escalating operational expenses, EMS workforce decline, inability for agencies to provide a competitive wage, and no funding for the cost of readiness. These challenges place rural EMS agencies in jeopardy and heighten the risk of agency closures resulting in a loss of emergency healthcare to rural communities. The cascading consequences of these issues manifest in prolonged EMS response times, exposing patients in crisis to heightened risks of serious medical and traumatic

complications including increased morbidity and mortality, further stressing the healthcare system as a whole and robbing communities of their neighbors.

To avert this crisis and fortify the rural EMS system, immediate and strategic government action and investments are crucial. These investments should address the financial sustainability of EMS agencies who meet public need and performance standards, increase, and maintain certified practitioners, pay competitive wages, prioritize the well-being of EMS personnel, and ensure equal access to life-saving services across all regions of the state. In addition, EMS must be recognized as an essential service and receive necessary public funding (County, State & Federal) with increased insurance reimbursements including Medicaid, as well as assuring that EMS agencies are reimbursed for patients who are treated but not transported, as well as those who are transported to alternative destinations.

There are other critical areas such as the reinvention of the EMS educational system, the allocation of critical resources to the Bureau and the need to establish a minimum wage set for EMTs, AEMTs and Paramedics in New York State that must be addressed as we move forward. **The stakes are high, and timely intervention is paramount to preserving the health and well-being of rural communities in New York State.**

The EMS system in New York State should align with the EMS Agenda 2050 in being people-centered, adaptable and innovative, sustainable and efficient, socially equitable, reliable and prepared, integrated and seamless as well as inherently safe and effective[3].

Similarly, New York State must be consistent with the National Emergency Medical Services Advisory Councils EMS Star of Rights as our EMS system needs to be essential, funded, equitable, excellent, desirable, and organized[4].

The RASTF is in a unique position, appointed by elected officials and tasked with providing a report directly to those officials. We are a governmentally created body which allows us, outside of the SEMCO and the Bureau, to effectively evaluate and provide Proposals to our elected officials on the topic of EMS. **There is a need for the work of the Rural Ambulance Services Task force, as an independent body, to continue.**

[3] Planning for the Future: EMS Agenda 2050 | EMS.gov

[4] FINAL---[se]---EMS-Star-of-Rights---2022NOV03.pdf

CHARGE OF THE TASK FORCE

To better understand the overall state of rural EMS in New York State, in 2021, the New York State General Assembly created the New York state rural ambulance services task force.

The charge of the Rural Ambulance Task Force is as follows:

> *"The department of health is hereby authorized to establish the New York state rural ambulance services task force within the bureau of emergency medical services to examine, evaluate and make Proposals concerning New York state ambulance services in rural areas."*[5]

In addition, that Task Force may collect, and shall be provided, all relevant information necessary to carry out its functions from any relevant agency.

Such task force shall conduct a study on the availability of ambulance services in rural areas, with a particular focus on the unique challenges they face and their ability to provide services.

As per the legislation, this study will include, but not be limited to,

- an analysis of the total number of ambulance services available in rural areas of the state provided by service type and geographic region they serve.
- assessing current reimbursement structures in place for ambulance services as well as various methods to fund or otherwise raise revenue for such services.
- assessing barriers that currently exist that may have led to a shortage of available ambulance services to meet the need.
- studying any other issue such task force deems relevant.

In summation, the New York State Rural Ambulance Services Task Force is responsible for evaluating the unique challenges faced by EMS agencies and EMS practitioners, in rural areas of New York, and making Proposals for improvements that support the health and safety of those communities.

[5] Senate Bill S3503C

KEY PROPOSALS & FORMAT OF PAPER

As the Rural Ambulance Services Task Force contemplated the various solutions that must be implemented, several key Proposals emerged. These are categorized in the following manner:

- IMMEDIATE – 0-18 mo. – The RASTF identified that these Proposals can be fully implemented in a short period of time with maximal impact for STABILIZING the EMS System.
- INTERMEDIATE – 18 mo.-3 yrs. – The RASTF identified that these Proposals can be implemented immediately and will take longer to implement with maximal impact for SECURING the Rural EMS System.
- LONG TERM – 3+ yrs. – The RASTF identified that these Proposals can be implemented quickly and will take the longest time to implement with maximal impact on SUSTAINING the Rural EMS System in the future.

To align with each of the sections (aka "asks") as outlined in the enabling legislation, the RASTF has separated its responses into four corresponding sections.

The four sections include:

- SECTION A - an analysis of the total number of ambulance services available in rural areas of the state provided by service type and geographic region they serve.
- SECTION B - assessing current reimbursement structures in place for ambulance services as well as various methods to fund or otherwise raise revenue for such services.
- SECTION C - assessing barriers that currently exist that may have led to a shortage of available ambulance services to meet the need.
- SECTION D - studying any other issue such task force deems relevant.

In each section, there is a summary of findings as well as key recommendations. Additional information about each specific Proposal is laid out in the sections behind the key findings.

LIST OF PROPOSALS:

The Rural Ambulance Service Task Force created 38 Proposals based on its findings during the time period when the task force was gathered. Each of the Proposals below will be highlighted in one of the four sections in this paper.

Below is a list of the Proposals in the order of priority that the Task Force feels it is most important to address.

Priority	Proposal
Proposal #1:	Declaration of a Public Health Emergency About Issues of Rural EMS
Proposal #2:	EMS should be declared an essential service & Special Taxing Districts should be permitted
Proposal #3:	Remove Emergency Medical Services from the limit on real property tax levies by local governments (2% tax levy)
Proposal #4:	Provide State funding to subsidize the formation, and sustainability, of County EMS System Readiness.
Proposal #5:	Each County should become responsible for their County's EMS System with responsibilities to include: • The development of a comprehensive County EMS Plan, inclusive of existing Ambulance Service Certificates holders. • Enhancement of the County EMS Coordinator position. • Ensuring the delivery of emergency medical services to all areas of their county.
Proposal #6:	Through the development of regulation, Counties must be given the responsibility, and the resources, to develop, and manage, the County EMS system.
Proposal #7:	Legislation should be created to mandate the provision of EMS at the County-level inclusive of current ambulance service certificate holders who meet public need.
Proposal #8:	Develop tiered response systems (CFR, BLS Ambulance, ALS, Paramedic Fly car) across the state with the use of the closest, most appropriately staffed ambulance. There needs to be a level of authority for dispatch (PSAP) to dispatch the appropriate level of unit, and there needs to be reasonable response time and accountability.
Proposal #9:	Require each County to have an EMS Coordinator.
Proposal #10:	Medicaid rates should be reviewed on a regular basis (annually or biennially to assure they keep pace with the rising cost of delivering EMS.
Proposal #11:	Targeted Medicaid Rate Increase for EMS Agencies

Proposal #12:	Establishment of payment mechanisms that allow EMS services to be compensated for care rendered without transportation to a hospital emergency room (TIP) as well as transportation to an alternate care destination (TAD) such as a mental health clinic, rehabilitation facility or urgent care
Proposal #13:	Allocate personnel and resources to the Bureau to support rural EMS initiatives, agencies, and systems
Proposal #14:	Creation and implementation of an expanded ambulance service certificate specifically for the purpose of providing Interfacility (IFT) and Specialty Care (SCT) transports
Proposal #15:	SEMAC and SEMSCO should develop, and promulgate, guidance regarding interfacility transfers that address priority levels and appropriate response levels.
Proposal #16:	Update the New York State statutes and regulations to fully address the role of community paramedicine in the state.
Proposal #17:	Improve data collection and create additional performance standards. The Bureau, in conjunction with the SEMSCO, should create additional standards requiring EMS agencies to report and meet: • Determination of mandatory call response in primary response area/assurance of adequate coverage • Agency response times • Response percentage tied to call volume • EMS agency onboarding/orientation standards • Agency safety requirements • Cost reporting • Public transparency • Quality Improvement / Quality Assurance Initiatives
Proposal #18:	Align the current EMS Regions with Regional Economic Development Councils (REDC's)
Proposal #19:	Create a Critical Access EMS model like that of Critical Access Hospitals.
Proposal #20:	Create a set minimum wage for EMTs, AEMTs and Paramedics in New York State.
Proposal #21:	The legislature should enact a legislative change to allow up to $25.00 per call (tax free) to allow volunteers to get a stipend per call up to $5,500.00 annually.
Proposal #22:	Pass legislation to increase the tax credit and allow volunteer EMS practitioners to claim both tax credit and local property tax credit.
Proposal #23:	Fund and task the Bureau, in coordination with the SEMSCO, to create standards related to EMS leadership positions that are like that of the New York State Fire Service.
Proposal #24:	Fund and task the Bureau with the development of leadership training programs.
Proposal #25:	Redefine the role of the Regional EMS Councils and Program Agencies in the EMS system
Proposal #26:	SEMAC and SEMSCO should review and, where appropriate, modify medical treatment protocols with the focus on higher BLS

	unit utilization and increased use of BLS adjuncts. Ensure that BLS practitioners are provided guidance with the managing of patient care when ALS resources are not available.
Proposal #27:	County EMS Medical Director Coverage - The Counties should ensure county EMS medical director coverage either by contracting with existing services or by the development of a County Medical Director position. This "County EMS Medical Director" position will have either direct, or shared, oversight of all clinical areas of EMS agencies.
Proposal #28:	As a part of the Healthcare System, EMS representation/professional relationships on various professional bodies that make decisions related to the practice of EMS must increase.
Proposal #29:	EMS systems are actively involved in the substance use disorder (SUD) crisis and should be assured that they have the resources to respond.
Proposal #30:	Redesign the EMS educational system to be more accommodating to students as well as ensure a steady supply of Instructors.
Proposal #31:	There is a necessity to extend the deadline for the NYS Rural Ambulance Services Task Force as a Legislatively developed charge. There is a need for the work of the Rural Ambulance Services Task force to be funded and continued.
Proposal #32:	Fund a three-year, $5 million campaign to promote EMS volunteerism and careers in New York State through an "EMS – About Us" campaign
Proposal #33:	EMS System Performance Audits - Create legislation for municipalities to conduct 5-year audits of their EMS system performance.
Proposal #34:	The RASTF recommends the development of a Paramedic Urgent Care (PUC) system to mitigate various rural-area specific EMS issues.
Proposal #35:	The RASTF calls on federal and state partners to establish EMS-specific funding like the Staffing for Adequate Fire and Emergency Response Grants (SAFER) grant
Proposal #36:	Hospitals need to have dedicated staff, at the administrative level, who work with EMS agencies to facilitate Interfacility & Non-Emergency transport.
Proposal #37:	SEMSCO should develop standardized nomenclature for various areas of EMS to allow for better understanding and bring forth proposed changes to General Municipal Law by modernizing terminology.
Proposal #38:	Address the Diversity, Equity, Inclusion, and Accessibility Realities

SECTION A:

(a) An analysis of the total number of ambulance services available in rural areas of the state, provided by service type and geographic region they serve and compared to the documented need for such services;

Summary of Findings:

Ensuring the availability of ambulance services in the rural areas of our state is crucial and forms the foundation of this analysis. As the Rural Ambulance Services Task Force (RASTF) reviewed data on rural ambulance service availability, several key areas emerged for future initiatives, including the need for improved EMS system funding, the development of county-coordinated EMS systems, and updates to the state statutes and regulations specific to Community Paramedicine.

Challenges in Data Collection and System Fragmentation:

Our efforts to assess ambulance availability in rural communities were hindered by gaps in the current data reporting systems, as this specific type of information is not systematically tracked. Although we can analyze multiple variables such as the overall population of a county, the number of EMS agencies, and the volume of EMS calls, this provides only a partial view of the challenges we know exist based on the operational realities of the system.

In assessing EMS system response performance, the Task Force encountered significant hurdles due to fragmented 9-1-1 dispatch systems. Counties, towns, villages, and individual EMS agencies often use non-interoperable dispatch centers, each relying on different Computer Aided Dispatch (CAD) systems, standards, and protocols. This lack of uniformity prevents a true, comprehensive assessment of agency response times, performance, and outcomes. Additionally, the reliance on geopolitical boundaries to assign ambulances often ignores the potential availability of a closer, better-equipped unit, further complicating system efficiency.

Without mandatory reporting of calls for service, the Task Force was unable to fully evaluate individual EMS agency performance or understand the broader impact of ambulance availability on the overall EMS system.

Key Findings:

The Task Force identified several key findings that require immediate attention, including:

1. **Lack of Reporting Requirements - Enhancing EMS Data Collection:**

   As stated above, the task force further confirmed the large gaps in consistency specifically in the areas of data collected on response times and availability of resources, among EMS agencies that collect data. There is a critical need to improve data collection efforts and establish standardized performance metrics for EMS agencies. This will enable a clearer understanding of system performance and ensure more effective resource allocation.

2. **Lack of EMS System Coordination - County-Coordinated EMS Systems:**

   In reviewing and analyzing EMS in the more-than 40 rural counties throughout New York State, the task force found that each county, and in many cases localities within the county, handles EMS differently. The lack of true system development and coordination has led to a fragmented system that lacks the benefits found within well-coordinated EMS systems. County-level coordination of EMS services, particularly in rural areas, would help overcome the inefficiencies of fragmented dispatch systems and ensure that ambulances are deployed based on need and proximity, rather than arbitrary boundaries.

3. **Lack of understanding regarding unit availability/overall reliability**

   An additional facet of EMS system analysis that came up in the Task Force's evaluation was a lack of knowledge regarding unit availability. Although the RASTF was able to determine the overall number of EMS agencies, we were unable to establish which of these agencies was regularly available to handle an emergency call or even potentially a second emergency call.

   Agencies that rely on volunteers reported struggling with coverage due to the lack of staff on site and competing priorities, i.e., paid jobs. But it is not just volunteer EMS agencies that struggle with coverage and unit availability.

Rural EMS Resource Constraints:

According to federal standards, counties with populations under 200,000 are classified as rural. The data on the following page outlines the current resources available in New York State's rural counties, alongside population figures and EMS call volumes. It is important to recognize that rural communities typically experience longer transport times and face significant resource constraints in meeting rising system demands.

The Proposals outlined in this paper are designed to address these identified challenges. Supporting data and further analysis are provided to guide decision-making and future initiatives.

Ambulance Services by New York State Rural County:

County	Regional Economic Development Council	2023 County Population (US Census Bureau	Interfacility and Medical Transports	911 Responses	Total Responses	# of ALS FR Agencies	# of BLS FR Agencies	# of ALS Ambulance Agencies	# of BLS Ambulance Agencies
Allegany	Western New York	46,651	2,061	7,034	9,095	0	1	17	6
Broome	Southern Tier	196,077	3,975	37,630	41,605	0	25	11	4
Cattaraugus	Western New York	75,600	2,731	12,430	15,161	2	7	14	14
Cayuga	Central New York	74,485	949	17,785	18,734	6	18	13	6
Chautauqua	Western New York	124,891	7,408	16,388	23,796	0	3	16	25
Chemung	Southern Tier	81,325	2,743	18,488	21,231	0	21	4	0
Chenango	Southern Tier	45,920	640	6,110	6,750	0	6	13	7
Clinton	North Country	78,115	494	10,143	10,637	0	6	19	2
Columbia	Capital Region	60,470	1,849	8,991	10,840	0	6	7	2
Cortland	Central New York	45,752	1,565	8,978	10,543	0	9	6	0
Delaware	Southern Tier	44,410	1,328	6,700	8,028	1	5	17	10
Essex	North Country	36,775	397	5,300	5,697	0	1	20	1
Franklin	North Country	46,502	1,453	6,533	7,986	1	4	15	5
Fulton	Mohawk Valley	52,234	1,808	12,078	13,886	0	9	9	0
Genesee	Finger Lakes	57,529	1,742	12,745	14,487	1	10	8	3
Greene	Capital Region	47,062	31	11,523	11,554	2	6	7	6
Hamilton	North Country	5,082	2	898	900	0	0	10	4
Herkimer	Mohawk Valley	59,484	971	11,309	12,280	0	9	12	0
Jefferson	North Country	114,787	3,353	19,146	22,499	0	18	13	3
Lewis	North Country	26,548	774	2,806	3,580	0	0	6	5
Livingston	Finger Lakes	61,158	795	8,678	9,473	4	10	6	5
Madison	Central New York	66,921	1,772	10,673	12,445	1	16	14	0
Montgomery	Mohawk Valley	49,368	2,554	10,881	13,435	1	13	7	1
Ontario	Finger Lakes	112,494	4,235	17,152	21,387	3	13	12	4
Orleans	Finger Lakes	39,124	502	5,066	5,568	1	10	6	0
Oswego	Central New York	118,162	1,071	29,983	31,054	3	25	8	1
Otsego	Mohawk Valley	60,126	1,255	6,970	8,225	1	13	15	6
Putnam	Mid-Hudson	98,060	1,589	10,616	12,205	0	4	5	13
Rensselaer	Capital Region	159,305	2,959	25,144	28,103	0	27	14	9
Schenectady	Capital Region	159,902	3,512	41,252	44,764	2	17	9	3
Schoharie	Mohawk Valley	30,105	291	4,482	4,773	1	3	4	10
Schuyler	Southern Tier	17,507	422	2,789	3,211	0	8	5	2
Seneca	Finger Lakes	32,349	31	4,514	4,545	0	6	7	0
St. Lawrence	North Country	106,940	3,243	15,032	18,275	1	16	18	6
Steuben	Southern Tier	92,162	3,987	15,676	19,663	1	14	5	17
Sullivan	Mid-Hudson	79,920	2,139	5,994	8,133	1	7	6	15
Tioga	Southern Tier	47,715	26	5,903	5,929	3	4	9	1
Tompkins	Southern Tier	103,558	1,678	18,617	20,295	1	13	6	0
Ulster	Mid-Hudson	182,333	4,588	21,981	26,569	1	14	12	13
Warren	Capital Region	65,380	2,819	9,913	12,732	0	6	14	2
Washington	Capital Region	60,047	61	9,417	9,478	0	12	13	0
Wayne	Finger Lakes	90,829	1,615	15,709	17,324	3	6	10	4
Wyoming	Finger Lakes	39,532	570	4,031	4,601	0	3	11	7
Yates	Finger Lakes	24,472	493	3,443	3,936	1	9	5	2

Note: Agencies listed above are based on information listed on EMS agency operating certificate. Some agencies may not operate in every county they have operating authority.

Summary of Proposals for Section A:

The Proposals below, and listed in each section, are related to the findings the task force found while reviewing the data collected and discussed during the meetings held in development of this white paper.

Proposal:	**Provide State funding to subsidize the formation, and sustainability, of County EMS System Readiness.**
Task Force Priority:	#4, Immediate
Area:	Funding
Current proposed legislation:	No

Description: Counties must be provided state funding to subsidize the formulation of county EMS systems and their future sustainability; this will include the creation of formulas to ensure the funding is distributed equitably, based on demonstrated need. This will include the creation of a funding mechanism to fund critical access EMS systems in super-rural areas.

As these systems will need to be constantly evaluated and right-sized, Counties should make use of available grant funds to effect operational consolidations or agency consolidations.

Proposal:	**Each County should become responsible for their County's EMS System with responsibilities to include:** • **The development of a comprehensive County EMS Plan, inclusive of existing Ambulance Service Certificates holders.** • **Enhancement of the County EMS Coordinator position.** • **Ensuring the delivery of emergency medical services to all areas of their county.**
Task Force Priority:	#5, Immediate
Area:	Systems
Current proposed legislation:	No

Description: It has become clear that, unless a municipality takes responsibility for its EMS system, there is no mandate or accountability for the provision of EMS services, including the mandate to respond to all addresses within the primary operating area. As such the Task Force's Proposal is that each County hold this responsibility.

