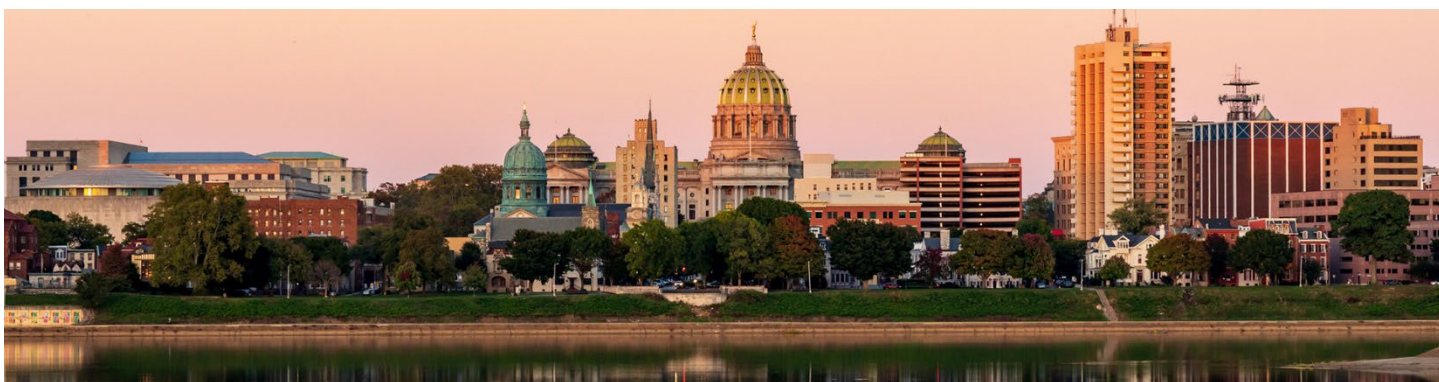




FISCAL YEAR 2025-2026 ANNUAL REPORT



PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL

Your Voice In EMS

Pennsylvania Emergency Health Services Council
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Mission, Vision and Values

Mission

The Pennsylvania Emergency Health Services Council (PEHSC) serves as an independent advisory body to the Pennsylvania Department of Health and other appropriate agencies on matters pertaining to Emergency Medical Services. As an advocate for its diverse member organizations, PEHSC fosters continuous improvement in the quality, accessibility, and delivery of emergency health services throughout the Commonwealth.

Vision

Pennsylvania is a national leader in providing a unified, high-quality system of emergency medical services and related health services. In partnership with organizations involved in emergency services across the Commonwealth, PEHSC advances advocacy, legislative education, outcomes research, system development, financial sustainability, public education, and organizational excellence to strengthen emergency health services for all Pennsylvanians.

Core Values

Value	Statement
Service	PEHSC advocates for and advances Pennsylvania's statewide EMS system through leadership, collaboration, and support.
Diversity	PEHSC engages EMS agencies, healthcare organizations, and stakeholders from across Pennsylvania's emergency services and medical communities.
Objectivity	PEHSC develops unbiased recommendations, resources, and initiatives that accurately reflect the needs of Pennsylvania's EMS system and professionals.
Responsiveness	PEHSC remains accountable to its members and responds proactively to emerging challenges, opportunities, and innovations in emergency medical services.
Synergy	PEHSC brings together diverse components of Pennsylvania's EMS system to identify challenges, share expertise, and create comprehensive solutions.

History, Funding and Function

History

PEHSC was incorporated in 1974. The Council's Board of Directors was recognized as the official EMS advisory body to the Pennsylvania Department of Health through the Emergency Medical Services Act of 1985 and was reauthorized in Act 37 of 2009.



PENNSYLVANIA EMERGENCY
HEALTH SERVICES
COUNCIL

1980



PENNSYLVANIA
Emergency Health Services Council

1990



2005



PENNSYLVANIA EMERGENCY
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2010



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Funding and Operating Context

The Board of Directors reviewed the impacts of the state budget impasse, ongoing constraints associated with a flat EMS Operating Fund (EMSOF) allocation, and delays in the Emergency Medical Services for Children (EMSC) contract. The Executive Director prepared the FY 2026-2027 draft workplan for submission to DOH, oversaw the annual 990 filing and Pennsylvania Annual Report requirement, and engaged a new audit firm.

Audit and Compliance

PEHSC's FY 2025 program-specific audit reviewed SAP# 4000025931 (PEHSC -July 2025- June 2026) / 4100097659 (EMSC -July 2025- March 2026). The auditor identified one deficiency related to a timing issue under the federal EMSC contract. In response, the Board confirmed that there were no questioned costs, fraud, or noncompliance findings, and that all vendor costs were later billed in full.

Function

The Pennsylvania Emergency Health Services Council (PEHSC) is built upon a strong grassroots network of EMS providers, stakeholders, committees, and task forces that meet regularly to identify, discuss, and address issues affecting emergency medical services throughout the Commonwealth.

These grassroots groups develop recommendations for consideration by the PEHSC Board of Directors. Following review and approval, PEHSC provides formal recommendations to the Pennsylvania Department of Health and other appropriate agencies to support the continued advancement of Pennsylvania's EMS system.

Through the active participation of volunteer EMS professionals from across the Commonwealth, PEHSC ensures that the voices of pre-hospital providers are represented in statewide policy development and decision-making. This volunteer-driven structure not only strengthens the EMS system but also provides significant value to the Commonwealth by reducing personnel costs. PEHSC members contribute their expertise by developing statewide guidance documents, educational programs, and other resources that support system improvement and informed decision-making.

Providers who wish to become involved in the PEHSC process may apply for membership on a task force. PEHSC establishes task forces on either a long-term or short-term basis to address specific issues, initiatives, or areas of interest affecting emergency health services in Pennsylvania.



Council Membership and Governance

PEHSC remains an organization-based, nonprofit corporation representing a broad cross-section of Pennsylvania's EMS, healthcare, public safety, and emergency services community. FY 2025-2026 Board materials identified several governance and membership changes during the year.

Governance / Membership Item	FY 2025-2026 Update
Board meeting dates	October 8, 2025; December 17, 2025; March 11, 2026; June 24, 2026.
Administrative officer	Alexander Snyder was welcomed as Administrative Officer.
Board of Directors Term ending 2026	Allegheny General Hospital, Cetronia Ambulance Corps, Lower Allen Township EMS, Volunteer Firemen's Insurance Services, Inc., and Wellspan York Hospital were thanked for service to the Board.
Organizations elected or welcomed for 2027-2029 term Board of Directors	Allegheny County EMS Council, Ambulance Association of PA, Bucks County Emergency Health Services Council, INC, Centre LifeLink EMS, Cranberry Township EMS, Cumberland Goodwill EMS, Elverson Honey Brook EMS, EMS of Northeastern PA, Harrisburg Area Community College, Hospital and Healthsystem Association of PA, Lehigh Valley Health Network, McCandles Franklin Park Ambulance Authority, Montgomery County Regional EMS Office, National Association of EMS Physicians – PA, Non-Profit Emergency Services of Beaver County, PA Chapter – ACEP, PA Trauma Systems Foundation, PA Fire & Emergency Services Institute, Penn State Hershey Medical Ctr, Riddle Hospital - Main Line Health, Second Alarmers Association and Rescue Squad of Montgomery Co., Southern Chester County EMS, Tower Health, UPMC EMS Physicians, UPMC Presbyterian Hospital, Uwchlan Ambulance Corps, Warwick Community Ambulance, West Grove Fire Company, Western Berks Ambulance Association, Williamsport Area Ambulance Services Cooperative dba Susquehanna Regional EMS.
Membership applications	VMSC Emergency Medical Services, a nonprofit EMS agency based in Lansdale, PA, was added as a Council member.
Special election	Christopher Chamberlain, Hospital and Health System Association of PA, was presented as Member-at-Large for FY 2025-2026 to replace Justin Eberly from Volunteer Fireman's Insurance Services (VFIS).