Proposal:	Through the development of regulation, Counties must be given the responsibility, and the resources, to develop, and manage, the County EMS system.
Task Force Priority:	#6, Immediate
Area:	Systems
Current proposed legislation:	No

Description: In developing County EMS system responsibility and design, Counties must incorporate existing ambulance service certificate holders, who meet call for service standards when requested or dispatched and serve the public need. All participating agencies shall respond to all addresses within their primary operating area.

The RASTF recommends mandated use of Emergency Medical Dispatch (EMD) for all primary Public Safety Answering Points (PSAP) or secondary PSAPs dispatching EMS agencies.

Proposal:	Legislation should be created to mandate the provision of EMS at the County-level inclusive of current ambulance service certificate holders who meet public need.
Task Force Priority:	#7, Immediate
Area:	Legislative/Regulatory
Current proposed legislation:	No

Description: It is recommended that rural counties have countywide EMS response plans in place that involve regularly relocating resources to cover gaps in the county system. There should be a PSAP center that serves as a central point of communication for EMS agencies within the county and provides direction in conjunction with the county EMS coordinator to ensure the countywide response plan is executed. It is recommended that agreements should be in place with the existing agencies within the county to relocate and post EMS resources where and when needed. Relocating and pre-staging resources will improve response times to the portions of the county when resources are depleted. If not enough of the existing services and/or resources are able to participate in a countywide response plan the county should take the necessary steps to add additional resources to supplement the countywide system. This may involve providing additional financial support and resources to the existing services within the county to offset the costs associated with increasing resources and staffing.

Proposal:	Develop tiered response systems (CFR, BLS Ambulance, ALS, Paramedic Fly car) across the state with the use of the closest, most appropriately staffed ambulance. There needs to be a level of authority for dispatch (PSAP) to dispatch the appropriate level of unit, and there needs to be reasonable response time and accountability.
Task Force Priority:	#8, Immediate
Area:	Systems
Current proposed legislation:	No

Description: Tiered response systems should be utilized to appropriately distribute resources and ensure that transporting EMS units are appropriately dispatched and utilized. Particularly, tiered response models consisting of BLS transporting units and ALS non transporting EMS vehicles may greatly increase response capabilities and create more resilient response systems by preserving ALS level care for when it is needed. In addition, we should encourage Regions and Program Agencies to incorporate Advanced Emergency Medical Technician (AEMT) training and utilization.

Proposal:	Require each County to have an EMS Coordinator.
Task Force Priority:	#9, Immediate
Area:	Funding/System
Current proposed legislation:	No

Description: The State should mandate and, at least partially, fund each County's EMS Coordinator, with part of the position responsible for being an engaged partner participant in the State EMS Task Force. The role of the County EMS Coordinator must be defined and include deliverables to the Bureau. The deliverables associated with this position will include the creation, and submission, of a plan to address their current County struggles as well as a role with the State EMS task Force.

Proposal:	Update the New York State statutes and regulations to fully address the role of community paramedicine in the state.
Task Force Priority:	#16, Immediate/Intermediate
Area:	Systems
Current proposed legislation:	No

Description: Community Paramedicine resources can be utilized to better provide access to care in underserved rural areas, including rural areas where patients lack access to primary care and utilize 911 and EMS to receive healthcare in non-emergency situations. This creates a burden for EMS and health systems in rural areas.

Utilization of Community Paramedics in public health and primary care roles addresses the needs of rural residents in a more efficient and productive manner. By limiting inappropriate and unnecessary use of transporting EMS resources the chances of such resources being available for when they are truly needed increases. This Improves access to care for both non-emergency and emergency situations.

Proposal:	Improve data collection and create additional performance standards. The Bureau, in conjunction with the SEMSCO, should create additional standards requiring EMS agencies to report and meet: • Determination of mandatory call response in primary response area/assurance of adequate coverage • Agency response times • Response percentage tied to call volume • EMS agency onboarding/orientation standards • Agency safety requirements • Cost reporting • Public transparency • Quality Improvement / Quality Assurance Initiatives
Task Force Priority:	#17, Immediate/Intermediate
Area:	Systems
Current proposed legislation:	No

Description: Currently, there is a lack of mandatory EMS system standards for EMS agencies to be held accountable to and, at the same time, benchmark from. It is difficult, if not impossible, to evaluate what is not measured and there are currently no clear requirements for EMS agencies to report calls which they are dispatched to and are unable, or choose not, to respond to.

With this and other potential data gaps in mind, the Bureau/SEMSCO should create a SEMSCO committee on data to further investigate the gaps in data gathering as well as to investigate how to better utilize our data for supporting public health and other professional areas. This Proposal also includes updating databases to more modern technology platforms.

SECTION B:

(b) Assessing current reimbursement structures in place for ambulance services as well as various methods to fund or otherwise raise revenue for such services;

Summary of Findings:

The current EMS reimbursement model, which is based on an outdated, transportation-centered funding, is no longer sufficient to financially sustain modern EMS systems. Acknowledging that not all patients require a trip to the ED, but that the assessment and care provided to such patients remains valuable, is an important step toward bringing financial stability to EMS agencies. To promote more cost-effective care and recognize the professional healthcare role EMS provides, there must be a fundamental shift in funding paradigm to one based on performance and patient care services.

Rural EMS agencies are struggling to cover their operational costs, primarily due to inadequate insurance reimbursements and a lack of public financial support.

Key Financial Challenges Identified:

1. **Lack of Accountability - Recognizing EMS as an Essential Service:**

   To address the financial instability, EMS must be formally declared an essential service, which would allow for the establishment of special taxing districts. This would provide a stable funding source for EMS agencies, particularly in rural areas where revenue generation is limited.

2. **Outdated Medicaid Rates - Annual Review of Medicaid Rates:**

   Current Medicaid insurance rates have been found to be significantly less than those in neighboring states. In addition, it was found that the increase in the percentage of patients whose primary insurance is Medicaid has greatly increased over the past 20 years. These factors lead us to recommend that Medicaid reimbursement rates should be reviewed and adjusted **annually** to reflect the rising costs of providing EMS services and the increasing EMS provider salaries. This is critical for rural EMS agencies that provide services to a large number of Medicaid patients.

3. **No payment unless transported - Compensation for Non-Transport Care:**

   New payment mechanisms need to be rapidly established to compensate EMS agencies for care provided without transporting patients to a hospital emergency room. This includes reimbursement for alternative patient care delivery models, such as transporting patients to alternate care destinations like urgent care centers or providing treatment on-site. The current reimbursement model encourages patients to be brought to the ER when they may be able to be treated on scene or through an alternative pathway.

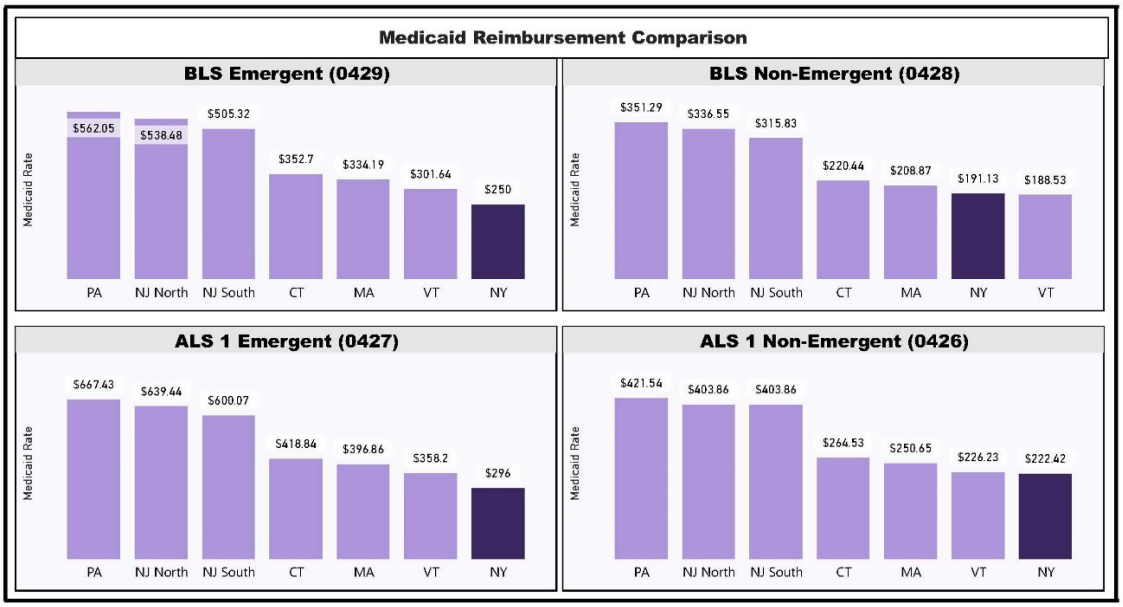
Comparative Data Analysis:

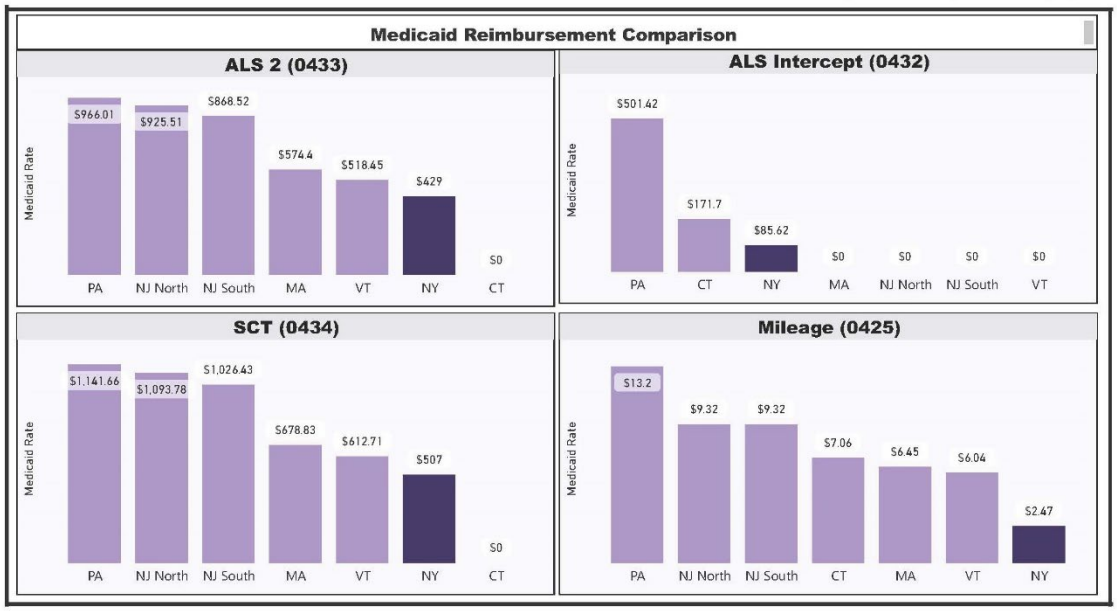
A review of Medicaid reimbursement rates in neighboring states highlights a significant discrepancy between New York's rates and those of other states, as illustrated in the graph below. Addressing this disparity is critical for the sustainability of EMS services in New York.

The issues identified above address the financial shortcomings through this analysis.

Further expanded details and supporting data can be found in the following sections of the report.

Source: New York State Department of Health, Bureau of Emergency Medical Services and Trauma Systems





PA: https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/ma-fee-schedule.html

NJ: https://www.nj.gov/humanservices/providers/grants/public/publicnoticefiles/Public%20Notice%20for%20Jan%202024%20rates%2011.20.23%20v4vam.pdf

CT: https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download

MA: https://www.mass.gov/doc/rates-for-ambulance-and-wheelchair-van-services-effective-september-29-2023-0/download

VT: https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/FY2024%20Budget/W~Alicia%20Cooper~Historical%20Vermont%20Medicaid%20Ambulance%20Rates~2-28-2023.pdf

Summary of Proposals for Section B:

Proposal:	EMS should be declared an essential service & Special Taxing Districts should be permitted
Task Force Priority:	#2, Immediate
Area:	Legislative/Regulatory
Current proposed legislation:	Yes

Description: EMS should be made an essential service in New York State and introducing statutory changes to declare this is paramount. Ensuring that every county within NYS has the necessary resources, trained personnel, and operational capabilities to provide emergency medical services is a matter of public interest and state priority. Much like police and fire protection, EMS is an essential public safety service and must have a stable source of funds to ensure readiness. Regardless of the delivery model, maintaining a state of readiness for emergency medical services is in the public's interest. EMS must remain the community's safety net to ensure timely access to emergency medical care. In order to achieve this objective, Counties need the option to be able to set up a countywide EMS taxing district when necessary.

Proposal:	Remove emergency medical services from the limit on real property tax levies by local governments (2% tax levy)
Task Force Priority:	#3, Immediate
Area:	Funding
Current proposed legislation:	Yes

Description: To allow for additional financial flexibility in establishing County EMS systems, there is a need for legislation which would exempt EMS from the real property tax cap. This would allow local municipalities to expand and better support their local EMS services. This legislation would help municipalities fund and support EMS districts without having to worry about property tax cap compliance.

Proposal:	Medicaid rates should be reviewed on a regular basis (annually or biennially to assure they keep pace with the rising cost of delivering EMS.
Task Force Priority:	#10, Immediate
Area:	Funding
Current proposed legislation:	No

Description: There is a definitive need to improve the timeliness and consistency in reviewing Medicaid rates for EMS to assure that these rates reflect the realistic costs associated with delivering EMS services. In addition, EMS agencies will be required to complete, and report to, the Bureau a cost-reporting exercise periodically which will include, but not be limited to, expenditures, revenues, utilization, and other departmental statistics as requested.

Proposal:	Targeted Medicaid Rate Increase for EMS Agencies
Task Force Priority:	#11, Immediate
Area:	Funding
Current proposed legislation:	Yes

Description: There is a need for a methodology for ambulance reimbursement under Medicaid that more closely approximates the cost of providing the service thus allowing EMS agencies to be fairly reimbursed for the costs of providing services to Medicaid patients.

Proposal:	Establishment of payment mechanisms that allow EMS services to be compensated for care rendered without transportation to a hospital emergency room (TIP) as well as transportation to an alternate care destination (TAD) such as a mental health clinic, rehabilitation facility or urgent care
Task Force Priority:	#12, Immediate
Area:	Funding
Current proposed legislation:	Yes

Description: Current funding models from Insurers, including Medicaid and Medicare, are not sufficient and do not reimburse for Treatment-in-Place (TIP) or Transport to Alternative Destinations (TAD) initiatives. The establishment of funding that speaks to these treatment modalities is critical for EMS agencies.

Proposal:	Create a Critical Access EMS model like that of Critical Access Hospitals.
Task Force Priority:	#19, Intermediate
Area:	Legislative/Regulatory
Current proposed legislation:	No

Description: The Critical Access Hospital model is predicated upon federal funding to hospitals in rural and super rural areas. This model is successful in keeping medical care accessible in areas where care would be otherwise unavailable and should be expanded to include rural access EMS agencies.

Proposal:	The legislature should enact a legislative change to allow up to $25.00 per call (tax free) to allow volunteers to get a stipend per call up to $5,500.00 annually.
Task Force Priority:	#21, Intermediate
Area:	Legislative/Regulatory
Current proposed legislation:	No

Description: Volunteerism is declining, especially in rural areas, at an alarming rate and unless there are incentives given to strengthen local EMS services, the system will continue to see their number dwindle. This stipend could assist in covering the personal costs associated with volunteering and at a reasonable cost for a volunteer agency to be able to afford.

Proposal:	Pass legislation to increase the tax credit and allow volunteer EMS practitioners to claim both tax credit and local property tax credit.
Task Force Priority:	#22, Intermediate
Area:	Funding
Current proposed legislation:	Yes

Description: The current incentives for volunteers are not enough to make a real difference and create an incentive to spend time and effort obtaining and keeping certifications etc. These must be increased if they are to have real benefit to volunteers and potentially motivate them to continue to volunteer.

SECTION C:

(c) Assessing barriers that currently exist that may have led to a shortage of available ambulance services to meet the need;

Summary of Findings:

The assessment of barriers affecting rural EMS agencies in delivering effective ambulance services revealed several critical challenges. These challenges, which include areas ranging from a lack of fair compensation for EMS providers to a lack of flexibility in EMS education & training initiatives and including a distinct lack of public awareness/understanding of EMS, form the basis of the key Proposals aimed at advancing the EMS system and ensuring the sustainability of services in rural areas.

Key Findings:

1. **Lack of Interfacility (IFT) and Specialty Care Transport (SCT) Guidelines:**

   It was found that there is a lack of clear and specific guidance for both IFT and SCT operations. It is recommended that this be corrected as soon as possible. The creation of a specialized ambulance service certification for these types of transports is essential. Additionally, the State EMS office must have the support needed to take a more active role to ensure each community has these services available to them and plans for how to handle these types of patients should a lack of coverage exist.

2. **Lack of Fair Compensation for EMS Providers:**

   The EMS provider survey performed as part of this task force identified a significant concern among EMS providers related to fair wages for the work in which they perform. A minimum wage for EMS providers, similar to that established in New York State for Certified Nursing Assistants (CNA), should be implemented statewide. This measure is particularly critical in rural areas, where compensation disparities contribute to workforce shortages for both recruitment and retention of EMS providers.

3. **Lack of Flexibility of EMS Education and Training:**

   The state EMS educational system must be reimagined to better accommodate students, particularly in rural regions. This includes ensuring a steady pipeline of qualified instructors for EMS programs in these underserved areas. Research and town hall meetings during the development of this paper outlined that more EMS providers may have considered advancing their certification level if they were able to find an educational program that was more adaptive to their work and home needs.

4. **Lack of Public Awareness about EMS - Statewide Public Relations Campaign:** It was reported that many communities lack a clear understanding of how EMS services are provided in their area and, in addition, are often using EMS inappropriately. A targeted public relations campaign is necessary to elevate the profile of EMS as a critical service and career path. Raising public awareness will help to attract more candidates to the profession, particularly in rural areas, and potentially impact the appropriateness of EMS utilization.

Workforce Recruitment and Retention Challenges:

Both volunteer and career EMS agencies are struggling with recruitment and retention, which continues to undermine workforce stability. These issues are particularly pronounced in rural communities, where workforce shortages are compounded by unique geographical and financial barriers.

Supporting Data:

The data gathered from the Rural Ambulance Task Force survey, which surveyed hundreds of New York State EMS providers, underscores these challenges. The findings listed above, and Proposals listed below, are directly informed by this data and are designed to address the most pressing issues identified.

Further details on these findings are outlined in the later sections of this document.

Attraction/Retention Factor Ranking			
Paid EMS Providers*		Volunteer EMS Providers*	
1	Higher Wages	1	Ability to have State health benefits for all EMS professi..
2	Ability to have State health benefits for all EMS professi..	2	Participation in a State pension system (LOSAP or simil..
3	Participation in a State pension system	3	Stipend for Calls
4	Recognition as a health care profession (respect)	4	A life Insurance benefit for all EMS professionals
5	A life Insurance benefit for all EMS professionals	5	Recognition as a health care professional (respect)
6	Better leadership	6	Paid Academy-style training (earn as you learn)
7	Professional licensure	7	Better leadership
8	A well-defined career ladder	8	A well-defined career ladder
9	Improved Schedules	9	Professional licensure
10	Paid Academy-style training (earn as you learn)	10	Improved Schedules
The Rural Ambulance Service Task Force recognizes the need to improve recruitment and retention efforts in order to support the rural EMS provider workforce. For paid EMS providers, what benefits do you think would be most impactful in attracting and retaining people in careers in EMS in rural areas of NY?(Please rank from most impactful to least impactful with 1 being least impactful and 10 being most impactful) *Responses filtered to include only paid EMS providers		For volunteer EMS providers, what benefits do you think would be most impactful in attracting and retaining people as volunteers in EMS in rural areas of NY?(Please rank from most impactful to least impactful with 1 being least impactful and 10 being most impactful) *Responses filtered to include only volunteer EMS providers	

Summary of Proposals for Section C:

Proposal:	Declaration of a Public Health Emergency About Issues of Rural EMS
Task Force Priority:	#1, Immediate
Area:	Legislative/Regulatory
Current proposed legislation:	No

Description: A Declaration of a Public Health Emergency about Issues of Rural EMS should be declared to address the challenges facing Rural EMS and facilitate initiatives to stabilize the EMS System. This declaration will bring to the attention of local and state leaders the most important initiatives needed in order to enact Proposals from this paper and help in stabilization of the EMS systems throughout the state. The declaration should empower the appropriate bodies as needed, to have expedited contracting processes by counties and government agencies to facilitate initiatives listed in this document that are critical to system sustainability, prioritize statutory and regulatory changes needed to enact recommendations, and work to reduce hurdles that may otherwise take extended periods of time to implement.

Proposal:	Creation and implementation of an expanded ambulance service certificate specifically for the purpose of providing Interfacility (IFT) and Specialty Care (SCT) transports
Task Force Priority:	#14, Immediate
Area:	Systems
Current proposed legislation:	No

Description: The provision of Interfacility and Specialty Care is a critical component of the EMS system. There are rural areas in New York State that do not have an adequate number of commercial providers to fill the IFT/SCT needs. Thus, the creation of an IFT/SCT specific ambulance service certificate would benefit the rural areas of the state.

Proposal:	SEMAC and SEMSCO should develop, and promulgate, guidance regarding interfacility transfers that address priority levels and appropriate response levels.
Task Force Priority:	#15, Immediate
Area:	Systems
Current proposed legislation:	No

Description: Interfacility Transports (IFTs) and Specialty Care Transports (SCTs) are an often-overlooked component of the EMS system that take extended periods of time, even when crucial, thus further taxing a fragile system. Utilization of the NYS Surge Operations Center (SOC) could assist in logistics statewide.

As a component of this issue, New York State should incorporate nationally recognized Interfacility and Critical Care training designations for EMS practitioners engaged in these transports – these include, but aren't limited to, Critical Care Paramedic Certified (CCP-C). Flight Paramedic Certified (FP-C), Critical Care Emergency Medical Transport Program (CCEMTP) and Community Paramedic – Certified (CP-C).

In addition, Medicaid reimbursement for IFTs of greater than 100 miles is insufficient to meet the expenses associated with this transportation and must be increased.

Proposal:	Create a set minimum wage for EMTs, AEMTs and Paramedics in New York State.
Task Force Priority:	#20, Intermediate
Area:	Funding
Current proposed legislation:	No

Description: There is no specific minimum wage for EMTs, AEMTs and paramedics in New York State. Utilizing the example of the establishment of minimum pay scales for Certified Nursing Assistants (CNA) in both urban and rural areas of New York State, the Bureau of EMS must work with the New York State Department of Labor (NYS DOL) to develop a minimum wage for EMTs, AEMTs and paramedics in both rural and urban areas. This is required to stabilize the EMS workforce. These are the recommended minimum wages - EMT 1.75 times the local or state minimum wage; AEMT/EMT-CC 2.0 times the local or state minimum wage; paramedic 2.5 times the local or state minimum wage.

Proposal:	Fund and task the Bureau, in coordination with the SEMSCO, to create standards related to EMS leadership positions that are like that of the New York State Fire Service.
Task Force Priority:	#23, Intermediate
Area:	Leadership development
Current proposed legislation:	No

Description: Leadership standards are practically non-existent and there is a definitive need for standards specific to EMS agencies supervisory/managerial and executive level and rank positions.

Proposal:	Fund and task the Bureau with the development of leadership training programs.
Task Force Priority:	#24, Intermediate
Area:	Leadership development
Current proposed legislation:	No

Description: As the challenges facing EMS agencies increase, leadership coursework and professional development needs to be developed. This includes coursework in critical areas such as human resources, managerial acumen, and decision-making. The Bureau should be the leader on professional development initiatives that include, but are not limited to:

- Professional development for EMS practitioners
- Field Training officer courses
- Leadership training for all levels of EMS management

Development of said programs will also assist with an EMS career ladder and defined steps in growth.

Proposal:	As a part of the Healthcare System, EMS representation/professional relationships on various professional bodies that make decisions related to the practice of EMS must increase.
Task Force Priority:	#28, Intermediate
Area:	General
Current proposed legislation:	No

Description: In general, EMS lacks representation on, and with, other professional bodies who may make determinations impacting EMS systems. With representation we could potentially work more collaboratively to positively impact future EMS initiatives, while, at the same time, allowing for the promotion of synergy and political goodwill.
Some examples include:

- The New York State Association of Counties
- The Legislative Commission on Rural Resources
- Interaction with Firefighters Association of the State of New York (FASNY) and Fire Districts
- The New York State Association of Towns
- State Interoperable and Emergency Communication Board
- Hospital associations (HANYS, GNYHA, etc.)
- Public Health and Health Planning Council (PHHPC) /other boards

Proposal:	Redesign the EMS educational system to be more accommodating to students as well as ensure a steady supply of Instructors.
Task Force Priority:	#30, Intermediate
Area:	Educational
Current proposed legislation:	No

Description: These changes must include increased awareness of EMS (CFR, EMT, AEMT and paramedic courses) as well as no cost access to CFR and EMT courses. Assuring access to CFR courses in High Schools and EMT Courses in Technical Schools (BOCES) as well as 2 and 4-year Colleges and Universities. We must increase funding to Course Sponsors and develop systems to increase the pool of EMS Education instructors.

The use of prior learning assessments (PLA) to award appropriate college credits must also be developed. Also, the RASTF recommends that the Bureau work with the New York State Education Department (SED), to create micro-credentialing programs to assist EMS practitioners in advancing their education and credentials.

Proposal:	Fund a three-year, $5 million campaign to promote EMS volunteerism and careers in New York State through an "EMS – About Us" campaign
Task Force Priority:	#32, Intermediate/Long-term
Area:	Funding
Current proposed legislation:	No

Description: As the number of active EMS practitioners continues to decline for a variety of reasons, there is a need to promote EMS throughout the state. The "EMS - About Us" campaign will serve the dual purpose of both building awareness among the public as well as providing departments with the tools and resources to recruit and retain EMS practitioners. This effort will need a dedicated funding stream.

Proposal:	The RASTF recommends the development of a Paramedic Urgent Care (PUC) system to mitigate various rural-area specific EMS issues.
Task Force Priority:	#34, Long-term
Area:	Operations
Current proposed legislation:	No

Description: Rural areas have a lack of urgent care facilities which leads to a gap in medical care. The development of paramedic staffed urgent care, that partners with telemedicine providers, as a demonstration project with appropriate funding, incorporates out of the box thinking for the utilization of ALS practitioners while also serving a need in rural areas.

Proposal:	SEMSCO should develop standardized nomenclature for various areas of EMS to allow for better understanding and bring forth proposed changes to General Municipal Law by modernizing terminology.
Task Force Priority:	#37, Long-term
Area:	Systems
Current proposed legislation:	No

Description: There are various terms utilized to describe EMS agencies across the state. These include, but are not limited to, "*First Aid Squads*", "*Rescue Squads*", "*Emergency Squads*", "*Ambulance Corps*", and just "*EMS*". In understanding the need for a unified voice in EMS, as well as to assure the public understands and recognizes our mission, it is important that all use the same terminology. To effect this change areas of General Municipal Law will need to be updated.

This is also applicable to the various categories of EMS practitioners with a shift needed to use the general terms of "*EMS Practitioners*" or "*EMS Clinicians*".

Proposal:	Address Diversity, Equity, Inclusion, and Accessibility (DEIA) Realities
Task Force Priority:	#38, Long-term
Area:	General
Current proposed legislation:	No

Description: EMS agencies should reflect the diversity of the population they serve and implement DEIA initiatives to ensure this is accomplished EMS has historically had challenges in recruiting and retaining persons of color (POC) as well as women and, in general, has not excelled in being representative of the communities EMS agencies serve. Diversity, equity, inclusion, and accessibility (DEIA) is a relatively new frontier for many EMS agencies and one that includes a steep learning curve.

SECTION D:

(d) Studying any other issue such task force deems relevant.

Additional Areas of Concern:

Several additional areas of concern impacting the rural EMS system in New York State were brought to the attention of the Rural Ambulance Services Task Force (RASTF), each requiring careful consideration and targeted recommendations.

1. **Outdated Structural Design - Oversight and Structural Alignment:**

   The current EMS system design is not aligned with other regions created by different state initiatives. One significant Proposal involves realigning EMS Regions to match the structure of the Regional Economic Development Councils (REDCs) even if it was to mean that several regions would be wholly within one REDC. This would create a more cohesive and strategically aligned system across regions. Additionally, there is a need to modernize the roles of Regional EMS Councils and Program Agencies to enhance their effectiveness, increase possible funding opportunities and expand their integration within the broader health and emergency response landscape.

2. **Gaps in Meeting Patient Needs - Operational Opportunities:**

   On the operational front, modifications to several Basic Life Support (BLS) treatment protocols are essential to ensure that EMS providers can deliver the most effective and up-to-date care in rural areas. Furthermore, rural EMS agencies must play a greater role in addressing the opioid crisis by being fully incorporated into the state's efforts to combat overdoses.

3. **Lack of Funding and Sustainability - Dedicated Funding and Support:**

   Many EMS agencies are facing increasing operational and financial sustainability issues due to a lack of funding models to sustain the increasing costs and community needs. To ensure the sustainability of rural EMS agencies, we recommend the creation of EMS-specific funding streams, such as those available through the Staffing for Adequate Fire and Emergency Response (SAFER) grants. Additionally, hospitals should have dedicated administrative staff responsible for collaborating with EMS agencies, ensuring smoother operations and communication between EMS and healthcare facilities.

4. **Lack of Focus on Needs of Rural EMS - Continuity of the Task Force's Work:** The work of this task force has shown the significant need to have a group of dedicated professionals from rural EMS agencies to focus on the needs of our rural communities. The critical work of the RASTF must continue, both in identifying the multitude of challenges facing rural EMS in New York State and in developing actionable Proposals to resolve these issues. The ongoing efforts of the Task Force will be vital to the future of rural EMS services and the health and safety of rural communities.

Summary:

The issues identified related to Section D, and the Proposals listed below, highlight key areas of concern and potential solutions for improving the rural EMS system in New York State. Proposals include better aligning EMS regions with state economic development councils, updating BLS treatment protocols, integrating EMS into the fight against overdoses, and securing dedicated EMS funding. Additionally, the continued work of the RASTF is crucial to address ongoing challenges and sustain rural EMS services moving forward.

Summary of Proposals for Section D:

Proposal:	Allocate personnel and resources to the Bureau to support rural EMS initiatives, agencies, and systems
Task Force Priority:	#13, Immediate
Area:	Systems
Current proposed legislation:	No

Description: The Bureau must have the personnel and resources to handle the rural EMS crisis. This includes, but is not limited to, a communications director, a rural EMS lead and support staff dedicated to SEMSCO and SEMAC initiatives. The Bureau needs additional funding to modernize its data collection and analysis capabilities as well as its technological footprint. This includes, but is not limited to, the modernization of the Bureau website to make it more user-friendly and communications technology that all can use (via an app), which will enhance communication between the Bureau and EMS leadership as well as between EMS agencies, for the purpose of collaboration. Lastly, the procurement of electronic data collection tools will allow for a move away from paper documents, thus allowing for additional data capture and analysis.

Proposal:	Align the current EMS Regions with Regional Economic Development Councils (REDC's)
Task Force Priority:	#18, Intermediate
Area:	Systems
Current proposed legislation:	No

Description: To maximize the efficiency of the various regional entities that are carved out in statute, there are potential opportunities in aligning the Regional EMS Councils with the 10 New York State Regional Economic Development Councils for the purposes of funding and workforce development (Note that more than one Regional EMS Council can potentially be in a Regional Economic Development Councils).

Proposal:	Redefine the role of the Regional EMS Councils and Program Agencies in the EMS system
Task Force Priority:	#25, Intermediate
Area:	Legislative/Regulatory
Current proposed legislation:	No

Description: The Regional EMS Councils and Program Agencies are foundational elements in the New York State EMS system - their roles need to be modernized to include coordination of regional educational initiatives, daily operations guidance for EMS agencies, protocol oversight, system collaboration, and interaction with County EMS Coordinators. Regions and Program Agencies are encouraged to ensure the education, and utilization of, AEMT's to enhance the tiered response system. These changes would also entail a commensurate increase in the funding given to these regional entities.

Proposal:	SEMAC and SEMSCO should review and, where appropriate, modify medical treatment protocols with the focus on higher BLS unit utilization and increased use of BLS adjuncts. Ensure that BLS practitioners are provided guidance with the managing of patient care when ALS resources are not available.
Task Force Priority:	#26, Intermediate
Area:	Operations
Current proposed legislation:	No

Description: In order for the tiered EMS system to achieve optimization, protocols should be developed which maximize BLS units. This could potentially go a long way towards addressing the over-reliance on paramedics. In addition, policies should be developed for BLS practitioners that sometimes the closest ALS is the hospital AND that they should not delay transport waiting or looking for an ALS resource. In addition, the Bureau should review and standardize the various policy statements regarding BLS adjuncts.

Proposal:	County EMS Medical Director Coverage - The Counties should ensure county EMS medical director coverage either by contracting with existing services or by the development of a County Medical Director position. This "County EMS Medical Director" position will have either direct, or shared, oversight of all clinical areas of EMS agencies.
Task Force Priority:	#27, Intermediate
Area:	Operations
Current proposed legislation:	No

Description: The County EMS Medical Director position should at least be partially funded by the State and would have specific deliverables to be developed in conjunction with the Bureau of EMS and Trauma Systems and the State EMS Advisory Committee.

Currently, many smaller rural agencies are unable to pay an EMS medical director for their services or they may not understand the valuable role a medical director can have in their clinical care. The establishment of a county EMS medical director will provide another option for small, rural agencies with limited funding the access to this important piece of clinical care.

Proposal:	EMS systems are actively involved in the substance use disorder (SUD) crisis and should be assured that they have the resources to respond.
Task Force Priority:	#29, Intermediate
Area:	Operational
Current proposed legislation:	No

Description: As the number of overdoses is ever-increasing, EMS practitioners serve a critical role in responding to opioid overdoses for individuals living in rural or remote areas.

EMS agencies must continue to be incorporated into the fight against opioids through the *Naloxone Leave Behind* program (such as the one seen in the REMO Region) as well as drug testing and buprenorphine programs to bridge an existing treatment gap related to substance use disorder (SUD).

Proposal:	There is a necessity to extend the deadline for the NYS Rural Ambulance Services Task Force as a Legislatively developed charge. There is a need for the work of the Rural Ambulance Services Task force to be funded and continued.
Task Force Priority:	#31, Intermediate
Area:	Operations
Current proposed legislation:	No

Description: The issues facing the Rural EMS system in New York State are myriad and will not simply go away. Issues such as adequate reimbursement and the overall funding of the EMS system, future directions for various policy initiatives, lengthy hospital wait times and workforce scarcity have all been documented by the Rural Ambulance Services Task Force and need significant action if the system is to survive.

The RASTF is in a unique position, appointed by elected officials and tasked with providing a report directly to those officials; we are a governmentally created body which allows us, outside of the SEMCO and the Bureau, to effectively evaluate and provide Proposals to our elected officials on the topic of EMS.

Proposal:	EMS System Performance Audits - Create legislation for municipalities to conduct 5-year audits of their EMS system performance.
Task Force Priority:	#33, Intermediate/Long-term
Area:	Operations
Current proposed legislation:	No

Description: To enhance standards for EMS in New York State, the RASTF asks that the NYS legislature, in conjunction with Bureau of EMS as well as SEMSCO, to find a long-term funding source to assist with municipalities to conduct 5-year audits on EMS performance, including areas of improvement, within their geographical coverage area.

Proposal:	The RASTF calls on federal and state partners to establish EMS-specific funding like the Staffing for Adequate Fire and Emergency Response Grants (SAFER) grant
Priority:	#35, Long-term
Area:	Funding
Current proposed legislation:	No

Description: The SAFER grant was specifically created "to provide funding directly to fire departments and volunteer firefighter interest organizations to help them increase or maintain the number of trained, front-line firefighters available in their communities"[6]. Similarly, as EMS agencies find themselves in extreme circumstances regarding workforce, there is a need for grants such as this one and they should be inclusive of all EMS agencies.

Proposal:	Hospitals need to have dedicated staff, at the administrative level, who work with EMS agencies to facilitate Interfacility & Non-Emergency transport.
Task Force Priority:	#36, Long-term
Area:	Operations
Current proposed legislation:	No

Description: The work involved in the hospital/EMS agency communication and coordination is intricate and critical. As this relationship is essential, it is essential that each hospital in New York State be required to have a staff member designated as the EMS Outreach Coordinator/Ambulance Discharge Coordinator to facilitate day-to-day communication, planning, and collaboration, as well as quality assurance feedback, with ambulance services.

[6] Staffing For Adequate Fire and Emergency Response (SAFER)

OVERVIEW AND BACKGROUND OF EMS IN RURAL COMMUNITIES

Emergency Medical Services (EMS) fulfills a critical role in rural areas across the United States. Every year, nearly 10 million rural Americans receive EMS care. There are 23,272 EMS agencies in the United States, with 73 percent of those agencies serving rural areas, yet universal access to requests for emergency medical service is in jeopardy in rural areas where people live, work, or recreate. Every day, we see new headlines across the nation on topics affecting the EMS system; including staffing shortages, the decline of volunteerism, stagnant reimbursement, hospital over-crowding, inadequate coverage, use of mutual aid, pay disparities, absence of consistency in the EMS model and the lack of EMS educational opportunities.

New York State is no exception to these trials and tribulations with access to timely and appropriate emergency medical care in various rural areas in jeopardy of complete collapse. New York State's rural areas are incredibly expansive; 43 out of the 62 counties in New York State are considered rural and 30 of those 43 counties cover more than 1,204 square miles each. In addition to rural counties, there are many communities in New York State that qualify as rural and are experiencing the same challenges as the counties. For the purposes of this paper, we will define "rural" as counties with fewer than 200,000 residents or towns with fewer than 200 persons per sq/mi (New York State Office of Rural Health). In addition, the Centers for Medicare & Medicaid Services (CMS) uses or recognizes the term "super rural" when referring to the bottom quartile of nonmetropolitan ZIP codes by population density and the term "Frontier" is used by the Health Resources and Services Administration (HRSA) and other federal agencies. (Hamilton County is the only county that meets the federal definition of frontier but there is no specific state designation for this).

With the rural area designation comes a rapidly aging population with its own specific health and socioeconomic issues. The populations living in these areas are impacted by decreased access to health care, the prevalence of food desserts, and lower rates of broadband service.

In rural areas, where transport times to the nearest definitive medical care are generally longer, a fully optimized and modernized EMS system is crucial to ensuring good patient outcomes. Studies have shown a direct correlation between shorter ambulance response times and increased survival in cardiac arrests that happen at home. Due to workforce shortages, inadequate public financial support, increasing costs, and inadequate reimbursement rate, it is becoming increasingly difficult for EMS to respond to calls for service in a timely manner.

Many rural EMS agencies in New York State, and the United States as whole, are in immediate operational jeopardy because they are unable to cover their operational costs, largely due to insufficient insurance reimbursements and lack of public financial support. Although private insurance typically reimburses at a higher rate than Medicaid, EMS agencies are still unable to make up the difference due to low call volumes in rural areas. It is critical to note that these reimbursements only cover, on average, about one third of the operational costs which must go

to paying to maintain existing equipment and vehicles, stock medications, purchase new equipment and pay for insurance and fixed expenses. One of the foundational elements behind this is that, from a reimbursement perspective, EMS has traditionally been and continues to be considered a transportation benefit as opposed to a treatment benefit - there is a necessity to change this model to one where EMS agencies are funded for the cost of readiness. In addition, these payments do not typically cover calls where patients are assessed and treated, but not transported (two examples include diabetic patients where medication is administered and overdose patients where naloxone is administered).