Executive Leadership and Council Staff

Executive Committee

Role	FY 2025-2026
President	Alvin Wang, DO
Vice President	Anthony Deaven
Treasurer	Bryan Wexler, MD
Secretary	Keith Laws
Member-at-Large	Christopher Chamberlain, RN
Member-at-Large	Gregory Porter
Immediate Past President	J. David Jones

Council Staff

Position	Staff Member
Executive Director	Janette Swade
Senior EMS Systems Specialist	Donald “Butch” Potter Jr.
EMS Systems Specialist	Andrew Snavelly
EMS for Children State Partnership Project Manager	Duane Spencer
Administrative Officer	Alexander Snyder

Executive Offices



Pennsylvania Emergency Health Services Council
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Board of Directors

Organization	Primary Rep
Allegheny General Hospital	Robert Twaddle
Allegheny County EMS Council	Greg Porter
Ambulance Association of PA	Donald DeReamus
Centre LifeLink EMS	Kent Knable
Cetronia Ambulance Corps	Robert Mateff
Cranberry Township EMS	Matt Nicki
Cumberland Goodwill EMS	Nathan Harig
Elverson Honey Brook EMS	Matthew Welch
EMS of Northeastern PA	Robert Carpenter
Harrisburg Area Community College	John Brindle
Hospital and Healthsystem Association of PA	Christopher Chamberlain RN
Lehigh Valley Health Network	Jeffrey Kuklinski, DO
Lower Allen Township Emergency Medical Services	Anthony Deaven
McCandles Franklin Park Ambulance Authority	Christopher Dell
Montgomery County Regional EMS Office	David Brown
National Association of EMS Physicians – PA	Alvin Wang, DO
PA Chapter – ACEP	Bryan Wexler MD
PA Fire & Emergency Services Institute	John Sly
Penn State Hershey Medical Ctr	Keith McMinn
Riddle Hospital - Main Line Health	Keith Laws
Southern Chester County EMS	Robert Hotchkiss
Tower Health	Brad Cosgrove
UPMC EMS Physicians	Christian Martin-Gill, MD
UPMC Presbyterian Hospital	Myron Rickens
Uwchlan Ambulance Corps	Keith Jones
Volunteer Firemen’s Insurance Services, Inc.	Richard Gurba
Warwick Community Ambulance	Casual Vacancy
Wellspan York Hospital	Avram Flamm, MD
West Grove Fire Company	Gary Vinnacombe
Williamsport Area Ambulance Services Coop.	Tony Bixby

Council Membership

The Council is an organization-based, non-profit corporation consisting of 118 organizations representing every facet of EMS in Pennsylvania. Each organization appoints a representative and one alternate representative to serve on the Council. Our member organizations include representatives of ambulance services, hospitals, health care providers, and firefighters, among others.

Council Membership Organizations

Albert Einstein Med Center - EMS Division	Emergency Medical Services of Northeastern PA
Allegheny County EMS Council	Emergency Nurses Association, PA
Allegheny General Hospital	EMMCO West, Inc.
Ambulance Association of PA	EMS West
American Heart Assn - Great Rivers Affiliate	First Aid & Safety Patrol of Lebanon
American Medical Response Mid-Atlantic Inc.	First Capital EMS
American Red Cross American Trauma Society, Pennsylvania Division	Forbes Hospital
Best Practices of Pennsylvania	Fraternal Association of Professional Paramedics
Binns and Associates, LLC	Geisinger-Lewistown Hospital
Bucks County Emergency Health Services Council, Inc	Good Fellowship Ambulance and EMS Training Institute
Bucks County Squad Chief`s Association	Harrisburg Area Community College
Butler County Community College	Highmark Inc.
Canonsburg Hospital	Horsham Fire Company No 1
Center For Emergency Medicine of Western PA	Hospital & Healthsystem Association of PA
Centre LifeLink EMS	J R Henry Consulting
Cetronia Ambulance Corps.	Jefferson Hospital
Chal-Brit Regional EMS / Chalfont EMS	Jeffstat
Chester Co Dept of Emergency Services	JET Response EMS
Chester County EMS Council, Inc.	Lancaster County EMS Council
City of Allentown EMS	Lehigh Valley Health Network
City of Pittsburgh-Bureau of Emergency Medical Services	Levittown-Fairless Hills Rescue Squad
Community Life Team	Lower Allen Township EMS
County of Schuylkill - Office of Public Safety	Lower Alsace EMS
Cranberry Township Emergency Medical Service	LTS EMS Council
Cumberland Goodwill EMS	Marple Township Ambulance Corps
Delaware County Regional EMS Council	McCandles-Franklin Park Ambulance Authority
Eastern Lebanon County School District (ELCO)	Medical Rescue Team South Authority
Eastern PA EMS Council	Medic-CE (A Career Step Company)
Elverson Honey Brook Area EMS	Minquas Fire Co. No. 2 EMS
Emergency Health Services Federation, Inc.	Montgomery County Ambulance Association



Montgomery County Regional EMS Office
Municipal Emergency Medical Services Authority of Lancaster Co
Murrysville Medic One
Myerstown First Aid Unit
National Assoc of EMS Physicians - PA Chapter
National Collegiate EMS Foundation
National Ski Patrol
New Holland Ambulance Association
Non-Profit Emergency Services of Beaver County
Northeast PA Volunteer Ambulance Association
PA Department of Health
Penn Medicine - Lancaster General Hospital
Penn State Milton S Hershey Medical Center
Pennsylvania ACEP
Pennsylvania Athletic Trainers Society
Pennsylvania Committee on Trauma-American College of Surgeons
Pennsylvania Fire and Emergency Services Institute
Pennsylvania Medical Society
Pennsylvania Neurosurgical Society
Pennsylvania Orthopedic Society
Pennsylvania Osteopathic Medical Association
Pennsylvania Professional Fire Fighters Association
Pennsylvania Psychological Association
Pennsylvania Society of Internal Medicine
Pennsylvania Society of Physician Assistants
Pennsylvania State Nurses Association
Pennsylvania State University, The
Pennsylvania Trauma Systems Foundation
Philadelphia Fire Fighters Union IAFF Local 22
Philadelphia Paramedic Association
Philadelphia Regional EMS Council
Plum EMS
Public Safety Training Associates
Rehabilitation And Community Providers Association
Riddle Hospital - Main Line Health

System Second Alarmers Association and Rescue Squad.
Seven Mountains EMS Council
Shaler Hampton EMS
Southern Alleghenies EMS Council
Southern Chester County EMS
Southwest Ambulance Alliance
St Luke's University Health Network
State Firemen's Association of PA
Suburban EMS
Susquehanna Regional EMS
Technical College High School – Brandywine
Temple Health System Transport Team Inc.
Thomas Jefferson University
Tioga County EMS Council
Topton A L Community Ambulance Service
Tower Health
UPMC EMS Physicians
UPMC Hamot
UPMC Presbyterian
UPMC Susquehanna
Uwchlan Ambulance Corps
Valley Ambulance Authority
VFIS
VMSC Emergency Medical Services
Volunteer Medical Service Corps of Lower Merion and Narberth
Wakefield EMS
Warwick Community Ambulance Association
Washington County EMS Council
Washington Hose Company #1
Wellspan York Hospital
West End Ambulance Service
West Grove Fire Company
West Penn Hospital
West York Ambulance
Western Berks Ambulance Association
Westmoreland County EMS Council Inc



Affiliate Council Membership

This group is comprised of 120 organizations or individuals who are members of the Council, but do not have voting privileges.

Affiliate Council Membership Organizations

7th Ward Civic Association Ambulance Service

Acute Care Medical Transports Inc.

Adams Regional Emergency Medical Services

American Health Medical Transport

American Life Ambulance

American Patient Transport Systems, Inc. (APTS)

Amserv. Ltd.

Area Services, Inc

Auburn Fire Company Ambulance Service

Beavertown Rescue Hoe Co. Ambulance Service

Blacklick Valley Foundation & Ambulance Service Inc.

Blakely Borough Community Ambulance Association

Borough of Emmaus Ambulance

Brighton Township Volunteer Fire Department

Brownsville Ambulance Service Inc

Central Medical Ambulance Service

Centre County Ambulance Association

Chippewa Township Volunteer Fire Department

Christiana Community Ambulance Assoc Inc

Citizens Volunteer Fire Company EMS Division

Clarion Hospital EMS

Community Ambulance Association Ambler

Community Ambulance Service, Inc

Community College of Beaver County

Conemaugh Township EMS Inc.

Cambria Alliance EMS

Delaware County Community College

Dover Area Ambulance Club

Duncannon EMS, Inc

East Brandywine Fire Company QRS

Eastern Area Prehospital Service

Easton Emergency Squad

Ebensburg Area Ambulance Association

Elizabeth Township Area EMS

Elysburg Fire Department EMS

Emergycare, Inc.

Event Medical Staffing Solutions

Fame Emergency Medical Services, Inc

Fayette Township EMS, Inc.

Fayetteville Volunteer Fire Department, Inc.

Fellows Club Volunteer Ambulance Service

Forest Hills Area Ambulance Association, Inc.

Gilbertsville Area Community Ambulance Service

Goshen Fire Company

Greater Pittston Ambulance & Rescue Assn.

Greater Valley EMS, Inc

Guardian Angel Ambulance Service Inc.

Halifax Area Ambulance and Rescue Association, Inc

Hamburg Emergency Medical Services, Inc.

Hamlin Fire & Rescue Co.

Harmony EMS

Hastings Area Ambulance Association, Inc.

Haverford Township Paramedic Department

Health Ride Plus

Hose Co #6 Kittanning Ambulance Service

Invona Volunteer Ambulance Service

Jacobus Lions Ambulance Club

James Wall

Jefferson Hills Area Ambulance Association

Jessup Hose Co No 2 Ambulance Association

Karthaus Ambulance Service

Kutztown Area Transport Service, Inc.

Lack Tuscarora EMS
 Lancaster EMS
 Lehigh Carbon Community College
 Lehighon Ambulance Association, Inc.
 Liverpool Emergency Medical Services
 Longwood Fire Company
 Lower Kiski Ambulance Service Inc.
 Loyalsock VFC #1 EMS Division
 Macungie Ambulance Corps
 Manheim Township Ambulance Assn.
 Mastersonville Fire Company QRS
 McConnellsburg Fire Department
 Meadville Area Ambulance Service LLC
 Med-Van Transport
 Meshoppen Fire Company
 Midway Volunteer Fire Company
 Mildred Ambulance Association, Inc
 Mount Nittany Medical Center - EMS
 Mountain Top Fire Company
 Muncy Township Volunteer Fire Company Ambulance
 Nazareth Ambulance Corps.
 New Holland Ambulance Association
 Northampton Community College
 Northampton Regional Emergency Medical Services
 Norwood Fire Co #1 EMS
 PAR Medical Consultant, LLC
 Penn Township Ambulance Association Rescue 6 Inc.
 Pennsylvania Office of Rural Health
 Pleasant Volunteer Fire Department

Point-Pleasant-Plumsteadville EMS
 Pottsville Area Emergency Medical Services, Inc.
 Radnor Fire Company
 Regional EMS & Critical Care, Inc.
 Rices Landing Volunteer Fire Department
 ROBB Consulting, LLC
 Robinson Emergency Medical Service, Inc
 Ross/West View EMS Authority
 Rostraver/West Newton Emergency Services
 Russell Volunteer Fire Department
 Scott Township Emergency Medical Services
 Shippensburg Area EMS
 Smiths Medical ASD Inc
 Snow Shoe EMS
 Somerset Area Ambulance
 South Central Emergency Medical Services, Inc.
 Southern Berks Regional EMS
 Stat Medical Transport, LLC
 Superior Ambulance Service, Inc
 Trans-Med Ambulance, Inc.
 Tri-Community South EMS
 UPMC Passavant
 Valley Community Ambulance
 Veterans Memorial Ambulance Service
 Western Alliance Emergency Services, Inc.
 Westmoreland County Community College
 White Mills Fire Department Ambulance
 White Oak EMS

Volunteer Activity

Activity Area	FY 2025-2026 Hours
Board of Directors / Council	476
Executive Committee	126
Membership Committee	9
Nominating Committee	12
Medical Advisory Committee	825
Protocol Update Workgroup	750
Critical Care Transport Task Force	176
EMS for Children Committee	260
EMS Education Task Force	123
EMS Operations Committee	5 (chairperson meetings)
Special Operations Task Force	20 (chairperson meetings)
Other Activities	275
Total Estimated Volunteer Activity	3,057

Financial and Operational Information

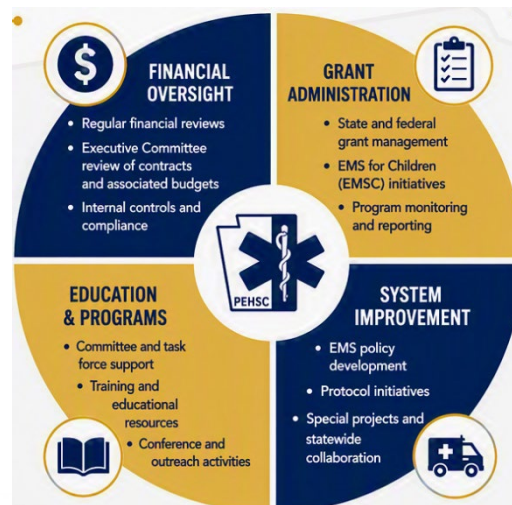
During FY 2025-2026 the emphasis was on budget and contract monitoring, audit completion, annual filing requirements, and continued attention to improving operational processes.

Category	FY 2025-2026 Status
State contract / EMSOF	The funding for PEHSC was impacted by the state budget impasse and the continued renewal status of the 2022 contract which limited flexibility in meeting current needs.
EMSC contract	The agreement for the period beginning April 1, 2025 was not finalized until June 2026. PEHSC (corporate) financially supported the basic functionality of the program until the federal grant was processed at the PA Department of Health. The delay has generated a funding carryover request with the federal program for 2026-27.
Audit	FY 2025 audit noted one deficiency related to a timing issue and no questioned costs, fraud, or noncompliance findings. The audit did not cover the April – June 2025 period for EMSC due to a lack of a signed agreement for the period.
Administrative filings	990 filing and Pennsylvania Annual Report requirement were completed
Member software	A transition from MemberZone to StarChapter was initiated to improve communications with member organizations and committee members

FY 2025-2026 Financial Information

Category	Budget	Actual*
State Contract		
Income	\$424,597.00	\$406,883.08
Expense	\$424,597.00	\$406,883.08 (carryover of \$ 17,713.92 approved for FY 26-27, due to delayed contract)
EMSC Contract Period: April 2025 – March 2026 (aligned with federal grant year)		
Income	Contract was not received until June 18, 2026 \$186,254	\$102,029.27
Expense	\$186,254.00	\$102,029.27 (carryover for this period and the prior federal period = \$277,397.00)
EMS Conference		
Income	\$22,000.00	\$39,669.42
Expense	\$17,000.00	\$16,732.30 Note: Income over expense of \$22,937.12 applied to 2026 conference

*Fiscal Year 2025-2026 amounts listed are pending the year end audit. The complete financial audit is available upon request to the council.



Recommendations to the PA Department of Health

The following recommendations, Concepts for Consideration, and related Board action items were presented during FY 2025-2026 Board materials.

Date	Identifier / Status	Originating Group	Subject / Recommendation Summary
October 8, 2025	CFC 1025-01 Submitted: Pending	President / Board discussion	EMS Peer-Driven Disciplinary Board concept, presented as a professionally led, fair, transparent, collaborative, supportive, and educational approach to strengthening professionalism.
December 17, 2025	VTR 1225-01 Submitted: Pending	Medical Advisory Committee	Recommendation that CPAP become required equipment for all BLS ambulances and squad vehicles.
December 17, 2025	VTR 1225-02 Submitted: Pending	Special Operations Task Force	Wilderness EMS recommendations addressing education standards, competency, reciprocity, scope of practice, formulary, operational considerations, and medical director best practices.
December 17, 2025	VTR 1225-03 Submitted: Accepted	EMS for Children Committee	Establishing the Prepared for Pediatrics - Emergency Department Program in Pennsylvania as a partner program to Prepared for Pediatrics - EMS.
March 11, 2026	VTR 0326-01 Submitted: Pending	Medical Advisory Committee	Amending equipment requirements for prehospital capture and transmission of 12-lead ECG by Basic Life Support to allow paper printout and/or digital display and transmit capabilities.
March 11, 2026	VTR 0326-02 Submitted: Pending	EMS Education Task Force	Student minimum competencies and related education standards work, as presented by the EMS Education Task Force.
June 24, 2026	VTR 0626-01 Submitted: Pending	EMS Education Task Force	Proposed Pennsylvania Standards for EVOC Program Sponsors and Authorized Training Sites.
June 24, 2026	VTR 0626-02 Submitted: Pending	Medical Advisory Committee	Recommendation to amend equipment and supplies to make the ECG printer requirement optional if the device can display, store, and transmit a diagnostic quality 12-lead ECG.