Insurance payments only cover charges related to transporting patients, but not for vital, yet underappreciated, expenses related to what is referred to as the *cost of readiness.* EMS agencies are expected to be prepared to respond to an emergency at every minute of the day. To meet these goals, EMS agencies must have personnel and ambulances available that are not already on emergency calls. An EMS agency does not create revenue for "being ready" and, similarly, insurance payers do not reimburse for this specific cost. This must be accounted for in any discussion about adequately funding the EMS system. This strategy is like fire departments always being ready, with personnel and vehicles, to respond to emergency calls.

There are a myriad of challenges facing EMS in rural America. Rural Americans are often older and sicker than their urban counterparts due to ease of access and issues with affordability creating unique challenges for EMS practitioners. Rural areas are less likely to have broadband coverage, reducing the opportunity for telehealth. This issue is compounded by the increasing distance between and availability of primary care providers, hospitals and specialty centers such as trauma centers, stroke centers, and the like.

The EMS system in New York State should align with the EMS Agenda 2050 in being people-centered, adaptable and innovative, sustainable and efficient, socially equitable, reliable and prepared, integrated and seamless as well as inherently safe and effective.

To achieve this vision, EMS systems in 2050 will be designed around six guiding principles.

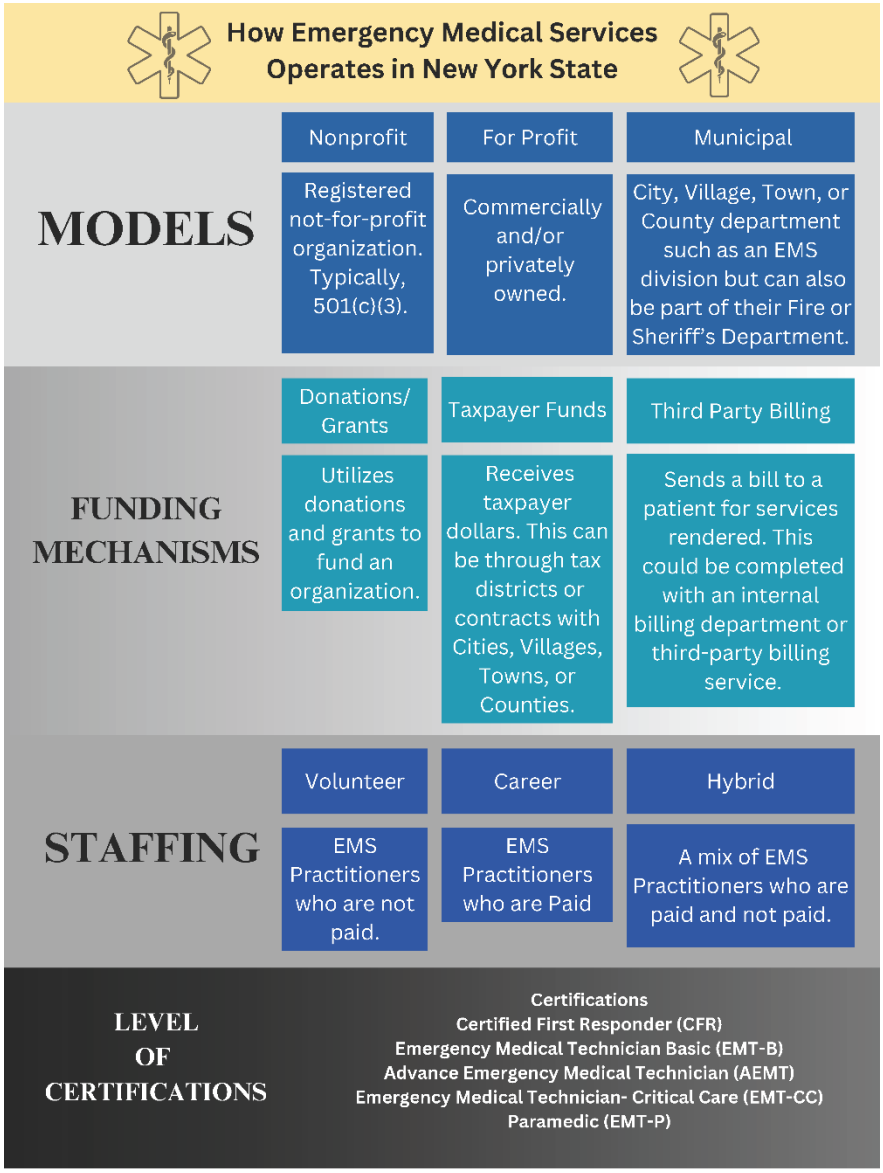
These principles provide a framework for addressing the most critical aspects of developing a people-centered EMS system. By considering the future of EMS through the lens of these principles, the EMS profession can imagine how the individual attributes of an EMS system—described by our predecessors in the original EMS Agenda for the Future—fit together to create a people-centered system.

Similarly, New York State must be consistent with the National Emergency Medical Services Advisory Council's EMS Star of Rights as our EMS system needs to be essential, funded, equitable, excellent, desirable, and organized.

EMS IN NEW YORK STATE

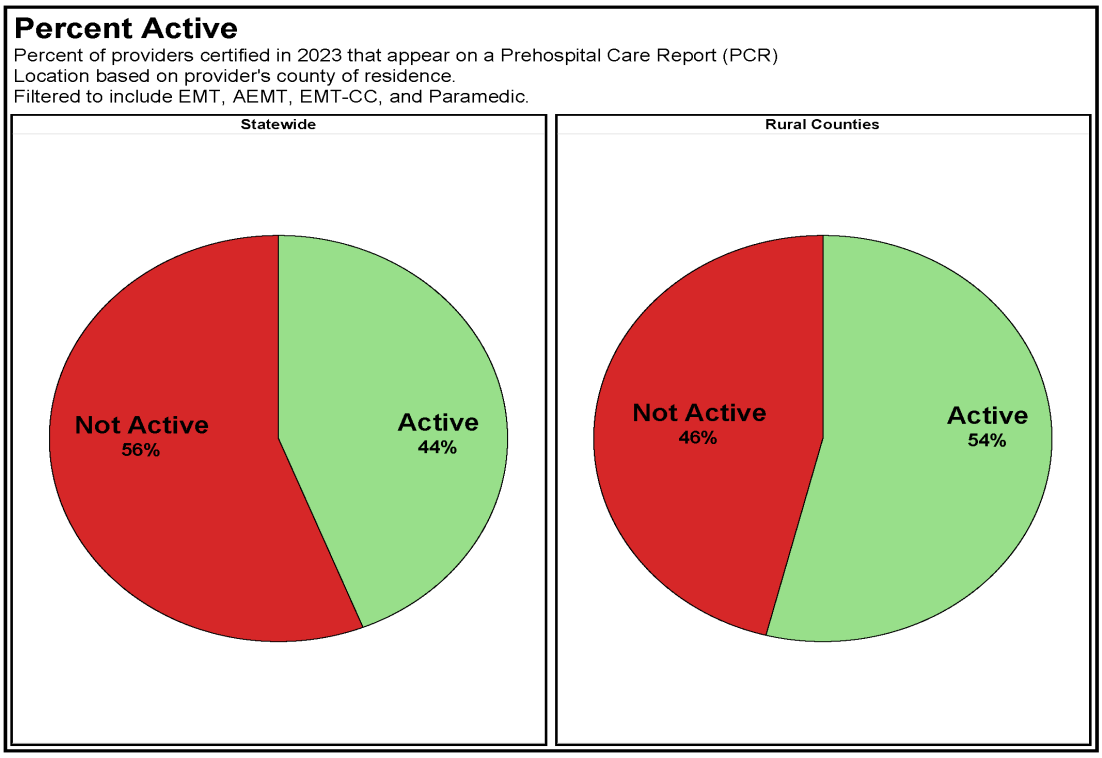
Historically, the backbone of rural EMS systems in New York State was based on the volunteer model; with communities realizing the need for EMS Systems and building those systems, often without the need for local government involvement. Many independent ambulance services were formed mostly by fund raising. As our healthcare needs expanded, visionaries and entrepreneurs entered the system and expanded the role of commercial EMS agencies to supplement the volunteer system. Municipalities and hospitals also entered the industry to provide EMS service.

Currently, in New York State, emergency medical services (EMS) are delivered through an assortment of public and private entities including for-profit, non-for-profit, municipal, volunteer, fire-based, hospital-based, and others with a wide variety seen regarding funding mechanism, staffing levels, and even levels of services they provide (see chart below).



EMS agencies in New York State's rural areas face the same, or similar, daunting challenges as other rural EMS agencies across the country. These challenges are exacerbated by changing workforce demographics, a struggling economy, and diminishing reimbursement. In the 2024 State of the State Report, as well as in the previous two annual State of the State messages, Governor Hochul highlighted various challenges facing the EMS system including the need for EMS to be deemed an essential service, the decline seen in the EMS workforce and the need to increase EMS insurance reimbursements.[7]

According to a 2019 report titled *"EMS Workforce Shortage in NYS: Where are the Emergency Medical Responders?"* from the New York State EMS Council and the Hospital Association of New York State (HANYS), both career and volunteer emergency medical service agencies in New York State are struggling to cope with a growing shortage of certified EMS responders.8 In 2023, only 44% of the certified EMS practitioners in New York State were actively providing care in the pre-hospital environment (see below). This mirrors the substantial number of EMS agencies reporting an impaired ability to respond to calls for service due to shortages of active certified EMS practitioners. This is true for agencies that utilize volunteer responders, as well as those that use career responders. Information collected from a Rural Ambulance Services Task Force-initiated survey showed that respondents had an unfavorable outlook on their agency's ability to recruit the workforce necessary to adequately serve their community in the future.



Source: New York State Department of Health, Bureau of Emergency Medical Services and Trauma Systems

[7] Governor Kathy Hochul, 2024 State of the State Report
https://www.governor.ny.gov/sites/default/files/2024-01/2024-SOTS-Book-Online.pdf

[8] https://ubmdems.com/wp-content/uploads/2020/01/Download-2019-NYS-EMS-Workforce-Report.pdf

Some of the reasons behind this severe workforce shortage include:

- A decline in the number of new volunteers to replace long-time volunteers aging into retirement.
- Limited new volunteers due to increased responsibilities, work/life balance, people not living where they work and/or people who just can't afford to volunteer.
- Low wages for career EMTs and paramedics, especially given the tremendous responsibilities that come with the job. These wages are simply not comparable to similar fields such as Police Officers, Firefighter's, and the nursing industry.
- Limited capacity to raise wages as the result of the negative fiscal outlook facing most ambulance services.
- A need for additional EMS practitioners to meet increasing response demands for ambulance services due to aging communities, surges in drug and alcohol abuse, upward trends in facing patients with behavioral health challenges, and growing chronic care needs associated with the rural population's decreasing access to healthcare.

According to the SEMSCO/HANYS report, rural New York State EMS agencies face a grim reality with alarming statistics. These include:

- **59% of rural volunteer responders** reported their ability to provide timely EMS responses in their community was moderately or severely impaired by certified volunteer staff shortages.
- **68% of rural agencies** using only paid responders reported that the shortage in the number of qualified paramedics diminished their ability to cover calls or scheduled shifts. Similarly, **46%** reported that the shortage of qualified EMTs diminished their ability to cover calls or scheduled shifts.
- **59% of rural agencies** utilizing only paid responders reported an increase of more than 11% in paid overtime hours over the last two years to compensate for responder shortages.
- **68% of rural respondents** had an unfavorable outlook on the future of responder recruitment.

Another seminal document, the *NYS 2023 Evidence Based EMS Agenda for the Future*, further outlined that the New York State EMS system has markedly deteriorated in recent years due to declining volunteerism, lack of public funding to cover costs of readiness, inadequate staffing, rising operational costs, insufficient insurance reimbursement and, rising call volumes[9]. This report highlighted that a lack of EMS-specific performance standards, a poor understanding of the EMS system by elected officials and the public, New York State home rule, and the lack of transparency and accountability for EMS agencies negatively impact EMS as a whole.

[9] https://www.health.ny.gov/professionals/ems/docs/february_2023_sustainability_tag.pdf

That report went on to document that multiple ambulance services have closed their doors in just the past several years, and many of those that remain open are unable to respond to emergency calls in any consistent fashion. The paper concluded that although EMS was originally established as a transportation provider, EMS has evolved over time to encompass elements of healthcare, public safety, disaster response mitigation, and public health. **Today, EMS is an unanticipated safety-net provider of pre-hospital healthcare, to all patients regardless of their ability to pay for services.**

The New York State Rural Ambulance Services Task Force has engaged in various endeavors to involve New York State EMS practitioners, agencies, and stakeholders in its efforts to address the circumstances now being faced. This included, but was not limited to, the development and distribution of a survey for EMS practitioners to contribute their thoughts, as well as the hosting of Town Hall meetings to collect additional input and data related to the various issues and challenges facing rural EMS agencies and practitioners.

To address the myriad significant issues revealed to be debilitating rural EMS agencies and practitioners, there must be a coordinated, concerted effort to take the various Proposals developed by the Task Force and turn them into necessary and impactful governmental action.

SECTION A: DETAILED EXPLANATIONS OF KEY PROPOSALS

(a) An analysis of the total number of ambulance services available in rural areas of the state, provided by service type and geographic region they serve and compared to the documented need for such services;

RESPONSIBILITY FOR, AND CREATION OF, THE COUNTY EMS SYSTEM (#4/#5/#6/#7/#8)

Unless a municipality takes financial responsibility for its EMS system, there is no mandate or accountability for the provision of EMS services, including the mandate to respond to all addresses within the primary operating area.

Thus, each County would become responsible for their County's EMS System with responsibilities to include:

- The development of a comprehensive County EMS Plan, inclusive of existing Ambulance Service Certificate holders.
- Enhancement of the County EMS Coordinator position.
- Ensuring the delivery of emergency medical services to all areas of their county.

The need exists for a well-funded, redesigned EMS system with foundational seed money (money to get the various initiatives/projects moving forward) that can be distributed among counties to improve the overall design and operational efficiencies of their EMS system. This could include, but not be limited to, county-organized, agency collaboration, consolidation and/or merging of EMS agencies. Recently, two other states with significant rural areas, specifically Maine and South Dakota, have infused similar funding into their systems in the form of stabilization and sustainability grants. There is a need for short-term grants specifically targeted to improve EMS system design at a County-level, inclusive of existing Ambulance Service Certificate holders, which may include agency mergers and consolidations, as appropriate. Additionally, these grants could be directed at any project or initiative that increases sustainability of the EMS system at the county level, further reinforcing the important role that counties play in the overall improvement and longevity of the EMS system.

This specific funding would allow for the costs of a mandated, full-time County EMS Coordinator with a specific set of deliverables. The County EMS Coordinator would be a part of the EMS system structure and integrated into the existing Bureau of EMS and Trauma Systems / Regional EMS Council / Program Agency reporting structure. To further substantiate this funding, the County EMS Coordinators would be responsible for creating and submitting a plan to address their current system and opportunities for improvement.

EMS agencies must be consistently in a state of readiness, that is having the ability to respond to an emergency at any minute of the day. To meet this goal, EMS agencies must have personnel and ambulances available that are not already on emergency calls. An EMS agency does not create revenue for being ready and, similarly, insurance payers do not reimburse for this specific cost. Similarly, the National EMS Advisory Council (NEMSAC) reported that EMS funding has mostly been centered on the transport of patients and there must be a shift to one based on performance and patient care services and the cost of readiness. This "State of Readiness" needs to be funded, and this issue must be addressed in any discussion about adequately funding the EMS system.

Similarly to other healthcare safety net providers, such as hospital emergency departments, a significant portion of the costs associated with EMS are directed towards achieving and maintaining readiness and to responding in a timely and effective manner. According to the Institutes of Medicine, "*EMS costs include the direct costs of each emergency response, as well as the readiness costs associated with maintaining the capability to respond quickly, 24-hours a day, 7-days a week.*"[10] These costs include 24/7 staffing levels based on call demand experience, response time reliability, level of service provided, competency training, costs of equipment and supplies, and administrative expenses. These costs are inherent in the delivery of service and must be adequately accounted for in the reimbursement models.

Regardless of the source, municipalities need to be responsible to ensure that sufficient funding is provided for the readiness of the EMS system that services the people of that community. The municipal responsibility should be a calculated amount based on the expected number of units that are ready to respond, and the total expected annual call volume based on historical data.

There are multiple potential sources for readiness funding through various fees and non-property taxes including, but not limited to:

- Cell Phone 911 tax
- County Ambulance Districts / Special Districts
- DMV registration fee
- Hotel tax
- Ski or sporting event tax
- Excise tax on items such as cannabis, alcohol, and tobacco
- Surcharge on traffic tickets

[10] NEMSAC Final Advisory EMS System Funding Reimbursement

The RASTF believes that the State should partially fund County-based EMS systems. Systems and agencies that achieve accreditation will receive additional funds.

The cost of providing EMS is a fluctuating and dynamic expense. Understanding and evaluating the cost of providing the service is essential to long term sustainability. The cost reporting initiative, already in progress with Medicare, should be utilized to regularly access payor rates.

The RASTF agrees with the findings of the New York State Evidence Based NYS Agenda for the Future report from 2023 which stated that through both statutory and regulatory changes, the Bureau should implement regionalized EMS demand coverage reliability standards and policies that require a transport capable ambulance be available to respond to calls for service within a clinically appropriate response time and level of service (BLS/ALS), inside an agency's Ambulance Service Certificate regulated corresponding area(s) of primary service responsibility.

Responsibilities of the County government would also include upstream reporting (e.g., Regional EMS Council, Program Agency, Bureau of EMS and Trauma Systems), public access to system reports, and, when feasible, the utilization and enhancement of existing resources within the county, including municipal, commercial, and non-for-profit or private agencies.

The creation of the local EMS system must be based on County Responsibility and include the following components:

- Use, and integration of, existing Ambulance Service Certificate holders, who meet public need.
- Mandatory emergency medical dispatching (EMD) utilization for all primary Public Safety Answering Points (PSAP) or secondary PSAPs dispatching EMS agencies.
- Clear authority and responsibility for the PSAPs to fill gaps and meet call for service demands by having the authority to dispatch the closest most appropriate resource.
- Tiered response EMS systems, which include first response, should be utilized to appropriately distribute resources, and ensure that transporting EMS units are appropriately dispatched and utilized. Specifically, tiered response models consisting of BLS transporting units and paramedic-level Emergency Ambulance Service Vehicles (EASV) (e.g., ALS Fly Car) may greatly increase response capabilities and create more resilient response systems by preserving ALS level care for when it is needed. This includes:
    - BLS and or ALS-First Response
    - BLS Ambulance with adjuncts
    - Advanced Life Support
    - Paramedic level care
- EMS Agencies need to be response ready (in-service with a known crew commitment). EMS agencies should not be in a position where crews are "toned out" to see if there are available members to respond. When this occurs, there is an unnecessary, often significant, delay in response or no response at all.

Other considerations should include:

- Higher utilization of BLS units.
- Paramedics in Emergency Ambulance Service Vehicles (EASV) (e.g., ALS Fly Car). The advantages of utilizing paramedics in non-transporting fly-car vehicles is multi-fold and includes the ability to utilize this resource more judiciously, reserving them for higher priority calls and potentially resulting in longer retention of paramedic personnel.
- Regions and Program Agencies are encouraged to utilize AEMT's to enhance the tiered response system.
- Implementation of Treat-in-place (TIP) and Transport to alternate destination (TAD) – see Proposal #12 for additional.

COUNTY EMS COORDINATORS (#9)

Interviews conducted with current County EMS Coordinators across NYS, along with supporting data, demonstrate there is no consistency regarding the position of County EMS Coordinator in New York State, including their overall responsibilities, qualifications, and salary.