Research and Pilot Program Recommendations

Throughout FY 2025-2026, PEHSC committees, task forces, and the Medical Advisory Committee (MAC) reviewed emerging clinical practices, pilot programs, and research initiatives aimed at improving patient care, clinical outcomes, and system performance across Pennsylvania's EMS system. Discussions focused on evaluating innovative treatment approaches, exploring new technologies, and assessing opportunities for future protocol development. Topics reviewed included analgesia and medication administration pilots, prehospital ultrasound applications, physician response models, blood product delivery systems, sepsis treatment initiatives, and other clinical advancements. Recommendations and findings from these efforts supported evidence-based decision-making and informed ongoing protocol, education, and system development activities throughout the Commonwealth.

Note: Clinical pilot programs and research initiatives discussed by PEHSC committees represent proposals, evaluations, or field experiences and do not constitute implementation or statewide adoption unless formally approved through the Pennsylvania Department of Health.

Topic	Reported Activity
Nitrous oxide-oxygen analgesia	The MAC discussed the completed Superior Ambulance pilot for BLS administration of 50:50 nitrous oxide-oxygen with no undesirable outcomes, with support for adding the analgesic option to the draft 2025 protocol update.
Dexmedetomidine / Precedex monitoring	Temple Transport's dexmedetomidine pilot was discussed, with later reporting of approximately 30 patients enrolled each month and no reported problems.
Prehospital ultrasound in OHCA	WellSpan Health presented a pilot project for prehospital ultrasound in out-of-hospital cardiac arrest.
Prehospital antibiotics in sepsis	Warwick Community Ambulance presented a pilot involving prehospital administration of antibiotics in sepsis.
Prehospital physician response vehicles	Penn State Health EMS presented a pilot involving prehospital physician response vehicles.
Regionalized prehospital blood products	A regional coordination concept for delivery of prehospital blood products was discussed and identified for sub group work.
Point of care ultrasound	The role of point of care ultrasound in the prehospital environment was identified for subgroup work.
Keppra and seizure care	A possible pilot for Keppra use in seizure patients experiencing signs of status epilepticus was noted as awaiting a proposal from the principal investigator.
Syringe-based glucagon	The MAC considered expanding syringe-based glucagon use versus autoinjectors for EMTs, but the materials noted that cost difference did not support a change and would require additional provider education.
Famotidine, metoprolol, and continuous bladder irrigation	These clinical topics were referred to the protocol development workgroup for consideration.

Council Activities

Unified Statewide EMS Treatment Protocol Project

Significant progress was achieved during FY 2025-2026 on the development of Pennsylvania's unified statewide EMS treatment protocols. Drafts of Sections 1 and 2 were completed and submitted to the Medical Advisory Committee (MAC) for review and comment, while workgroup members advanced the review of Section 3 prior to MAC consideration. Ongoing review efforts focused on standardizing medication dosage formatting, improving the organization and flow of information, and addressing grammatical consistency throughout the documents. The Pennsylvania Department of Health also explored opportunities to partner with a vendor to develop a mobile application that would provide EMS providers with convenient access to protocols and other critical information on smartphones and tablets.

Critical Care Transport Protocol Development

The Critical Care Transport (CCT) Task Force continued efforts during FY 2025-2026 to modernize and enhance Pennsylvania's statewide CCT protocols. Progress included converting existing protocols into editable formats, adapting the statewide EMS protocol template for CCT use, reviewing best practices from other states, and evaluating challenges related to online medical direction during critical care transports. These efforts support the development of a regulatory-compliant framework that enhances clinical guidance, promotes consistency, and supports high-quality patient care during critical care transport operations.

Drug Assisted Airway Management Taskforce (RSI)

During FY 2025-2026, the RSI Task Force advanced planning and data infrastructure efforts for the statewide RSI initiative. The task force received approval from Vanderbilt University to utilize the REDCap platform for data collection and analysis and worked closely with a dedicated data subgroup to establish key data elements, reporting parameters, and analytical queries. These efforts support the collection of meaningful outcome data to enhance patient safety, measure program effectiveness, and validate the initiative prior to implementation.



System Improvement and Organizational Development

As part of planning efforts for FY 2026–2027, PEHSC explored and advanced new opportunities to strengthen EMS system performance, operational effectiveness, and organizational development. This will include the finalization of the Regional Innovation Project and the establishment of a new task force for late 2026 focused on developing agency self-assessment tools to support continuous improvement, operational effectiveness, and organizational readiness across Pennsylvania’s EMS community.

PEHSC also supported several projects designed to address system-level challenges and improve coordination between EMS agencies, healthcare organizations, municipalities, and other system partners. These efforts included:

- **Respond-to-Dispatch Requirements:** Participation in a statewide workgroup examining concerns related to Pennsylvania’s requirement for EMS agencies to respond when dispatched. The initiative focused on identifying operational, financial, workforce, and system-level challenges associated with the current requirement and exploring potential approaches to improve system sustainability while maintaining appropriate access to emergency services.
- **Emergency Department Status Reporting:** Development of a proposal to streamline the reporting of hospital emergency department status information to EMS agencies. The effort considered the operational needs of EMS agencies while recognizing the importance of appropriately addressing hospital diversion, capacity, and patient-flow concerns. The goal was to improve the timeliness and usefulness of information available to EMS personnel when making transport and destination decisions.
- **Municipal Engagement and Education:** Development of two resources designed to help EMS agencies establish and strengthen relationships with municipal leaders. The documents provide agencies with practical guidance for educating municipal officials about EMS operations, financial and readiness needs, service demands, staffing challenges, and other factors affecting the sustainability of local EMS services. These documents are found in Appendix C of this document.
- **Municipal Operational Reporting:** The municipal engagement resources also provide a framework for EMS agencies to present meaningful operational information to municipal officials. This approach encourages agencies to move beyond basic call-volume reporting and provide information that demonstrates service demand, response activity, system utilization, resource requirements, performance trends, and areas where municipal support may be needed.

Collectively, these projects reflect PEHSC’s continued focus on identifying system barriers, developing practical solutions, and providing EMS agencies and system partners with tools that support informed decision-making. The initiatives are intended to strengthen communication, improve operational coordination, promote organizational readiness, and support the long-term sustainability of Pennsylvania’s EMS system.

Medical Advisory Committee

During FY 2025-2026, the Medical Advisory Committee (MAC) continued evaluating emerging clinical practices, protocol enhancements, and operational standards to support evidence-based patient care across Pennsylvania's EMS system.

Key activities included:

- Reviewing stroke assessment tools, including BEFAST, mRACE, and VAN, along with associated ePCR data collection considerations.
- Evaluating clinical pilot programs and emerging practices, including analgesia administration, dexmedetomidine (Precedex) monitoring, regional prehospital blood administration, high-flow nasal cannula transport, and interfacility transport considerations.
- Advancing protocol and equipment recommendations related to CPAP requirements, BLS 12-lead ECG capabilities, and optional ECG printer requirements when electronic display, storage, and transmission functions are available.
- Considering new medications and treatment approaches for potential inclusion in future protocol development and system guidance.
- Reviewing DEA controlled substance regulations affecting EMS agencies and emphasizing the importance of drug diversion prevention and regulatory compliance.
- Highlighting the need for agency-specific controlled substance compliance plans, including procedures governing the chain of custody from acquisition and storage through administration, documentation, and disposal.

These efforts support ongoing improvements in patient care, clinical consistency, and regulatory compliance throughout Pennsylvania's EMS system.

EMS Operations Committee

During FY 2025-2026, PEHSC committees continued to address operational, clinical, and regulatory issues affecting EMS agencies across the Commonwealth.

Key activities included:

- Advancing discussions on shared staffing models and collaborative operational approaches to help agencies address workforce challenges and maintain service delivery.
- Evaluating financial and operational impacts associated with adding Continuous Positive Airway Pressure (CPAP) equipment to the Basic Life Support (BLS) required equipment list.
- Reviewing VTR 0625-01 and discussing other high-priority issues affecting EMS operations, patient care, and system performance.

These efforts supported ongoing system improvement initiatives and helped inform recommendations impacting EMS agencies throughout Pennsylvania.

Special Operations Taskforce

During FY 2025-2026, the Special Operations Task Force continued advancing initiatives to support specialized EMS operations throughout the Commonwealth.

Key activities included:

- Advancing recommendations for Wilderness EMS, helping establish guidance and best practices for emergency care in remote and austere environments.
- Continuing development of Tactical EMS recommendations to support agencies providing medical services during law enforcement and high-risk operations.
- Developing tactical EMS licensure resources at the request of the Bureau of EMS, including a package of guidance documents, application materials, and operational checklists to assist agencies navigating the tactical EMS licensure process.

These efforts support the safe, consistent, and effective delivery of specialized EMS services across Pennsylvania.

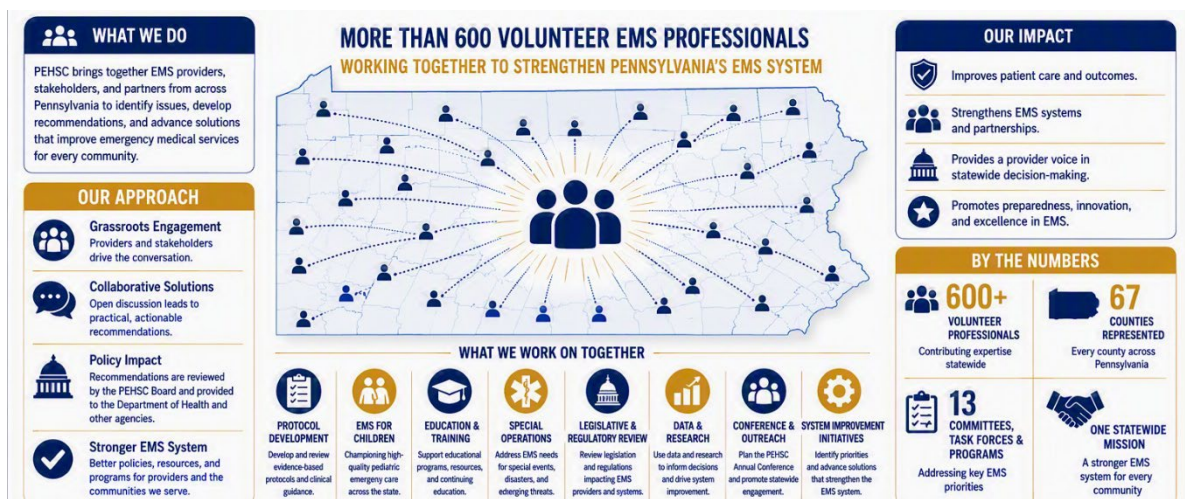
EMS Education Task Force

During FY 2025-2026, PEHSC continued to support the advancement of EMS education and training standards through collaboration with the Pennsylvania Department of Health and other stakeholders.

Key activities included:

- Providing feedback on EMS Information Bulletin 2025-11, which addressed Traffic Incident Management System (TIMS) requirements for initial EMS certification courses.
- Reviewing and commenting on Education Institute Accreditation documentation, helping refine accreditation resources prior to publication by the Department.
- Evaluating implications of the Interstate Nurse Licensure Compact and its potential impact on Prehospital Registered Nurse (PHRN) certification and practice within Pennsylvania.
- Developing proposed statewide standards for EVOC Program Sponsors and Authorized Training Sites to support consistency and quality in emergency vehicle operator training.
- Participating in Department-led discussions regarding student minimum competencies for BLS education programs and submitting formal recommendations to help guide future educational standards.

These efforts support the continuous improvement of EMS education, workforce development, and training quality across Pennsylvania's EMS system.



EMS for Children Committee

During FY 2025-2026, the EMS for Children (EMSC) Committee continued advancing pediatric readiness initiatives and strengthening emergency care for children across Pennsylvania.

Key activities included:

- Supporting EMSC grant activities, including the administration of partial and full funding awards and the development of program documentation and resources.
- Advancing the Prepared for Pediatrics - Emergency Department (ED) program following Department of Health approval on March 11, 2026. Planning activities included development of program standards and documentation, recognition level designations, an online application process, pilot hospital participation, and statewide implementation strategies.
- Expanding the Prepared for Pediatrics - EMS program, which became the statewide pediatric recognition pathway after July 1, 2026. As of May 26, 2026, 26 EMS agency applications were in progress and one agency had achieved recognition.
- Advancing additional pediatric initiatives, including development of a Family Advisory Network Task Force, creation of an education subcommittee, updates to the Emergency Guidelines for Schools, development of pediatric reference cards, and ongoing application review and site visit activities.

These efforts support PEHSC's commitment to enhancing pediatric preparedness, improving clinical outcomes for children, and promoting consistent pediatric standards across Pennsylvania's EMS and healthcare systems.

Pediatric Readiness Highlights

Program / Assessment	FY 2025-2026 Highlights
Prepared for Pediatrics - ED	Program outline received DOH approval on March 11, 2026. Program focus areas include pediatric emergency care coordination, patient safety and family-centered care, equipment/supplies/medications, policies and procedures, care team competencies, communications and collaboration, and quality improvement.
Prepared for Pediatrics - EMS	Agencies can complete recognition processes to continue pediatric recognition after July 1, 2026. Materials reported 26 applications in progress as of May 26, 2026 and one agency recognized.
2026 National Pediatric Readiness Project	Board materials reported a 73% response rate among Pennsylvania 24/7 emergency departments, totaling 125 ED responses, and 82.6% national response rate totaling 4,593 responses.
Prehospital Pediatric Readiness	Open assessment remains available anytime for EMS agencies to receive a current Gap Analysis Report. 2024 results were shown by BLS, ILS, and ALS level with average scores of 52.6, 63.3, and 72.2 respectively.



PENNSYLVANIA
EMSC State Partnership Program



New Member and Membership Updates

PEHSC continued to strengthen its membership during FY 2025-2026 through the recruitment and engagement of new organizations. Membership activities included the addition of organizations selected to serve on the Board of Directors for the 2027-2029 term and the review of a membership application submitted by VMSC Emergency Medical Services.



Contributions

PEHSC held or maintained representation on the following organizations and advisory bodies:

- **PEMA 911 Advisory Board** – Representation providing the statewide EMS perspective on emergency communications, 911 operations, PSAP coordination, and issues affecting the interface between emergency communications and EMS response.
- **Pennsylvania Trauma Systems Foundation (PTSF)** – Representation supporting coordination between the EMS and trauma systems and providing subject matter expertise on issues affecting prehospital and trauma care.
- **Pennsylvania Farm Safety Board** – Representation addressing EMS and emergency response considerations related to agricultural and rural safety, including the unique challenges associated with farm-related emergencies and rural response.
- **Office of the State Fire Commissioner – Volunteer Loan Assistance Program** – Representation providing an EMS perspective on the needs of volunteer emergency service organizations and opportunities to improve access to financial assistance, equipment, facilities, and other resources that support the operational readiness and sustainability of volunteer EMS agencies.

Professional Development and Outreach

PEHSC continued to support professional development, collaboration, and outreach across Pennsylvania's EMS community during FY 2025-2026. Activities included participation in regional and national initiatives through the following relationships:

- HRSA Atlantic Region EMSC Council
- National Association of State EMS Officials (NASEMSO) EAST Region,
- Pediatric Emergency Care Applied Research Network (PECARN) GLACIER .
- EMSC Innovation and Improvement Center (EIIC)
- Pennsylvania Fire & Emergency Services Institute Statewide Advisory Board Meetings
- * Dementia Friendly PA Community Advisory committee
- NAEMT Affiliate Council meetings

Legislative Affairs and Education

PEHSC serves as the independent, objective voice for Pennsylvania's EMS system by promoting high-quality, patient-centered care through collaboration, innovation, and advocacy. As such, the council monitors EMS related legislation and provides education to legislators and their staff on an as needed basis to meet systemwide needs.