The State must mandate and, at least partially, fund each County's EMS Coordinator, with part of the position responsible for being an engaged partner participant in the State EMS Task Force. The role of the County EMS Coordinator must be defined and include deliverables to the Bureau. In addition, this must be tied into each county creating and submitting a comprehensive County EMS plan. Lastly, there is a role for this position when the state EMS task force is activated.

UPDATE RELEVANT STATUTES AND REGULATIONS REGARDING COMMUNITY PARAMEDICINE (#16)

Community paramedicine (CP) is an umbrella term describing all the potential innovative and expanded roles that EMS can provide. There are various CP programs currently implemented by EMS agencies across New York State to address issues such as providing and connecting patients to primary care services, completing post-hospital follow-up care, integrating with local public health agencies, home health agencies, health systems, and other providers as well as providing education and health promotion programs and more.

It is recommended that Community Paramedicine be further expanded and utilized to better provide access to care in underserved rural areas. Some rural patients lack access to primary care and utilize 911 and EMS to receive healthcare in non-emergency situations. This creates a burden for EMS and healthcare systems in rural areas.

The utilization of Community Paramedics in a public health and primary care role addresses the needs of rural residents in a more efficient and productive manner. By limiting inappropriate and unnecessary use of transporting EMS resources, the chances of such resources being available

for when they are truly needed increases. This improves access to care for both non-emergency and emergency situations.

IMPROVE DATA COLLECTION AND CREATE ADDITIONAL PERFORMANCE STANDARDS (#17)

Currently, there is a lack of mandatory EMS system standards for EMS agencies to be held accountable to and, at the same time, benchmark from.

The Bureau, in conjunction with the SEMSCO, must create additional standards requiring EMS agencies to report and meet, including:

- Determination of mandatory call response in primary response area/assurance of adequate coverage.
- Tracking Agency response times.
- Monitoring response percentage tied to call volume.
- Developing EMS agency onboarding/orientation standards.
- Establishing Agency safety requirements.
- Requiring Annual Cost reporting.
- Providing Public transparency (local govt, counties, regions, etc.).
- Reporting all calls which the agency is dispatched to and does not respond to.
- Continuous Monitoring and Evaluation
    - Implement a robust monitoring and evaluation system to assess the progress of the comprehensive EMS approach.
    - Regularly review key metrics to track improvements and identify areas for further intervention.

In addition, there are several areas where standards are necessary and currently lacking – these include:

- Call processing time
- Chute time
- % of calls an EMS agency must respond to
- Onboarding standards
- Leadership standards
- Safety standards
- Staffing standards (number of staff per volume / geography)
- Public education and community engagement.

It is difficult, if not impossible, to evaluate what is not measured and there are currently no clear requirements for EMS agencies to report calls on which they are dispatched to and are unable, or choose not, to respond to. With this and other potential data gaps in mind, the Bureau/SEMSCO should create a SEMSCO committee on data to further investigate the gaps in data gathering as well as to investigate how to better utilize our data for supporting public health and other professional areas. This Proposal also includes updating databases to more modern technology platforms.

Presently, there are no enforceable ambulance/EMS standards in NYS. To enhance standards of EMS in New York State, a multi-tiered NYS version of accreditation for EMS should be established (like Public Health Accreditation), with a series of capabilities outlined to be met through incentivization, as opposed to punishment. Agency accreditation supports sustainable use of resources and fiscal responsibility. EMS agencies should be incentivized to seek out and maintain accreditation by requiring commercial payors, as well as Medicaid, to increase payment by 3%, and increased state funding, for agencies holding accreditation.

It is important to note that Section 3004 of Article 30 legislated for the creation of these performance standards and this is an area that is currently being worked on by SEMSCO. These accreditation standards could be tied to increased reimbursement rates, additional funding, or additional grant opportunities.

SECTION B: DETAILED EXPLANATIONS OF KEY PROPOSALS

(b) Assessing current reimbursement structures in place for ambulance services as well as various methods to fund or otherwise raise revenue for such services;

DECLARING EMS AS AN ESSENTIAL SERVICE WITH SPECIAL TAXING DISTRICTS (#2)

The Legislature and Governor must advance current proposed legislation to make EMS an essential service available to every person in New York State in a reliable manner. This will ensure that the provision of EMS is the responsibility of a governmental agency. This includes modification to the opening paragraph of subdivision 1 of section 122-b of the general municipal law (NYS GML) to specifically declare that general ambulance services are an essential service, as are the provisions of police and fire protection.

This legislation must require that, in every community, there be a designated government entity responsible for:

- ensuring adequate funding for EMS response and readiness
- ensuring the EMS service provided meets New York State performance standards.

There is currently legislation proposed regarding this specific Proposal and the RASTF feels that making statutory changes to establish EMS as an essential service in New York State and ensuring that every county within NYS has the necessary resources, trained personnel, and operational capabilities to provide medical emergency response is a matter of public interest and state priority. It is imperative to standardize the approach to EMS and dispatch services to ensure an appropriate response and enhance the quality of care, maximize efficiency, and improve outcomes. The designation of EMS as an essential service will ensure a uniform, effective, and coordinated response.

REMOVAL OF TAX LEVY/EMS SYSTEMS OPERATIONAL EFFICIENCY (#3)

Collaboration and integration of EMS resources within a county is necessary to ensure and maximize response capabilities, be operationally efficient and benefit from economies of scale. Simply put, not every Town, Village or municipality can afford their own system, which leads to the call for the creation of County based EMS systems utilizing existing resources. Through engagement with existing services who currently meet (or who contractually agree to enhance their performance to meet) public need, which may consist of not-for-profit volunteer and hybrid (volunteer and career), municipal, proprietary, fire based, hospital, faith-based and collegiate, it is recommended that a comprehensive county-wide EMS response plan be established that includes and addresses the following:

- A written agreement organized by the county that includes all existing EMS agencies within the county. The agreement is to include:
    - A comprehensive response plan designed to respond to all requests for EMS.

    - Mutual Aid Response plans that provide depth and clear guidance to Public Safety Answering Points (PSAPs).
    - Relocation and pre-staging of EMS resources that have the ability and flexibility to provide gap-coverage, aid in improving response times, and aid in providing equitable EMS coverage and support to all areas and EMS partners within the county.
    - PSAP's having the authority to effectively dispatch the closest most appropriately staffed resource to calls for service.
- The countywide EMS response plan should include one (1) Public Safety Answering Point (PSAP) center that serves as a common point of communication for EMS agencies within the county.
- The use of Automatic Vehicle Location (AVL) technology should be encouraged to enhance system status management.
- This would also add to an increase in buying power and a reduction in overall equipment costs.

We must create a safety net, system of systems architecture to direct EMS organizations that are unable to support themselves into a consolidated and coordinated regional entity for shared services and economies of scale or implement a regional mechanism to provide an independent secondary safety net service that can adequately provide fully functional ambulance services when the primary organization is unable to do so.

It is recommended that rural counties have countywide EMS response plans in place that involve regularly relocating resources to cover gaps in the county system. There should be a PSAP center that serves as a central point of communication for EMS agencies within the county and provides direction, in conjunction with the county EMS coordinator, to ensure the countywide response plan is executed. It is critical that PSAP's be constantly aware of the "in service" ambulances within the county. This will ensure that an adequate number of resources are available based on the anticipated call volume. It is recommended there are agreements in place with the existing agencies within the county to relocate and post EMS resources where and when needed. Relocating and pre-staging resources will improve response times to the portions of the county where resources are depleted. If not enough of the existing services and/or resources are able to participate in a countywide response plan, the county should take the necessary steps to add additional resources to supplement the countywide system. This may involve providing additional financial support and resources to the existing services within the county to offset the costs associated with increasing resources and staffing.

The advantages of a county-based system are that it ensures minimum capability across the state while also having the flexibility to tailor EMS systems to the diverse geography of New York State. It also provides the public with equal access and meets public expectations, ensuring public health and safety.

To allow for additional financial flexibility, we should exclude emergency medical services from the limit on real property tax levies by local governments (2% tax levy) for the purpose of establishing County EMS systems for 10 years. There is a need for legislation that exempts EMS services from the real property levy, allowing local municipalities to expand and better support their local EMS services. This legislation would help municipalities fund and support EMS districts without having to worry about property tax cap compliance and the associated penalties to citizens.

CONTINUOUS EVALUATION OF MEDICAID RATES (#10)

Approximately 37% of the people in New York State are covered by Medicaid and there is a definitive need to improve the timeliness and consistency in reviewing Medicaid rates for EMS to assure that these rates reflect the realistic costs associated with delivering EMS services[11]. This review could be on an annual or biennial basis.

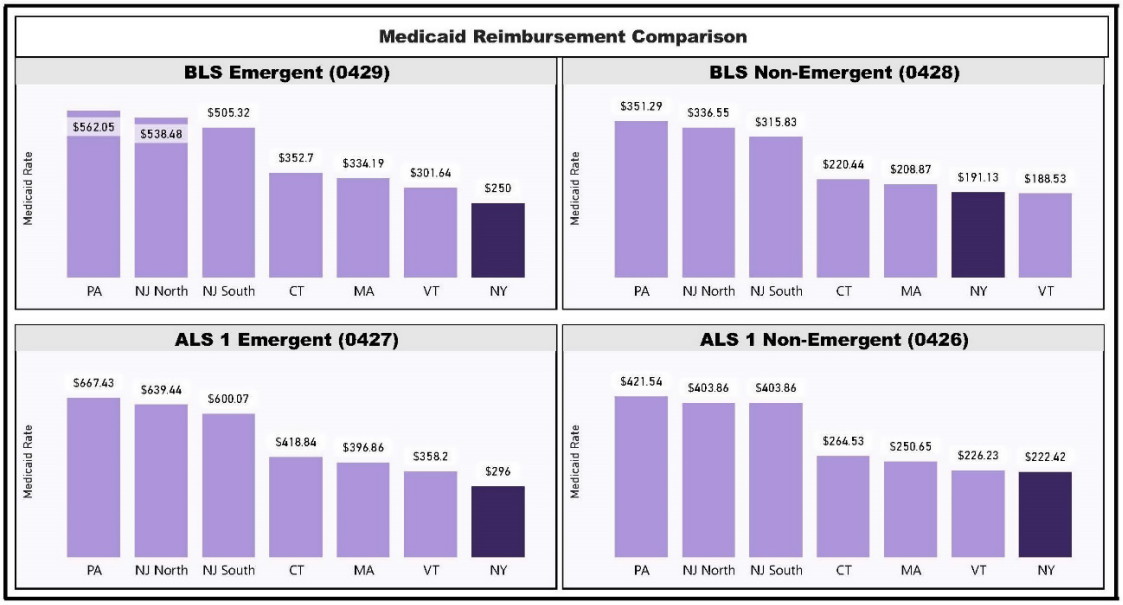
As a corollary to this, EMS agencies will be required to complete, and report to, the Bureau a cost-reporting exercise periodically which will include, but not be limited to; expenditures, revenues, utilization, and other departmental statistics as requested. This could mirror Medicare's (CMS) Ground Ambulance Data Collection System (GADCS) for use in evidence-based adjustment of ambulance reimbursement under Medicaid, municipal subsidies, and other sources of justifiable revenues. The data obtained by the Bureau will be made available to the New York State Department of Health Office of Health Insurance Programs, to be used as part of the continuous review of Medicaid reimbursement rates. This cost-reporting will be available to the municipalities that the EMS agencies serve.

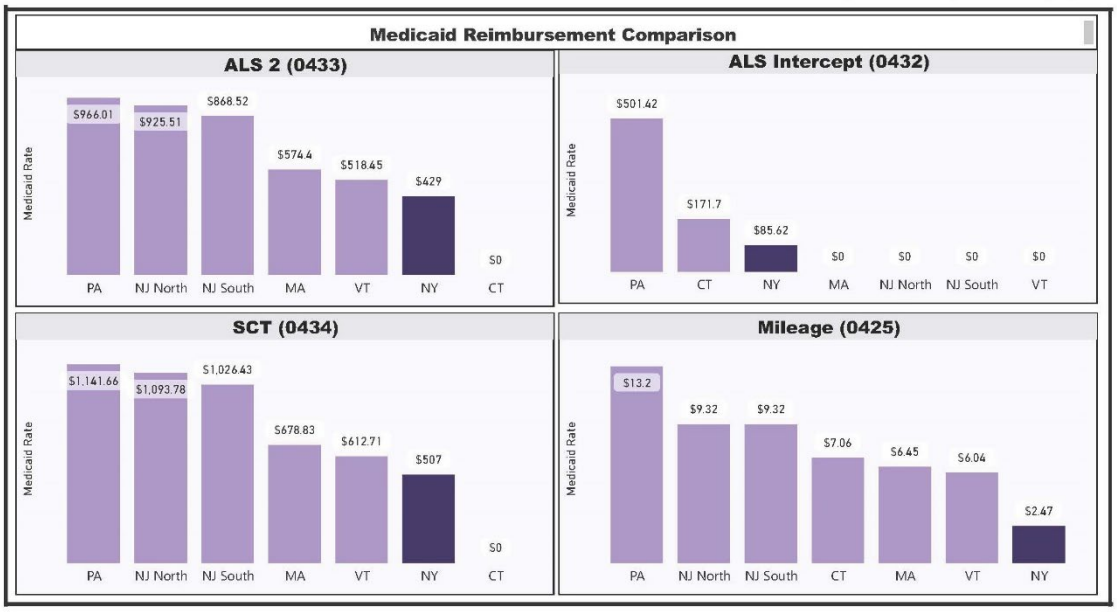
TARGETED MEDICAID RATE INCREASE FOR EMS AGENCIES (#11)

There is a need for ambulance reimbursement methodology under Medicaid that more closely approximates the cost of providing the service thus allowing EMS agencies to be fairly reimbursed for the costs of providing services to Medicaid patients. There is currently legislation proposed in both the House and the Assembly asking for this methodology to be developed; the RASTF agrees with this legislation. A good example of a state increasing its EMS Medicaid rates comes from Pennsylvania where the Pennsylvania Bulletin outlines the payment for ambulance transportation in the following manner *"the payment of ground mileage for every loaded mile and the fees for ambulance services are the greater of the highest Medicare rates published in the Ambulance Fee Schedule Public Use File."*[12] There is currently a bill proposed in the State Assembly, A9353, which specifically amends the social services law to allow the Commissioner of Health to increase Medicaid reimbursement rates for rural ambulance services. The RASTF supports this proposed bill. It should be noted that, of the states surrounding New York (specifically, Connecticut, Massachusetts, Vermont, Pennsylvania, and New Jersey), New York has the 6th lowest Medicaid rates for Mileage, BLS (emergency) and ALS 1 (emergency) and the 5th lowest rates for BLS (non-emergency) and ALS (non-emergency).

[11] https://www.health.ny.gov/health_care/medicaid/enrollment/historical/all_months.htm

[12] Pennsylvania Bulletin (pacodeandbulletin.gov)





PA: https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/ma-fee-schedule.html

NJ: https://www.nj.gov/humanservices/providers/grants/public/publicnoticefiles/Public%20Notice%20for%20Jan%202024%20rates%2011.20.23%20v4vam.pdf

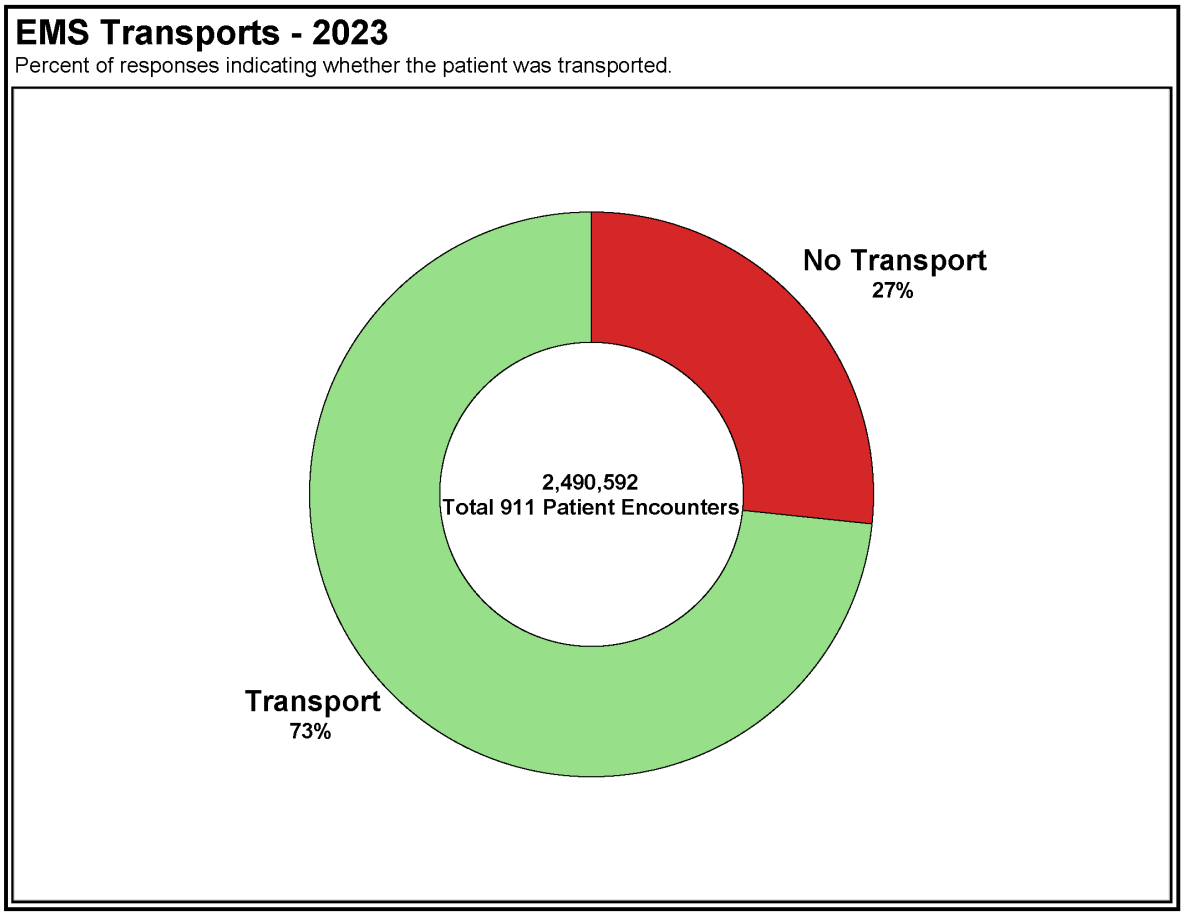
CT: https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download

MA: https://www.mass.gov/doc/rates-for-ambulance-and-wheelchair-van-services-effective-september-29-2023-0/download

VT: https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/FY2024%20Budget/W~Alicia%20Cooper~Historical%20Vermont%20Medicaid%20Ambulance%20Rates~2-28-2023.pdf

Treat-in-place (TIP) and Transport to alternate destination (TAD) (#12)

There is a need to modify various documents (statute, regulation, and policy statements) to more accurately define the role of emergency medical practitioners to fill unmet needs in the pre-hospital emergency health care system. The RASTF encourages treatment-in-place and transport to alternative destinations (e.g., medical offices or urgent care centers) initiatives by establishing payment mechanisms that allow EMS services to be compensated for care rendered without transport to a hospital emergency room. This also includes the utilization of telemedicine. Today, nearly 30% of the patients encountered are not transported (see graph below). As a result, these healthcare services are provided without reimbursement.



Source: New York State Department of Health, Bureau of Emergency Medical Services and Trauma Systems

It is recommended that transportation to alternate destinations be widely utilized by EMS - this can include, but not be limited to, health centers, physician offices, behavioral health centers, and urgent care centers. It is additionally recommended that EMT's, AEMT's, and paramedics be allowed to assess patients, and based on the level of acuity, decide what options are available for an appropriate destination. Utilizing alternate destinations will reduce emergency department overcrowding and will assist in faster EMS offload times at emergency departments, allowing ambulances to return to service in their communities faster. Transport to alternate destinations in rural communities will also decrease patient handling times which will ultimately increase availability of services due to a decrease in total time on task.