- **Statutory Advisory Role:** Since 1985, PEHSC has served as Pennsylvania's legislatively recognized advisory council for emergency medical services, providing expert recommendations and guidance to the Pennsylvania Department of Health on EMS policy, regulations, and statewide initiatives.
- **Representation and Engagement:** PEHSC brings together more than 230 member organizations, including EMS agencies, hospitals, healthcare professionals, educational institutions, and advocacy groups. This broad membership ensures that diverse perspectives from across Pennsylvania's EMS system contribute to planning, development, and decision-making.
- **Policy and System Development:** Through its committees, task forces, and workgroups, PEHSC evaluates emerging issues, develops recommendations, and supports clinical, operational, and educational initiatives that strengthen emergency medical services throughout the Commonwealth.
- **Independent 501(c)(3) Nonprofit Organization:** As an independent 501(c)(3) nonprofit organization, PEHSC operates free from political influence while fulfilling its public advisory mission. PEHSC does not lobby for specific legislation or political candidates. Instead, it provides objective information, education, and subject matter expertise to policymakers and stakeholders on issues affecting Pennsylvania's EMS system.
- **Why PEHSC Matters to the Legislature**
 - Serves as a trusted, informed advisor for EMS-related policy.
 - Offers non-bias insight from the field—urban, suburban, and rural providers.
 - Supports a cost-effective way to gather system-wide consensus without expanding state bureaucracy.

LEGISLATIVE AFFAIRS & EDUCATION

— Providing Objective EMS Expertise to Policymakers Since 1985 —

PEHSC serves as the independent, objective voice for Pennsylvania's EMS system by promoting high-quality, patient-centered care through collaboration, innovation, and advocacy. The council monitors EMS-related legislation and provides education to legislators and their staff on an as-needed basis to meet systemwide needs.





PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL
Your Voice In EMS

WHY PEHSC MATTERS TO THE LEGISLATURE

- Trusted, Informed Advisor**
Serves as a trusted, informed advisor for EMS-related policy.
- Broad, Real-World Insight**
Offers non-bias insight from the field—urban, suburban, and rural providers.
- Cost-Effective Consensus**
Supports a cost-effective way to gather system-wide consensus without expanding state bureaucracy.
- Data-Driven Recommendations**
Provides data-informed guidance that supports high-quality, patient-centered EMS care statewide.
- Stronger EMS for Every Community**
Helps build a stronger, more resilient EMS system that saves lives and supports communities across Pennsylvania.

1. STATUTORY ADVISORY ROLE

Since 1985, PEHSC has served as Pennsylvania's legislatively recognized advisory council for emergency medical services, providing expert recommendations and guidance to the Pennsylvania Department of Health on EMS policy, regulations, and statewide initiatives.

2. REPRESENTATION & ENGAGEMENT

PEHSC brings together more than 230 member organizations, ensuring diverse perspectives from across Pennsylvania's EMS system contribute to planning, development, and decision-making.

- EMS Agencies
- Hospitals
- Educational Institutions
- Healthcare Professionals
- Advocacy Organizations

3. POLICY & SYSTEM DEVELOPMENT

Through its committees, task forces, and workgroups, PEHSC evaluates emerging issues, develops recommendations, and supports clinical, operational, and educational initiatives that strengthen emergency medical services throughout the Commonwealth.

4. INDEPENDENT 501(c)(3) NONPROFIT ORGANIZATION

- Independent and objective
- Free from political influence
- Does not lobby for specific legislation or political candidates
- Provides objective information, education, and subject matter expertise to policymakers and stakeholders on issues affecting Pennsylvania's EMS system

5. LEGISLATIVE EDUCATION

PEHSC provides education and information to legislators and their staff on an as-needed basis to support informed decision-making and meet systemwide needs.

- Legislative briefings
- System data and trends
- EMS subject matter expertise
- Responsive to policy questions and initiatives

PEHSC BY THE NUMBERS

- 230+** Member Organizations
- 600+** Volunteer Professionals
- 67** Counties Represented
- 41** Years of EMS Leadership

“PEHSC is committed to collaboration, innovation, and advocacy to ensure Pennsylvania's EMS system continues to provide high-quality, patient-centered care for all.”

ONE VOICE. ONE MISSION.  ADVANCING EMS. SUPPORTING COMMUNITIES. SAVING LIVES.  TOGETHER, WE STRENGTHEN PENNSYLVANIA EMS.



2026 Pennsylvania EMS Awards

The 2026 Pennsylvania EMS Awards recognized individuals and organizations demonstrating excellence in service to Pennsylvania's EMS system.

Award	Description
Dr. George Moerkirk Memorial Contribution to EMS Award	This award is in memory of George E. Moerkirk, M.D., Past President of PEHSC. Dr. Moerkirk was instrumental in the development and growth of Pennsylvania's EMS system. He provided EMS education to EMTs and paramedics and was actively involved in clinical care as a medical command physician and facility director. Dr. Moerkirk was known throughout Pennsylvania as the "father of EMS."
Amanda Wertz Memorial EMS for Children Award	This award is in memory of Amanda E. Wertz, daughter of Patrick and Elizabeth Wertz. Amanda was a child with special health care needs who died suddenly in 2001 at the age of 14 and whose parents were both active paramedics in Pennsylvania for many years. The purpose of the award is to honor an EMS provider who has made a difference in the lives of children in the Commonwealth of Pennsylvania in accordance with the mission of the EMSC program.
EMS Physician of the Year	To honor a certified prehospital physician, medical command physician, or agency medical director who has contributed to the advancement of prehospital emergency medical care in the Commonwealth of Pennsylvania
David Lindstrom EMS Innovation Award	This award honors the lifetime achievements of one of the organizers of the Pennsylvania Emergency Health Services Council, who is recognized for his leadership skills, innovative thinking, and meaningful actions which improved Pennsylvania's EMS system. This award is made possible as a result of a philanthropic gift from Mr. Peter Weiss, a retired Penn State Systems Engineer for Teleprocessing.
EMS Educator of the Year Award	To honor an individual EMS educator who has contributed to the development and growth of EMS education in the Commonwealth of Pennsylvania.
EMS Clinician of the Year	To honor an individual basic or advanced life support provider who has contributed significantly to the development and growth of emergency medical services in the Commonwealth of Pennsylvania.
EMS Agency of the Year - Large Agency Division	To honor a Pennsylvania EMS agency for their contribution to the development and growth of quality prehospital care within their community, while complying with the rules and regulations of the Commonwealth of Pennsylvania. Medium to large volume (>5,000 responses).
EMS Agency of the Year - Small Agency Division	To honor a Pennsylvania EMS agency for their contribution to the development and growth of quality prehospital care within their community, while complying with the rules and regulations of the Commonwealth of Pennsylvania. Small volume (<5,000 responses).

Dr. George Moerkirk Memorial Contribution to EMS Award

Darrell Fisher - New Holland EMS



Amanda Wertz Memorial EMS for Children Award

Theresa Walls, MD - Children's Hospital of Philadelphia



EMS Physician of the Year

Chris Berry, MD - Geisinger Health



David Lindstrom EMS Innovation Award

Gerald Wydro, MD – PennDel-Middletown Emergency Squad & Bucks County EHS Council



EMS Educator of the Year Award

Kimmin Dara Kalyaniwala - Harrisburg Area Community College



EMS Clinician of the Year

Tarin Dawson - North Versailles EMS



EMS Agency of the Year – Large Agency Division

McCandless-Franklin Park Ambulance Authority



EMS Agency of the Year – Small Agency Division

City of Meadville Fire Department



Pennsylvania EMS Conference

The Pennsylvania EMS Conference continued to provide statewide continuing education and outreach in a virtual format.

The 2025 Pennsylvania EMS Conference was designed to provide accessible statewide continuing education for EMS and emergency care professionals, with a mix of clinical, non-clinical, and pediatric-focused content. The conference also supported broader system engagement by expanding participation across EMS, healthcare, emergency preparedness, fire service, and leadership audiences while creating opportunities for professional networking and interaction with industry partners.

A [detailed report](#) was published and submitted the Department following the event.

Key sponsors for the event were: Wellspan Health, Penn State Health and Glick Fire Equipment

Metric / Item	Reported Value
2025 attendance	3,103 attended
Prior-year attendance comparison	2024 attendance was 2,802; 2025 reflected a 10.75% increase.
Sessions and CE	21 sessions and 25 hours of continuing education.
Total views	50,006 total views; average of approximately 2,000 views per session.
2026 event dates	Online continuing education sessions September 1-4, 2026, with on-demand availability until November 30, 2026.



Continuity of Operations

PEHSC continued to maintain and update its Continuity of Operations Plan (COOP) and emergency response procedures to ensure organizational readiness during local, state, and national emergencies. These plans support uninterrupted operations, guide staff response during workplace emergencies, and provide direction for alternate work locations and operational continuity when needed. No significant changes to the organization's continuity planning framework were reported during FY 2025-2026.

Website and Social Media

PEHSC continued to expand its communications and outreach efforts during FY 2025-2026 by providing timely information, educational resources, and updates to EMS professionals, agencies, stakeholders, and the public.

Key accomplishments included:

- Maintaining the PEHSC website as a central resource for organizational information, EMS initiatives, clinical guidance, and operational resources. During the fiscal year, the website received 27,331 page views.
- Supporting the EMS for Children (EMSC) website, which provides pediatric emergency care resources and program information for EMS agencies, healthcare providers, schools, and families. The website recorded 17,000 page views during the fiscal year.
- Expanding PEHSC's social media presence through Facebook, X (formerly Twitter), LinkedIn, Instagram, and TikTok, increasing opportunities to engage EMS professionals, member organizations, and the public.
- Growing audience engagement on Facebook, where PEHSC maintains more than 6,381 followers.
- Establishing new LinkedIn, Instagram, and TikTok business profiles to broaden outreach, support recruitment and awareness efforts, and connect with emerging audiences through multiple communication channels.

Through these communication platforms, PEHSC continues to strengthen engagement, enhance information sharing, and support the advancement of emergency medical services throughout the Commonwealth.

Looking Ahead

As PEHSC looks to the future, several key initiatives remain at the forefront of its work to strengthen Pennsylvania's EMS system. Priority areas include advancing recognition of EMS as an essential service, supporting sustainable EMS funding and contract stability, modernizing statewide treatment protocols, and enhancing pediatric readiness efforts. Additional focus areas include the development of interfacility and critical care transport guidance, implementation of tactical and wilderness EMS recommendations, promotion of provider wellness, creation of agency self-assessment tools, and identification of practical solutions to address ongoing workforce and resource challenges. Through these efforts, PEHSC continues to support a resilient, innovative, and patient-centered EMS system for the Commonwealth.

Acknowledgement

PEHSC extends its sincere appreciation to the Council members, Board members, committee and task force participants, staff, partner organizations, and dedicated volunteers who contribute their time, knowledge, and expertise in support of the Commonwealth's EMS system. Their commitment, collaboration, and leadership enable PEHSC to fulfill its mission as Pennsylvania's independent EMS advisory council and to advance initiatives, recommendations, and programs that strengthen emergency medical services and improve patient care throughout the Commonwealth.

Appendices



Appendix A

Recommendations





PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL
Your Voice In EMS

October 10, 2025

Subject: Concept for Consideration of an EMS Peer-Driven Disciplinary Board

Dear Director Martin:

On behalf of the Pennsylvania Emergency Health Services Council (PEHSC), we respectfully submit this concept for consideration (CFC) of enhancements to the current disciplinary process for EMS professionals through the creation of a Peer-Driven Disciplinary Board (PDDB).

As the statutorily recognized advisory body to the Department of Health, PEHSC continually seeks to identify opportunities to strengthen the fairness, transparency, and professional credibility of Pennsylvania's EMS system. Through ongoing discussions among stakeholders, it has become clear that the current disciplinary process, while effective in ensuring regulatory compliance, could be further improved by integrating peer involvement into case review and decision-making.

A peer-driven disciplinary structure would align EMS with other healthcare professions such as nursing, medicine, and allied health fields, where similar boards have demonstrated success in promoting balanced, consistent, and educational focus in disciplinary outcomes. Incorporating EMS peer expertise can help ensure decisions reflect sound clinical practice standards, promote remediation when appropriate, and support public trust.

This proposal was developed with input from the PEHSC Board of Directors, the regional EMS council directors, and through a survey of PEHSC's membership to capture a broad range of perspectives. It represents a consensus-driven starting point for discussion within the scope of existing law and regulation.

PEHSC respectfully recommends that the Department consider convening a joint workgroup to explore the structure, membership, and procedural framework for integrating a peer-driven disciplinary component into the EMS system. PEHSC stands ready to assist in this effort and to provide ongoing subject matter expertise, stakeholder engagement, and technical support.



Thank you for your consideration of this initiative to modernize and strengthen Pennsylvania's EMS disciplinary process. We look forward to collaborating with the Department on the continued evolution of a fair, transparent, and trusted system for professional accountability and improvement.

Following your review of this concept for consideration, if you should have any additional questions or concerns, please contact Janette Swade, Executive Director, at (717) 795-0740 or jswade@pehsc.org.

Respectfully submitted,

A handwritten signature in black ink, reading "Alvin Wang", is displayed on a light gray rectangular background.

Dr. Alvin Wang, DO FAEMS PHP NRP
President



PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL

Your Voice In EMS

CONCEPT FOR CONSIDERATION

Board Meeting Date: October 8, 2025

Subject: EMS Peer-Driven Disciplinary Board (EMS-PDDB)

CFC#: 1025-01

Committee/Task Force: Executive Committee

Concept Statement

The establishment of an EMS Peer-Driven Disciplinary Board (EMS-PDDB) within the PA Department of Health Bureau of EMS. The addition of the Board will enhance a fair, transparent, and consistent disciplinary process within Pennsylvania's EMS system. By leveraging peer expertise, the EMS-PDDB ensures accountability, promotes a Just Culture, and strengthens trust among providers, patients, and stakeholders. The EMS - PDDB will advise the Pennsylvania Department of Health, with jurisdiction over cases of certified personnel, EMS agency licensure, and related entities under Act 37 of 2009.

Rationale

Unlike many other healthcare professions that utilize peer-driven disciplinary processes, EMS currently lacks a complete system that reflects the unique expertise, standards, and perspectives of its professionals. Establishing a peer-based disciplinary board ensures that EMS practitioners are held accountable through a process that is both fair and informed by the realities of the profession. This approach not only aligns EMS with broader healthcare practices but also strengthens professional integrity and credibility, consistency, and public trust. Entrusting disciplinary review to a peer-driven process addresses these improvements by:

- **Fairness & Consistency:** Peer review reduces bias by ensuring disciplinary cases are evaluated by individuals with relevant field expertise and familiarity with EMS standards.
- **Professional Accountability:** A peer-driven model fosters ownership of professional standards within the EMS community.
- **Just Culture:** Shifting from a punitive model to one that emphasizes learning, accountability, and systemic improvement strengthens the profession.



- **Trust & Transparency:** Providers and stakeholders, including patients, gain confidence in a process that balances regulatory oversight with peer judgment.
- **Operational Integrity:** Involving diverse perspectives—physicians, paramedics, administrators, EMTs, attorneys, and others—ensures decisions are well-informed and representative of the EMS system’s breadth.

Committee Comments

This proposal represents a package of consensus-driven ideas developed to initiate a constructive conversation on implementing an EMS Peer-Driven Disciplinary Board within the existing scope of Pennsylvania law and regulations. It is intended as a starting point for collaboration and refinement, not as a final or prescriptive model.