Treat-in-place and transport-to-alternative destinations were two areas that saw allowable reimbursement during the COVID-19 pandemic. There is legislation proposed in both the Senate and Assembly that would establish a mechanism within the Medicaid Fee Schedule for Ground Ambulance Services to authorize Medicaid reimbursement to emergency medical services agencies for providing Treatment-in-Place (TIP); as well as Transport to an Alternate Destination (TAD), getting a patient to the most appropriate health care setting other than a hospital, such as a mental health clinic, rehabilitation facility or urgent care. The RASTF supports this proposed legislation.

The recently enacted "direct pay" legislative change is a step in the right direction, but there are various additional areas specific to insurance reimbursement for EMS service that must be implemented to ensure system stabilization, security, and sustainability. These areas include the requirement for insurers to pay for 911 calls that result in Treatment-in-Place (TIP) and Transport to Alternative Destinations (TAD), including telehealth, as well as the assessment scoring requirement for payers to pay for transport to Alternate Destinations (sometimes referred to as NY ET3). There should be incentives from insurers to provide reimbursement for Treatment-in-Place and Transport-to-Alternate-Destinations in rural areas to reduce both risk as well as hospital visits based on community assessment like the Insurance Services Office (ISO) ratings.

A pilot program through the Centers for Medicare & Medicaid Services (CMS) for a version of Treatment-in-Place/Transport to Alternate Destinations (named ET3) ended early for various reasons. There were several barriers to participation in the ET3 Pilot project which included a complicated application process, minimum annual call volume, development of treatment protocols at the agency, regional and state levels, approved alternate destinations, creating and acquisition of technology to effect telemedicine, inadequate administrative staff to manage participation in a "pilot project" as well as other factors. Lessons learned from these experiences should be applied to future proposals.

CREATE A CRITICAL ACCESS EMS MODEL LIKE THAT OF CRITICAL ACCESS HOSPITALS (#19)

In the past, there has been resistance from Counties in rural New York State to establish EMS systems purely due to the costs associated with these systems. One of the reasons most

frequently cited is that rural areas simply do not have the tax base to establish, and sustain, EMS systems. **In these areas, State and Federal funding is essential to providing the service.**

The Critical Access Hospital model provides both State and Federal funding for hospitals in rural, super-rural and frontier areas in New York State. The Critical Access Hospital (CAH) designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. This model has been successful in keeping medical care accessible in areas where care would be otherwise unavailable. Many of these same areas are also underserved by EMS. A similar type of system needs to be created which would ensure that EMS resources are available in areas that cannot support an EMS system. Communities need a way for the ill and injured to be assessed, treated, and/or transported to the hospital and a Critical Access Ambulance Designation (CAAD), will ensure that level of care can be maintained in small, rural, and frontier communities. Specific funding needs to be secured for those agencies that are the critical access to the medical system in super rural and frontier communities, like the Critical Access hospital model.

The funding for this system could work in the following manner:

- Cost-based reimbursement with a capital add-on to facilitate equipment replacement in low-volume organizations that must spread costs over fewer patient encounters.
- Payment for transport to alternate destinations and treatment-in-place.
- Advance funding and prompt payment to maintain cash flow in smaller organizations.
- A mechanism to compensate for the higher percentage of uninsured residents in rural areas.

This model could further expand available services with clinic-like environments that can be temporarily operationalized to meet a specific need. This provides the flexibility for EMS to find alternative and unique delivery models that will meet the needs of rural communities where access to care is limited.

NEED FOR STIPEND (#21)

Volunteerism is declining, especially in rural areas, at an alarming rate and unless there are incentives given to strengthen local EMS services, we will continue to see their number dwindle. The legislature should enact a legislative change to allow volunteers to receive up to a $25.00 per call (tax free) stipend, up to a maximum of $5,500.00 annually. This stipend could assist in covering personal costs associated with volunteering.

TAX CREDIT/LOCAL PROPERTY TAX CREDIT (#22)

The current incentives for volunteers are not enough to make a real difference and create an incentive to spend time, and effort, obtaining and keeping certifications etc. New York State should increase these incentives if they are to have real benefit to volunteers and potentially motivate them to continue to volunteer.

New York State should enact legislation to increase the tax credit and allow EMS practitioners to claim both tax credit and local property tax credit. There are currently legislative initiatives proposed that would allow EMS practitioners the ability to claim both state income and local property tax credits as well as increase EMS practitioners' personal income tax credit; the RASTF supports these initiatives.

SECTION C: DETAILED EXPLANATIONS OF KEY PROPOSALS

(c) Barriers that currently exist that may have led to a shortage of available ambulance services to meet the need;

DECLARATION OF PUBLIC HEALTH EMERGENCY ABOUT RURAL EMS (#1)

Enact a Declaration of a Public Health Emergency to bring to light the challenges facing Rural EMS and facilitate immediate initiatives to stabilize the EMS System. An Emergency Declaration will allow the elected leaders to immediately address our most important, stabilizing recommendations. This declaration will also permit EMS initiatives – such as legislation and funding - to be fast-tracked. This declaration could speed up processes such as contracting to help address specific areas of concern such as bolstering County EMS system implementation, mandating a decrease in hospital emergency department wait times and allowing reimbursement for EMS initiatives that provide greater flexibility to address emergency health care needs such as treat in place, telemedicine, transport to alternative destinations and even non-transport.

State-level Emergency Declarations have been used by multiple other states in the recent past for non-natural disaster purposes, such as the Opioid Crisis and Gun Violence. In Minnesota, a state with EMS system issues including a decline in the number of EMS providers, the shuttering of multiple agencies and inadequate insurance reimbursement for EMS services, a bipartisan group of legislators is declaring "an EMS emergency" and requesting $120 million in funding to keep emergency medical services agencies functioning.

By law, these declarations allow for access to various state-level resources and allow for the waiver or exception to some statutes and regulations to expedite various actions. This declaration will serve as an acknowledgement of the severity of the circumstances. Lastly, it will provide a measure of immediate relief so that more long-term goals can be pursued simultaneously.

The New York State Rural EMS System simply cannot wait the traditional 18 to 36 months that it takes for the legislative process to play out or a contract to go into effect; stabilization of the EMS system is needed NOW, and this public health emergency declaration is a necessity!

EXPANDED AMBULANCE SERVICE CERTIFICATE FOR IFT/SCT (#14)

SEMSCO and the Bureau should create and implement an expanded Ambulance Service Certificate specifically for the purpose of providing Interfacility (IFT) and Specialty Care (SCT) transports. The provision of Interfacility and Specialty Care is a critical component of the EMS system, but there are rural areas in New York State that do not have an adequate number of commercial providers to fulfill their IFT/SCT needs. Thus, the creation of an IFT/SCT specific Ambulance Service Certificate would benefit the rural areas of the state.

GUIDANCE REGARDING INTERFACILITY TRANSFERS THAT ADDRESS PRIORITY LEVELS AND APPROPRIATE RESPONSE LEVELS. (#15)

As discussed extensively in the *EMS Sustainability Technical Advisory Group 2023 Evidence-Based NYS EMS Agenda for the Future*, hospitals need to improve discharge planning and IFT requests. Often several hospital departments are individually reaching out to ambulance transportation agencies to arrange for ambulance transportation for different patients. This poses several stressors as various departments and hospitals compete for limited available ambulance resources. Hospitals must be required to have dedicated staff, at the administrative level, who work with EMS agencies to facilitate all hospital discharges and interfacility transfers, work with Emergency Department off-load time (EMS turn-around) and coordinate Continuing Medical Education (CME).

Medicaid reimbursement for IFTs of greater than 100 miles is insufficient to meet the expenses associated with this transportation.

Hospitals need to properly plan for anticipated transportation resources, contract with and pay for ambulance service readiness who would then be available to provide these services. Interfacility and Non-Emergency Transports are a significant, and often overlooked and underappreciated, component of the Healthcare System. Today, interfacility transports (IFT) are not overseen as part of the mission of Article 30. On a regular basis, NYS experiences significant delays (from hours to days) in moving patients to tertiary care hospitals. Currently, the majority of IFTs are accomplished by commercial EMS agencies. EMS agencies that provide this level of services are experiencing staffing challenges while, at the same time, not properly compensated. In rural counties, there may be difficulty in obtaining services from a commercial provider, resulting in the local 911 center taxing the municipal EMS system with these transportations. IFTs are the responsibility of the hospital, and these hospitals should have contracts with a designated provider. Backup contingency planning should be addressed in County EMS plans with specific attention to the impact on the EMS system as a whole.

In today's environment, with limited EMS resources, hospital IFTs pose operational challenges for ambulance agencies. The trials to provide these services include significant time on task. Time on task is defined as the amount of time involved to facilitate the transport. Components often not considered include the time the call is received from the hospital until an appropriately staffed ambulance is available for the transport, travel time to the hospital, accessing the patient in the hospital, obtaining patient report, loading the patient and initiating the transport. With the current hospital census at high levels, distances to tertiary care can vary significantly, and often may be several hours. Another complicated factor involves the time once the patient arrives at the tertiary care facility until the ambulance can return to their primary response area. This return time is not reimbursed.

One of the entities that could provide support is the New York State DOH Surge Operations Center, or SOC. The SOC is a 24/7 virtual call center, developed to assist hospitals in planning, reporting, and coordinating resources during a disaster. Since the pandemic, the SOC has been enshrined in Public Health Law and provides 24/7 monitoring and situational awareness of the

state's health care system. The SOC staff coordinate, monitor, and analyze data; develop and maintain disaster plans; coordinate the statewide transportation system; and serve as a 24/7 watch group - alerting and responding to issues that occur. Utilizing the SOC, long-distance, statewide, interfacility transports could be better directed and managed, including the use of EMS Task Force assets, to ensure efficient and effective movement of patients without the need to remove limited rural resources from the 9-1-1 system.

SEMSCO and SEMAC must provide guidance regarding IFTs that address not only priority levels but also appropriate response levels. In addition, SEMSCO and SEMAC should move to create statewide collaborative IFT protocols up to the specialty care transport (SCT) level for the appropriate care of patients. In addition, there is a need for EMS practitioners with additional levels of training and education as well as credentials. These credentials include but are not limited to: Critical Care Paramedic Certified (CCP-C). Flight Paramedic Certified (FP-C), Critical Care Emergency Medical Transport Program (CCEMTP) and Community Paramedic – Certified (CP-C).

CREATION OF A MINIMUM WAGE SET FOR EMS PRACTITIONER'S (#20)

There is currently no minimum wage set for EMTs, AEMTs and paramedics in New York State. Part of the reason is the diversity in service delivery models; not-for-profit, and commercial entities, are limited by insurance reimbursement and if they are able to obtain municipal funding to supplement that revenue. A municipality can potentially raise taxes to cover personnel and other operating costs, but other service models are far more constrained. **EMS practitioners need to be compensated on par with other healthcare professionals, fire, and law enforcement personnel.**

Rural areas have lower call volume and smaller, less robust tax bases and so they are behind in revenue streams consistently. Even if their billing were enough to cover the true cost per call, they would still likely fall short in funding as their call volume would still be inadequate for revenue purposes. Also, current models of funding make it nearly impossible to predict or forecast a steady upward progression of wages for an agency. Add to this the rising costs of benefits, insurance, and other taxes for an agency and you end up with stagnant hourly rates that do not provide a living wage for practitioners.

Utilizing the example of the establishment of minimum pay scales for Home Care Aides in both urban and rural areas of New York State, the Bureau of EMS and Trauma Systems must work with the New York State Department of Labor (NYS DOL) to develop a minimum wage for EMTs, AEMTs and paramedics in both rural and urban areas[13]. This is required to stabilize the EMS workforce**.**

[13] p105-home-health-aide-11-23-23.pdf (ny.gov)

The RASTF Proposal for these **minimum** wages is - EMT 1.75 times the local or state minimum wage; AEMT/EMT-CC 2.0 times the local or state minimum wage; Paramedic 2.5 times the local or state minimum wage.

FUND AND TASK THE BUREAU WITH THE DEVELOPMENT OF LEADERSHIP TRAINING PROGRAMS (#23)

A 2023 survey from NAEMT titled "What Paramedics Want" revealed that EMS personnel report that, when it comes to retention, poor leadership was cited by 7 out of 10 (72%) as being a factor in retention[14]. This is possibly because, historically, unlike other first responder segments, EMS does not train leaders, test them or qualify them, but rather promotes those that have been around the longest or are above-par clinicians (strong independent performers, not great leaders). As the challenges facing EMS agencies increase, leadership coursework and professional development need to be developed. This includes course work in critical areas such as human resources, managerial acumen and decision-making. The Bureau should be the leader in professional development initiatives that include, but are not limited to:

- Professional development for EMS practitioners.
- Field Training officer courses.
- Leadership training for all levels of EMS management.
- Budgeting and Finance.

Development of said programs will also assist with an EMS career ladder and defined steps in growth.

[14] Fitch, J. (2023). What Paramedics Need to Preserve. What Paramedics Want in 2023. www.EMS1.com

FUND AND TASK THE BUREAU TO CREATE STANDARDS RELATED TO EMS LEADERSHIP POSITIONS THAT ARE LIKE THAT OF THE NEW YORK STATE FIRE SERVICE (#24)

As previously mentioned with the need for additional bureau staff, we should fund and task the Bureau, in coordination with the SEMSCO, to create standards related to EMS leadership positions and rank that are like that of the New York State Fire Service.

The referenced New York State Office of Fire Prevention and Control (OFPC) Best Practices document is an example, and reference, for what rank and career development/career ladder opportunities could look like if adapted for EMS agencies and systems. It outlines a defined career ladder with job performance tasks that support EMS positions and the requisite training to achieve these performance measures[15]. In addition, the National EMS Management Association (NEMSMA) has developed EMS Officer Competencies and grouped them into seven distinct pillars, with each pillar containing several sub-sections that outline different attributes, tasks, and skills necessary to be a successful EMS officer[16]. Individual EMS agencies would need to adapt these to the specifics of their agency, including their specific organizational structure.

EMS REPRESENTATION ON PROFESSIONAL ORGANIZATIONS (#28)

In today's interconnected and complex healthcare environment, EMS agencies, as well as the Program Agencies, Regional EMS Councils, SEMAC, SEMSCO and the Bureau must understand why, when, and how, to collaborate with outside partners. EMS in general lacks representation on, and with, other professional bodies. With representation we could potentially work more collaboratively to positively impact future EMS initiatives, while, at the same time, allowing for the promotion of synergy and political goodwill.

We must establish more formal, ongoing collaborative partnerships with various governmental EMS entities (i.e. Regional EMS Councils, Program Agencies, the Bureau of EMS And Trauma Systems) and:

- The New York State Association of Counties
- The Legislative Commission on Rural Resources
- Firefighters Association of the State of New York (FASNY)
- Fire District Associations
- The New York State Association of Towns
- New York State 911 Board
- Hospital associations (HANYS, GNYHA, etc.)
- Public Health and Health Planning Council (PHHPC) /other boards

[15] https://www.dhses.ny.gov/system/files/documents/2021/05/training-best-practices.pdf

[16] https://www.nemsma.org/page/TheSevenPillarsofNationalEMSOfficerCompetencies

The goal for this Proposal is to identify and engage key stakeholders in a collaborative effort to address the identified challenges. This must include the marrying of EMS practitioners with healthcare organizations, government agencies, and educational institutions as we look to gather input, insights, and perspectives from these stakeholders to develop a comprehensive solution.

REDESIGN THE EMS EDUCATIONAL SYSTEM (#30)

While education standardization and certification testing have improved the overall quality of care delivered by EMS professionals, access to education, especially in rural environments, is limited. In many rural counties, there is a definitive lack of active Certified Instructor Coordinators (CICs), lack of adequate funding, and poor coordination, leading to a shortage of EMS classes.

Currently EMS education is underfunded and poses other structural challenges resulting in fewer opportunities for the initial development, retainment, and advancement of the EMS workforce. Substantially increasing EMS education funding will ensure that a continued stream of qualified and trained practitioners is 1) entering the field, 2) remaining in the field, and 3) are advancing their clinical education to meet the needs and fill the gaps in prehospital medicine.

The EMS education model is significantly different from the fire education model, in both scope and funding. **The overreaching Proposal is to increase and allow EMS Course funding at all EMS levels and specialized EMS training from a State EMS training fund to incentivize alternate delivery models, improve student enrollment, better compensate certified instructional staff, and coordinate geographic scheduling of classes to increase availability and prevent overlap.**

Challenges with Proposals to the current EMS education system.

Instructors / Instructor Development

Challenge: There is a noted lack of active EMS educators (Certified Instructor Coordinators – CIC's) in rural counties.

- Proposal: Create a scholarship program to provide financial assistance to attend instructor 'development courses, including tuition reimbursement, cost of materials, compensation for time in class, and for adequate pay during internship.
- Proposal: Revise the current instructor certification process to allow instructor-interns to complete internship requirements through all types of approved continuing education programs when properly monitored.

Challenge: CIC's outside of higher education are commonly compensated at a rate only equal to, or in some cases less than the average rate of pay that their students are receiving.

- Proposal: Create a minimum wage consistent with the EMS practitioner minimum wage for EMS educators and provide adequate funding to Course Sponsors for this purpose.

Challenge: CIC's are generally only compensated for actual time in the classroom. They are not compensated for preparation and/or course management time, traditionally 2 to 3 times more than actual classroom time.

- Proposal: Increase funding to Course Sponsors to adequately compensate course CICs for course management.

Challenge: Required instructor continuing education is at a cost to the instructor both in regard to tuition and/or time.

- Proposal: Create a fund for EMS educators for tuition assistance for required instructor continuing education and set an hourly rate for course attendance.

Challenge: There are no provisions to allow for advanced standing for non-EMS educators with EMS certification (e.g. licensed schoolteachers, fire or law enforcement instructors) to become EMS educators. Currently, those educators are required to complete the entire EMS instructor certification process.

- Proposal: Charge the Bureau with developing an advanced standing process for currently licensed educators or public safety instructors, with EMS certification, to become certified EMS educators.

Certified Practitioners (CFR, EMT, AEMT and Paramedic)

Challenge: Lack of accessibility to EMS education courses. Many Course Sponsors require a minimum number of students. The financial viability of courses is attached to the number of students who have enrolled and who have paid tuition or the number who pass the State certifying examination, for the Course Sponsor to be reimbursed for the tuition. In many rural areas this may need to be as many as eight to ten students for financial viability. It may take several years to have enough students for a course.

Challenge: The cost of tuition for EMTs and AEMTs is burdensome for students and/or agencies. The standard tuition rate for EMTs is $800, and over $1,000 for AEMTs. That cost is either passed on to the student or the student's EMS agency. The agency is eligible for reimbursement from the Bureau, but only if the student passes the certification exam. The current attrition rate for EMS courses is approximately 20%. The reimbursement does not cover the cost of books and materials, which approach $400 / student. This can be a significant deterrent for students and for agencies.

- Proposal (accessibility): EMS courses should be offered at all SUNY campuses, either directly as a credit-bearing or certificate course for the college or university, or through a partnership with an existing SUNY school that is also an EMS course sponsor.

- Proposal (accessibility): The Department of Health partners with the Department of Education to offer EMT courses through each regional BOCES center, specifically targeting high school students. The courses can be taught at the BOCES centers or as outreach courses throughout the district.

- Proposal (accessibility): Task the Bureau with developing blended learning and asynchronous teaching to make EMS courses more accessible.

- Proposal (cost): The Bureau would directly fund Course Sponsorship based upon the number of enrolled students or a sliding scale for courses with a limited number of students to ensure financial viability of the course without cost to the student or EMS agency. This would only apply to students who are currently members of a rural EMS agency. There is already a mechanism in place for reimbursement to the student for tuition directly if they become an active EMS member after certification.

Challenge: Registered nurses must currently complete an original EMT course to be eligible to obtain certification. This discourages nurses from becoming EMTs to provide prehospital care within their communities. Once an RN obtains EMT certification, they are eligible to "challenge" the AEMT and paramedic courses.

- Proposal: The Bureau should create a standardized process for practicing registered nurses to be able to complete a modified EMT course, much like an EMT refresher course, that will cover the educational gaps, including scope of practice, between the registered nurse and EMT. Completion of this course will allow the RN to be eligible for certification.

Challenge: Newly certified EMTs are simply not "street-ready." The EMT National Education Standards and NYS certification are designed to meet "minimum competency." Depending on the new EMT and their agency, they may be placed immediately into the field out of sheer necessity without proper field training onboarding, or conversely, not be permitted to practice on their own for a considerable period of time because the agency does not have a quality field training or onboarding process.

- Proposal: Charge the Bureau and SEMSCO with developing field training officer program that is available in multiple formats, that is of no cost to the individual or agency.

Challenge: Some EMS Regions (REMSCOs/REMACs) do not credential providers at the Advanced EMT (AEMT) level. In those Regions, AEMT's are only permitted to perform to the EMT level. This places additional stress on already limited and stressed paramedic resources. The AEMT has a scope of practice that should be a critical component of the rural EMS system and works perfectly in a tiered response system (previous recommendation).

- Proposal: Charge the SEMSCO/SEMAC with requiring all rural REMSCOs/REMACs with acknowledging and permitting the AEMT level to perform as advanced practice level practitioners within their EMS system.
- Proposal: The Bureau shall provide adequate funding to Course Sponsors to provide AEMT courses within their catchment area. Funding shall be like that of EMT level courses, with no expense to the student or the agency.

Challenge: It is difficult to incentivize current EMTs to want to become paramedics. Paramedic tuition is equivalent to the cost of an associate degree and impractical for many agencies to fund full-time education for an EMS practitioner. In addition, it is difficult to balance work with this level of educational commitment.

- Proposal: Develop a practical reimbursement program/scholarship program either for the EMS agencies or the practitioners themselves.

There are numerous accounts and surveys nationwide that affirm the pervasive staffing shortages and the impending decreased capacity for ambulance services to respond to health care emergencies. This is particularly the case in rural communities. While the issues associated with the shortages are numerous, some indicators point to the need to provide advanced education for EMS practitioners. Many EMS interrelated agencies nationwide are calling for changes in workforce training to address the shortages, levels of requisite skills and associated credentials, as well as compensation.

A report of National Association of Emergency Medical Technicians (NAEMT) provides a succinct overview and has come out in support of offering advanced education to keep up with the evolving and expanding skillsets required of EMTs and paramedics[17]. The Rural Ambulance Task Force supports the NAEMT findings and recommends that NYS move toward requiring a college degree as part of new paramedic education. This will provide enhanced access to financial aid, as well as a clear pathway that can build upon EMS and other types of health-related training. Hence attracting more talent at both the EMT and paramedic levels.

There are numerous pathways to achieve the concept of advanced EMS education in New York State including, but not limited to:

- Creating seamless avenues such as a New York State Pathways in Technology program (Ptech) from EMS education that can commence in high school and move through to a paramedic certification. This would include BOCES, community colleges and other higher education programs that currently offer paramedic training.

- Establishing pathways to allow non-degree providers to continue offering programs that can be converted into college credit through micro—credentialing (short-term, on

[17] 11-10-23-position-on-advanced-education-in-ems9429b18d-6632-4d89-b027-9ea38bd41aa1.pdf (naemt.org)

demand) and prior learning experience assessments that allow previous EMS work to count for college credit.

- Creating pilot hubs for paramedic regional core sponsorships through the 4-year SUNY's. These hubs would act as a central location for surrounding EMS agencies to deliver certificate programs, offer credit-bearing programs, and provide support, including pathways for students to obtain credit leading to a degree. Each REDC could identify a hub in its catchment area that would be able to partner with the local EMS agencies to apply for workforce development funding.

To accomplish this approach and address the challenges with reimbursements and other education-specific issues, the RASTF recommends the convening of New York State Education Department (SED) with college-level providers and High School and BOCES leaders along with DOH, SEMSCO and the Bureau to create a comprehensive advanced education model that provides flexibility in achieving varying levels of certification that are seamless and lead to college credits and degrees.

As there is a need for EMS practitioners at all levels to continue their education, we recommend that the SED, the Bureau and the SEMSCO work together to develop a system of Prior Learning Assessment (PLA) guidelines and create micro-credentialing programs to assist EMS practitioners in advancing their education and credentials.

The development of this type of educational path would be like that seen in the nursing field, with the development of both a path and specialties. EMS specialty paths could include:

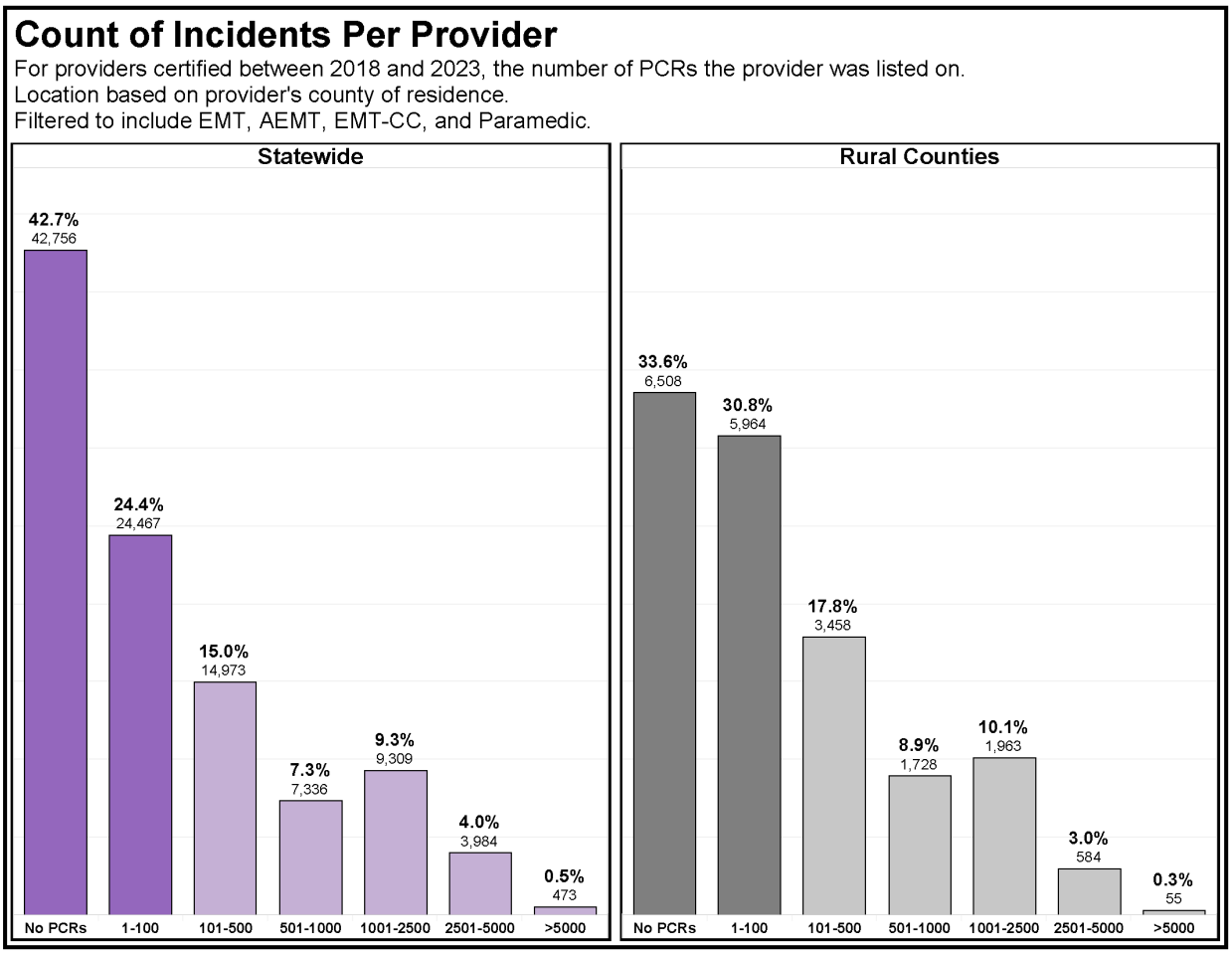
- Clinical Provider
- Field Training Officer
- Critical Care Paramedic
- Flight Paramedic
- Community Paramedic
- Education
- Management/Administration

Initiatives such as micro-credentialing can assist the entire profession and the ability for practitioners to advance their careers.

"EMS - ABOUT US" CAMPAIGN (#32)

As the number of active EMS practitioners continues to decline for a variety of reasons, there is a need to promote EMS throughout the state. One of the elements of this is the fact that a minority of EMS practitioners are handling the majority of EMS calls. Over a six-year period,

42.7% showed up on zero Pre-hospital Care Reports (PCR's), while during the same time period, .5% showed up on greater than 5000 PCR's.



Source: New York State Department of Health, Bureau of Emergency Medical Services and Trauma Systems

The "EMS - About Us" campaign will serve the dual purpose of both building awareness among the public as well as providing EMS agencies with the tools and resources to recruit and retain EMS practitioners. This effort will need a dedicated funding stream and the RASTF believes that the funding of a three-year, $5 million campaign to promote EMS volunteerism and careers in New York State through an "EMS – About Us" campaign will have demonstrable impact.

PARAMEDIC URGENT CARE (PUC) (#34)

Rural areas have a lack of urgent care facilities which leads to a gap in medical care. The development of paramedic staffed urgent care, either as mobile or fixed sites, as a demonstration project with appropriate funding, incorporates out of the box thinking for the utilization of ALS practitioners while also serving a need in rural areas. These urgent care facilities would be regulated by the Department of Health and have the additional benefit of utilizing telemedicine for greater flexibility.

ADDRESS THE EMS IDENTITY CRISIS (#37)

There are various terms utilized to describe EMS agencies across the state. These include, but are not limited to, "*First Aid Squads*," "*Rescue Squads*," "*Emergency Squads*," "*Ambulance Corps*," and just "*EMS*". In understanding the need for a unified voice in EMS, as well as to assure the public understands and recognizes our mission, it is important that we all use the same terminology. Many of these terms are currently found in New York State General Municipal Law and will need to be modernized.

This is also applicable to the various categories of EMS practitioners with a shift needed to use the general terms of "*EMS Practitioners*" or "*EMS Clinicians*".

The RASTF calls on the SEMSCO to develop standardized nomenclature for these areas.

ADDRESS DIVERSITY, EQUITY, INCLUSION, AND ACCESSIBILITY (DEIA) REALITIES (#38)

EMS agencies should reflect the diversity of the population they serve and implement DEIA initiatives to ensure this is accomplished EMS has historically had challenges in recruiting and retaining persons of color (POC) as well as women and, in general, has not excelled in being representative of the communities EMS agencies serve. Diversity, equity, inclusion, and accessibility (DEIA) is a relatively new frontier for many EMS agencies and one that includes a steep learning curve.

It's clear that for EMS agencies to not only survive, but thrive, they must be as diverse as possible. With that diversity also comes a need for organizational flexibility to assure that all personnel and resources are being utilized to achieve organizational goals.

One area that this includes is the utilization of large immigrant populations to bolster the ranks of EMS providers. One such program, located in Maine, is called the ESOL-to-EMT program — short for English for speakers of other languages to emergency medical technicians – and is run by Southern Maine Community College[18].

The RASTF recognizes that the SEMSCO has a Technical Advisory Group (TAG) discussing this issue, as well as working on potential initiatives to move forward, and we applaud this effort.

[18] https://www.bangordailynews.com/2017/02/28/news/this-program-teaches-new-mainers-how-to-be-emts/

SECTION D: DETAILED EXPLANATIONS OF KEY PROPOSALS

(d) Studying any other issue such task force deems relevant.

Additional detailed information can be found below for each of the items identified as part of other issues deemed relevant by the Task Force.

Many of the additional items identified came from the information gathered as part of the Rural Ambulance Task Force survey. The responses to the survey are located on the next few pages followed by detailed explanations to the Proposals for Section D.

ALLOCATE PERSONNEL AND RESOURCES TO THE BUREAU OF EMS AND TRAUMA SYSTEMS (#13)

To properly support the Proposals in this report, the Bureau would benefit from additional personnel and resources to support rural EMS initiatives. **At a minimum**, this support request should include, but not be limited to:

- **Hiring a Communications Director –** the Bureau is in the position of having to consistently communicate information not only to the EMS constituency, but also to the hospitals, counties, and the general public. This position would play an essential role in public education and information as well as the education of elected officials about the various types of EMS agencies, how EMS is funded, the differences between the levels of EMS practitioners and much more (i.e., EMS 101).

- **Develop and implement a single communications platform throughout the EMS community;** from the Bureau to EMS Coordinators, Regions and Program Agencies, Hospital EMS Coordinators, the EMS Task Force, EMS agencies and others. This needs to be a multifaceted dynamic communications platform that easily integrates with a variety of platforms. This platform should be used to disseminate information, share and collaborate information and be used in times of emergencies. The Bureau should continue and enhance monthly EMS Agency leadership meetings and should introduce training presentations on topics of interest to EMS leadership. The Communications Director should additionally take the lead to modernize the Bureau's website and develop a presence on other social media platforms.

- **Establish a long-term funding source to hire a marketing and communications firm** which can assist with marketing/communication of Bureau of EMS and Trauma Systems and the State EMS Council and the State Emergency Medical Advisory Committee to our practitioners, patients, and communities.

- **Establishing a Rural EMS Lead** - to manage all rural-specific initiatives, funding sources and information that the Bureau is managing. Broadly speaking, this position would be able to provide necessary technical assistance and customized support to rural EMS in New York State *(in the State of Wisconsin, this position is called an EMS rural outreach manager)*.

- **Hiring support staff for the State EMS Council and the State Emergency Medical Advisory Committee -** the State Emergency Medical Services Council (SEMSCO) and the State Emergency Medical Advisory Committee (SEMAC), are consistently in need of support staff for the various initiatives that their subcommittees develop. To date, this support-type work has been handled by the volunteers who serve on said boards, with little support from the Bureau team. There is a need for consistent, dedicated support staff to these bodies to advance their initiatives and agendas.

- **Improving data collection systems -** The Bureau needs additional funding and staff to modernize its data collection and analysis capabilities as well as its technological footprint. This includes, but is not limited to, the modernization of the Bureau of EMS website to make it more user-friendly and communications technology that all can use (via an app), which will enhance communication between the bureau and EMS leadership as well as between EMS agencies, for the purpose of collaboration. Lastly, the procurement of electronic data collection tools will allow for a move away from paper documents, thus allowing for additional data capture and analysis.

- **Establishing Professional Development and Leadership Programs -** Opportunities for professional development specific to EMS agencies are practically non-existent. As the dynamics of EMS agencies increase, leadership and professional development opportunities need to be developed. This includes course work in critical areas such as human resources, managerial acumen and decision-making. The Bureau should be the leader on professional development initiatives that include, but are not limited to:
    - Professional development for EMS practitioners.
    - Field Training officer courses.
    - Leadership training for all levels of EMS management.
        - Human Relations
        - Finance and budget management

- **Developing Leadership Standards** - In conjunction with the aforementioned point regarding leadership programs and professional development, the State should fund and task the Bureau, in coordination with the SEMSCO, to create standards related to EMS leadership positions and ranks that are like that of the New York State Fire Service.

ALIGN THE CURRENT EMS REGIONS WITH REGIONAL ECONOMIC DEVELOPMENT COUNCILS (#18)

To maximize the efficiency of the various regional entities that are carved out in statute, there are potential opportunities in aligning the Regional EMS Councils with the 10 New York State Regional Economic Development Councils (more than one Regional EMS Council can potentially be in a Regional Economic Development Councils).

This initiative would include educating the various Regional EMS Councils/Regional EMS Advisory Committees/Program Agencies on the benefits of Regional Economic Development Councils, with one specific example being the $20 million in funding available annually and how this funding could help increase sustainability for EMS agencies. This overall initiative can be accomplished with minimal county realignment into existing regions. With the existing workforce shortages, it is critical that EMS be afforded workforce development funding.

- Professional Development for all levels of EMS providers.
- Field Training officer courses.
- Leadership training for all levels of EMS management.
- Budgeting and Finance.

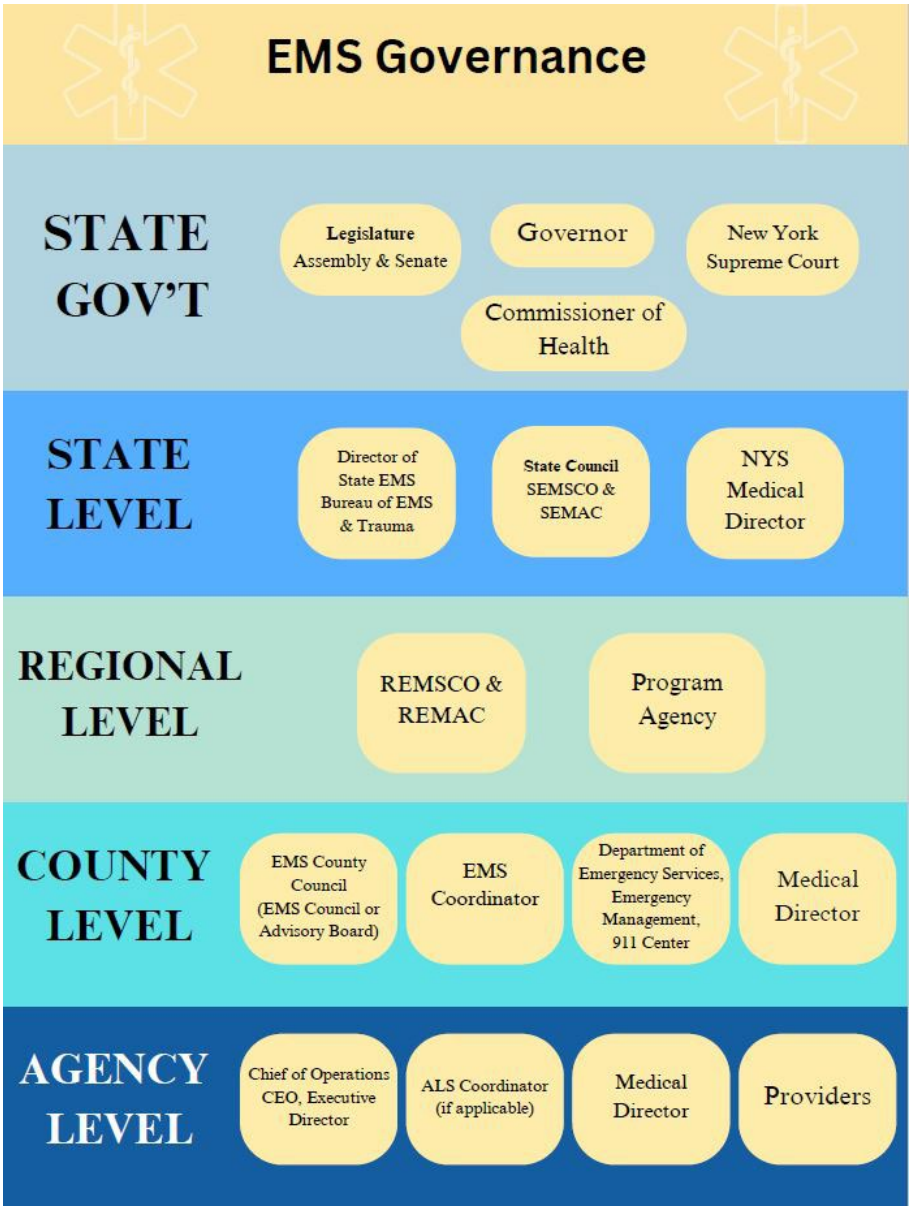
Development of said programs will also assist with an EMS career ladder and defined steps in growth.

REDEFINE THE ROLE OF THE REGIONAL EMS COUNCILS AND PROGRAM AGENCIES (#25)

The Regional EMS Councils and Program Agencies are foundational elements in the New York State EMS system - their roles need to be modernized to include coordination of regional educational initiatives, daily operations guidance for EMS agencies, protocol oversight, system collaboration, quality improvement and quality assurance, provide and coordinate EMS training, and interaction with County EMS Coordinators. Regions and Program Agencies are encouraged to ensure the education, and utilization of, AEMT's to enhance the tiered response system.

The various interlocking components responsible for the governance of the EMS system must be in constant communication with one another for the system to work.

The RASTF envisions a future state for those entities to coordinate and communicate in the following manner: EMS agencies to County (County EMS Coordinator), County to Region/Program Agency, Region to Bureau (see chart below).



MODIFY BLS PROTOCOLS (#26)

For the tiered EMS system to achieve optimization, protocols should be developed which maximize BLS unit utilization. This could potentially go a long way towards addressing over-reliance on paramedics. In addition, policies and protocols should be developed which impel BLS to understand that sometimes the closest ALS is the hospital and that they should not delay transport waiting, or looking for, an ALS resource.

SEMAC / SEMSCO should review and, where appropriate, modify medical treatment protocols with the focus on higher BLS unit utilization and increased use of BLS adjuncts, making most "adjuncts" part of the standard scope of practice for BLS practitioners. In addition, we should ensure that BLS practitioners are provided guidance with regard to managing patient care when ALS resources are not available.

COUNTY EMS MEDICAL DIRECTOR COVERAGE (#27)

Modern day EMS systems require a hands-on EMS medical director who is actively engaged in various aspects of the EMS system including, but not limited to, EMS operations, patient care, and quality assurance programs. Gone are the days of the EMS medical director simply delivering a signature when needed.

Although each EMS agency should have their own EMS Medical Director, the Counties shall ensure that there is coverage by contracting with existing services. This "County EMS Medical Director" position will have either direct, or shared, oversight of all clinical areas of EMS agencies. This position should at least be partially funded by the State and have specific deliverables, to be developed in conjunction with the Bureau and the SEMSCO. As an alternative, the REMAC may appoint a "System Medical Director", similarly funded.

There are a growing number of physician assistants and nurse practitioners practicing pre-hospital medicine, many of whom function in a medical control capacity working side-by-side with EMS Physicians. The role of "Associate Medical Directors" must be established and should be assigned to involve mid-level providers (e.g., Physician Assistants (PA), Nurse Practitioners (NP)) for hands-on / day-to-day interaction.

The individuals who fill the type of roles mentioned above need to have a working knowledge of the practice of emergency medical services and the medical oversight that is required to provide EMS as included in the FEMA Handbook for EMS Medical Directors, March 2012. All EMTs, AEMTs, and Paramedics must work with and under a New York State licensed medical doctor. Currently, many smaller agencies are unable to pay a medical director for their services or they do not understand the valuable role a medical director can have in their clinical care. The establishment of a county EMS medical director will provide another option for small, rural agencies with limited funding the access to this important piece of clinical care. Professionals who are mindful that there is an emergency service being provided under the auspices of their name, and license, should be involved to shape its success.

SUBSTANCE USE DISORDER CRISIS (#29)

The ongoing opioid crisis poses unique challenges to remote, and often under-resourced, rural communities. It has been documented that rural New Yorkers are more likely to die from an opioid overdose than people living in the city. As the number of overdoses is ever-increasing, EMS practitioners serve a critical role in responding to opioid overdose for individuals living in rural or remote areas.

EMS agencies are on the front lines of responding to overdoses and should continue to be incorporated into the fight against opioids through the *Naloxone Leave Behind* program (such as the one seen in the REMO Region) as well as drug testing and buprenorphine programs to decrease calls relating to overdoses. These programs should be encouraged statewide. Furthermore, we recommend that there be a specific person in the Bureau who regularly interacts with the New York State Office of Addiction Services and Supports (OASAS) to ensure that this training, education, and supplies are available to all EMS agencies. This bureau position would also ensure that EMS-specific policies, protocols, and training are developed and overseen.

In addition, there are various funding streams specific to the Opioid crisis and EMS may be eligible for some of this grant funding. One example of this funding is a grant through the Substance Abuse and Mental Health Service Administration (SAMHSA), which currently has a rural EMS grant specific to education and opioids.

CONTINUATION OF THE RURAL AMBULANCE SERVICES TASK FORCE (#31)

The issues facing the Rural EMS system in New York State are myriad and will not simply go away. Issues such as adequate reimbursement and the overall funding of the EMS system, future directions for various policy initiatives, lengthy hospital wait times and workforce scarcity have all been documented by the Rural Ambulance Services Task Force and are in need of significant action if the system is to survive. The RASTF is in a unique position to assist various entities – the Legislature, the Bureau, the SEMSCO and the SEMAC - with implementation of various recommendations. The RASTF is also in a unique position, appointed by elected officials and tasked with providing a report directly to those officials; we are a governmentally created body which allows us, outside of the SEMCO and the Bureau, to effectively evaluate and provide Proposals to our elected officials on the topic of EMS.

Proposals made through this report will take years to implement. There is a necessity to extend the deadline for the NYS Rural Ambulance Services Task Force as a legislatively developed charge and to assure there is funding for this effort. **There is a need for the work of the Rural Ambulance Services Task force, as an independent body, to continue.**

EMS SYSTEM PERFORMANCE AUDITS (#33)

The RASTF asks that the New York State legislature create legislation for municipalities to conduct 5-year audits of their EMS system performance. We additionally ask the legislature, in conjunction with Bureau and SEMSCO, to find a long-term funding source to assist with

municipalities to conduct 5-year audits on EMS performance, including areas of improvement, within their geographical coverage area.

GRANTS (#35)

The RASTF calls on federal and state partners to establish EMS-specific funding like the *Staffing for Adequate Fire and Emergency Response Grants (SAFER)* grant. The SAFER grant was specifically created "*to provide funding directly to fire departments and volunteer firefighter interest organizations to help them increase or maintain the number of trained, front-line firefighters available in their communities.*"[19] Similarly, as EMS agencies find themselves in extreme circumstances regarding the workforce, there is a need for grants such as this one, which is inclusive of all EMS agencies. Reliance on grant funding for personnel is a short-term solution, and any solution that includes this should also ensure that in "out" years when the funding opportunity sunsets, agencies will not be left to absorb personnel costs that they are not able to make good on.

DEDICATED HOSPITAL STAFF (#36)

The work involved in the hospital/EMS agency communication and coordination is intricate and critical. As this relationship is intricate, it is essential that each hospital in New York State be required to have a staff member designated as the EMS Outreach Coordinator/Ambulance Discharge Coordinator to facilitate day-to-day communication, planning, and collaboration with ambulance services. In addition, it must be reiterated that there is a requirement for hospitals to share patient-specific health related information with Emergency Medical Services (EMS) personnel for the purpose of pre-hospital performance improvement (letter attached). **Hospitals need to have dedicated staff, at the administrative level, who work with EMS agencies to facilitate Interfacility & Non-Emergency transport.**

OTHER CONSIDERATIONS

In addition to the various Proposals made above by the RASTF, there were several general areas that were mentioned as impacting the EMS system both in the present and the future. The RASTF felt strongly that these issues should be amplified and given their due by EMS agencies and leadership. They include:

UNIFIED VOICE FOR EMS

EMS in New York State is delivered by a variety of EMS agency types including municipal, commercial (proprietary), fire districts or departments, hospital-based, not-for-profit, faith-based and collegiate. There is no consistent, consolidated voice speaking for the overall field of EMS in New York State. There is no paucity of stakeholders including the United New York Ambulance Network (UNYAN), the New York State Volunteer Ambulance and Rescue Association (NYSVARA) and Firefighters Association of the State of New York (FASNY) as well as the various statutorily created entities such as the Regional EMS Councils (REMSCOs), the Regional EMS Medical Advisory Committees (REMACs), the State Emergency Medical Advisory Committee (SEMAC) and

[19] https://www.fema.gov/grants/preparedness/firefighters/safer

the State Emergency Medical Services Council (SEMSCO). We need an entity that will present a unified front to elected officials, the public and the media on the critical issues impacting EMS agencies and practitioners, compromising the vital services they provide to communities. With significant attention now focused on EMS in New York State, there has been increased awareness for the need to establish such a platform.

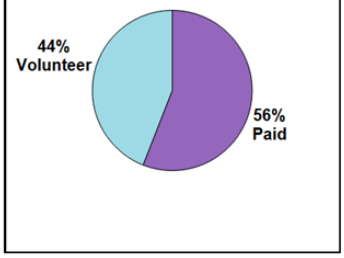
This issue was made even more apparent at the February 2024 SEMSCO meeting where, in relation to potential changes in the Public Health Law governing EMS, Assemblywoman Amy Paulin, Chair of the Assembly's Committee on Health, was quoted as saying "*there is really no agreement among you. There seems there were groups opposing last year's changes and yet there were groups within you supporting them. And that I think, cannot continue if we're going to make progress.*"[20]

To wit, many Proposals offered to elected officials on how to best handle the myriad issues facing EMS mirror the work of other similarly focused groups, but without intercommunication or coordination.

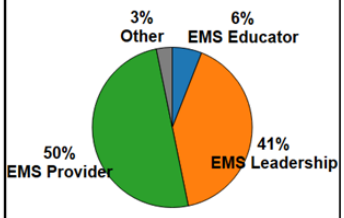
[20] https://www.health.ny.gov/professionals/ems/semac_semsco/past_meetings.htm

APPENDIX A – NYS RURAL AMBULANCE SERVICE TASK FORCE SURVEY

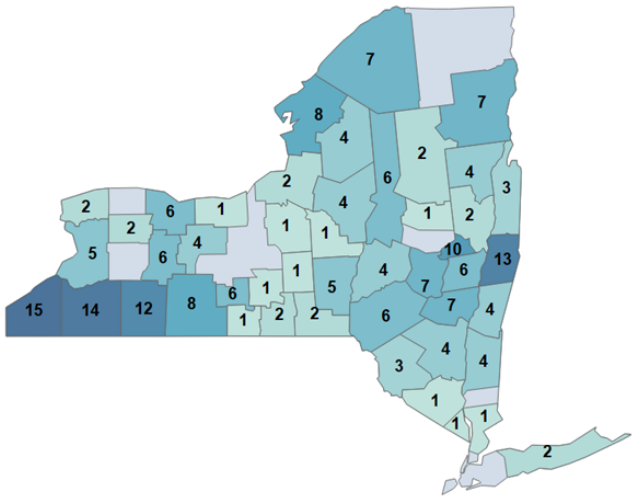
Paid/Volunteer Responses



Primary Role in EMS



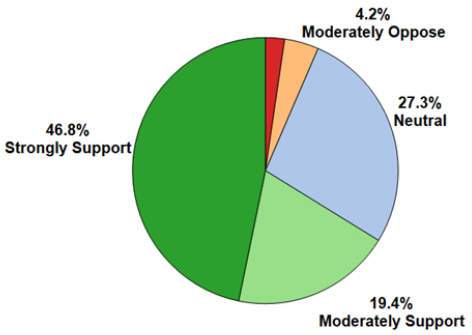
Submissions By County



Submissions By County Table

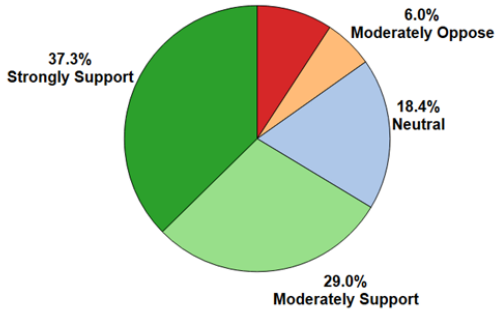
Chautauqua	15
Cattaraugus	14
Rensselaer	13
Allegany	12
Schenectady	10
Jefferson	8
Steuben	8
Essex	7
Greene	7
Schoharie	7
St. Lawrence	7
Albany	6
Delaware	6
Herkimer	6
Livingston	6
Monroe	6
Schuyler	6
Chenango	5
Erie	5
Columbia	4
Dutchess	4
Lewis	4
Oneida	4
Ontario	4
Otsego	4
Ulster	4
Warren	4
Sullivan	3
Washington	3
Broome	2
Genesee	2
Hamilton	2
Niagara	2
Oswego	2
Saratoga	2
Suffolk	2
Tioga	2
Chemung	1
Cortland	1
Fulton	1
Madison	1
Onondaga	1
Orange	1
Rockland	1
Tompkins	1
Wayne	1
Westchester	1
Grand Total	218

MIH and CP programs included in Public Health Law



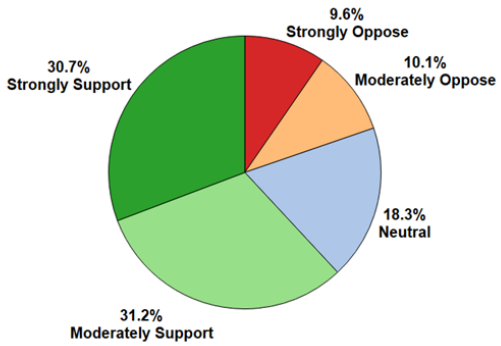
Current legislation provides authorization by amending Public Health Law to allow existing Mobile Integrated Healthcare and Community Paramedicine programs to operate as dictated by Executive Order Number 4 of 2021 for an additional two years. Should Mobile Integrated Healthcare and Community Paramedicine programs be incorporated into Public Health Law permanently in combination with legislatively mandated state funding for these programs?

Transport to Alternative Destinations



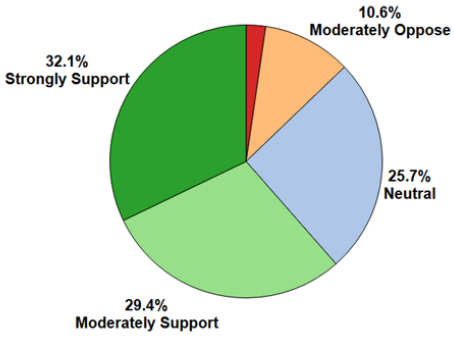
Do you feel that allowing EMS agencies to transport clinically appropriate patients to alternate destinations other than accredited article 28 facilities (including permission to bill and receive reimbursement for those transports under current ambulance billing guidelines) would improve the EMS system? Alternate transport destinations include but are not limited to health centers, physician offices, behavioral health centers, urgent care centers, and virtual emergency departments.

Combined EMT/AEMT Class



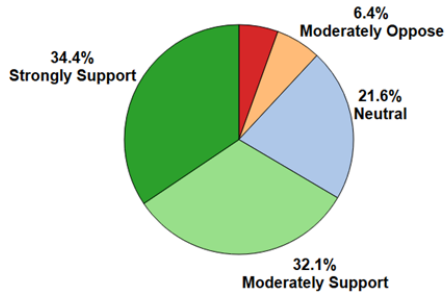
Do you feel it would be beneficial if there was an option for educators to conduct a combined EMT / AEMT class? This concept would allow students to progress directly into the AEMT program after completing the EMT section. The EMT / AEMT combination class concept would be designed to streamline and accelerate the education process involved with becoming and AEMT.

State-funded EMS Recruiting Platform



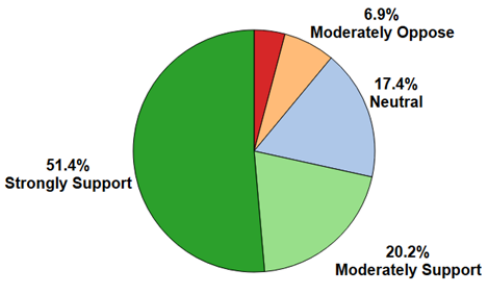
Do you think a state-funded recruiting platform would help with recruiting people to EMS?

ALS Resource Preservation and Tiered Response System Guidance



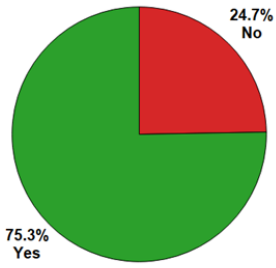
The Rural Ambulance Service Task Force is considering the potential benefit of creating an advisory or medical guidelines to provide guidance that assists counties and EMS agencies in building tiered response systems to preserve ALS resources for when truly necessary. Such an advisory would address expanded use of EMTs and AEMTs, call types that do not require an ALS level response, and call types that do not require to closest available transporting EMS resource to respond if that level of care is not believed to be necessary. If state advisory boards were assembled to create such advisories or guidelines, would the agencies and providers you represent benefit from those resources?

Require Countywide EMS Response Plans for EMS Readiness



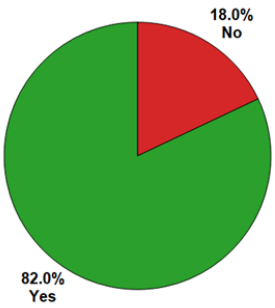
The Rural Ambulance Service Task Force feels it is important for counties to address EMS readiness as part of daily operations. EMS readiness at a county level includes mutual aid plans, gap coverage, and system status management operating in a unified system under the command of a common PSAP center. Do you support county governments being required to have countywide EMS response plans in place that address EMS readiness throughout the county regarding daily operations?

Streamlined mandatory cost reporting process tied to mandated increases in reimbursement*



Understanding the cost of running EMS agencies is the beginning of improving reimbursement rates. Would the agencies and providers you represent support the development of a streamlined mandatory cost reporting process if it was tied to legally mandated increases in reimbursement?
*Responses filtered to only include responses from EMS Leadership

Funding incentives for accreditation (i.e., CAAS, CAMTs)*



The Rural Ambulance Service Task Force is considering the potential benefit of developing funding streams to support the adoption of accreditation standards for EMS agencies. If the agencies and providers you represent were to have the opportunity to voluntarily become accredited (i.e., CAAS, CAMTs), would access to new funding be an incentive for them to do so?
*Responses filtered to only include repsonses from EMS Leadership

Attraction/Retention Factor Ranking			
Paid EMS Providers*		**Volunteer EMS Providers***	
1	Higher Wages	1	Ability to have State health benefits for all EMS professi..
2	Ability to have State health benefits for all EMS professi..	2	Participation in a State pension system (LOSAP or simil..
3	Participation in a State pension system	3	Stipend for Calls
4	Recognition as a health care profession (respect)	4	A life Insurance benefit for all EMS professionals
5	A life Insurance benefit for all EMS professionals	5	Recognition as a health care professional (respect)
6	Better leadership	6	Paid Academy-style training (earn as you learn)
7	Professional licensure	7	Better leadership
8	A well-defined career ladder	8	A well-defined career ladder
9	Improved Schedules	9	Professional licensure
10	Paid Academy-style training (earn as you learn)	10	Improved Schedules
The Rural Ambulance Service Task Force recognizes the need to improve recruitment and retention efforts in order to support the rural EMS provider workforce. For paid EMS providers, what benefits do you think would be most impactful in attracting and retaining people in careers in EMS in rural areas of NY?(Please rank from most impactful to least impactful with 1 being least impactful and 10 being most impactful) *Responses filtered to include only paid EMS providers		For volunteer EMS providers, what benefits do you think would be most impactful in attracting and retaining people as volunteers in EMS in rural areas of NY?(Please rank from most impactful to least impactful with 1 being least impactful and 10 being most impactful) *Responses filtered to include only volunteer EMS providers	

APPENDIX E – REFERENCES

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