The proposal reflects input from the PEHSC Board of Directors, the Regional EMS Council Directors, and a survey distributed to PEHSC membership as an initial step in the concept’s development. This inclusive approach was designed to ensure that the proposal reflects a broad range of professional perspectives and operational experiences from across the EMS system.

A review and feedback period of 60 days is recommended to allow the Department of Health, Bureau of EMS to evaluate the concept, propose adjustments, and align the implementation framework with regulatory requirements and operational realities.

It is important to note that the Pennsylvania Emergency Services Council (PEHSC) will have no controlling, operational or financial role in the governance or operation of the disciplinary board. Under this proposal, PEHSC’s sole function would be to facilitate the nomination and election process for board members, ensuring transparency and stakeholder representation.

Future Considerations

To ensure long-term success and sustainability, the following considerations should be addressed:

1. Governance & Structure

Establish clear bylaws and operational guidelines for the EMS-PDDB, including processes for case prioritization, appeals, and conflict-of-interest management.

Ensure balanced representation across geography, provider levels, and professional backgrounds.

2. Training & Education

Standardized training for board members in Just Culture principles, ethics, conflict resolution, and applicable EMS regulations.

Provide education for regional EMS councils to ensure consistency in investigation and quasi-determination processes.

3. Resource Allocation

Secure adequate funding (as needed) for board operations, including travel, staff support, and training.

Ensure regional councils have sufficient resources to conduct investigations effectively.

4. Accountability & Oversight

Implement a first-line appeals process outside of the Department of Health to maintain independence.

Establish periodic evaluations of board effectiveness, case timelines, and stakeholder satisfaction.

5. Implementation & Evaluation

Begin with a pilot phase to test procedures, gather feedback, and refine the process before full statewide adoption.

Conduct regular reviews to assess fairness, timeliness, and consistency in decisions, making adjustments as needed.

By adopting this concept, Pennsylvania EMS will strengthen its disciplinary framework, advance professionalism, and reinforce trust in the system.

Board Comments/Action

Passed as presented for submission to the PA Department of Health, 10-8-25



Signed: Alvin Wang DO, President

Date: 10-8-25

CONCEPT FOR CONSIDERATION for a Peer-Driven Disciplinary Board

PROPOSAL

Purpose A Peer-Driven Disciplinary Board (PDDDB) enhances fairness, transparency, and trust in the disciplinary process. By leveraging peer expertise, this initiative can contribute to a more accountable and ethical professional environment.

Introduction This proposal outlines the establishment of an EMS Peer-Driven Disciplinary Board (EMS-PDDDB) within the PA Department of Health, Bureau of EMS. The addition of the Board will enhance the current system to further promote fairness, accountability, and professional integrity. By entrusting disciplinary review to a panel of peers, this model fosters a just and transparent process while ensuring industry standards and regulatory compliance.

Objectives

1. Establish a fair, consistent and transparent disciplinary process.
2. Encourage accountability and professional ethics.
3. Encourage a Just Culture.
4. Reduce potential biases in disciplinary actions.
5. Foster trust among other healthcare professionals and stakeholders, including patients.

Board Composition

- The EMS-PDDDB will consist of up to 12 members (10 voting members with 2 at large members for identified conflicts) selected through a nomination and election process by their peers administered by the PEHSC, with PA Department of Health approval. Membership should include rotating terms and term limits.
- Members will represent diverse backgrounds within the field, ensuring varied perspectives. Specifically, the following provider groups should be represented: EMS Physicians with experience as an agency medical director, paramedics, EMS administrators, attorneys with a background in EMS/healthcare, AEMTs, and EMTs.
- Members will represent the geographic and provider diversity of Pennsylvania.
- Members should have no history of disciplinary action or ethical violations in relation to their role as a healthcare provider.
- Members should have appropriate professional experience, specifically, a minimum of 10 years of active EMS involvement.
- Terms will last 3 years, with staggered appointments to maintain continuity.
- Members must undergo training on the just culture model, ethics, confidentiality, conflict resolution, and due process.
- Members should have familiarity with state and federal EMS laws, protocols and standards of practice.

Jurisdiction and Authority

- The EMS-PDDB will handle cases as forwarded by the Department of Health, after a preliminary investigation and a recommended determination by the regional EMS council, which are related to violations of certified personnel, EMS agency licensure and any other accredited entity or personnel as identified in the EMS Act 37 of 2009.
- The board's decisions will be advisory to the Department of Health
- First line appeals may be directed to an independent oversight committee as identified by the EMS - PDDB. First line appeals should not be handled within the Department of Health.
- Final appeals will be handled via Commonwealth Court.

Process and Procedures

1. **Complaint Submission** – One access point / portal for complaints should be identified and complaints should be forwarded as per 1031.2 (b) Complaints and Investigations which identifies the filing office as,
“The complaint shall be filed with the regional EMS council that serves the EMS region where the conduct occurred. The regional EMS council shall provide the Bureau with a copy of the complaint. A complaint concerning the conduct of a regional EMS council shall be filed directly with the Bureau.”
2. **Investigation** – The regional EMS council will process each complaint to identify those that are suitable for the EMS-PDDB review.
The regional EMS council will follow a standardized process to conduct the investigation. Complaints will include a recommended determination (answering the question, did a violation occur or is the complaint an operational or clinical QA matter?) by the regional EMS council and will then be submitted to the PA Department of Health to review and to verify any violations. Complaints and the case file with supporting documentation of violations will be forwarded to the EMS-PDDB for review prior to the hearing.
3. **Hearing with EMS-PDDB** – Both the complainant and the respondent will have the opportunity to present their case, separately.
4. **Deliberation and Decision** – The board will deliberate and issue a decision with recommendations for corrective actions or sanctions.
5. **Appeals** – First line and final appeals (as appropriate) will be processed in a timely manner
6. **Follow-Up and Compliance** – The board will monitor compliance with any imposed corrective measures.
7. **Timeliness** – Adhere to established timelines for each process step to ensure timely case resolution.

8. **Transparency** – Maintain clear procedures for filing complaints, conducting investigation and issuing decisions.

Confidentiality and Ethics

- All proceedings will be confidential to protect involved parties.
- Conflicts of interest must be disclosed, and members with a direct conflict must recuse themselves.
- Ethical standards will be maintained to ensure impartiality and fairness.

Implementation Plan

1. Budget and fund the EMS-PDDB, as needed for travel, etc.
2. Provide staff support for the EMS-PDDB, with existing resources.
3. Draft governing and operational guidelines for the EMS-PDDB. These guidelines should include a process to manage priority cases of an emergent nature. The guidelines must identify timelines to process cases prudently.
4. Review and standardize the investigation process conducted by the regional councils. Provide associated education to ensure consistency at the regional level.
5. Budget and fund the regional councils as needed to support the investigation process
6. Select and train inaugural board members.
7. Establish a reporting and appeals structure.
8. Launch a pilot phase and refine processes based on feedback.
9. Fully implement the board and conduct periodic evaluations.



RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: December 17, 2025

Subject: Mandatory CPAP for BLS Ambulances and Squad Vehicles

VTR#: 1225-01

Committee/Task Force: Medical Advisory & EMS Operations

☐ Recommended Goal

☒ Recommended Policy Change

☐ Other:

Recommendation:

"The Department should amend the list of required equipment and supplies for licensed EMS vehicles to include one (1) CPAP device, equipped with at least one (1) adult facemask, on each licensed BLS ambulance and squad vehicle."

Rationale [Background]:

On November 5, 2025, PEHSC received a letter from the Emergency Health Services Federation, requesting the medical advisory committee consider a recommendation to the Department requiring a continuous positive airway (CPAP) device on vehicles at the basic life support licensure level.

The use of CPAP for BLS was an EHSF pilot in 2008. After the pilot was approved, CPAP only remained optional for BLS. The 2019 National EMS Scope of Practice Model included CPAP at the BLS level. However, in Pennsylvania it continues to remain optional. CPAP helps EMS providers manage respiratory distress and decrease the need for intubation, which correlates to decreased intensive care admissions, length of hospital stays, and death.

In 2024, there were 1,069 patients meeting the criteria for CPAP in the EHSF region. However, 265 of 1,069 (24.8%) patients had CPAP administration. The criteria included primary or secondary impression of congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD) with an oxygen saturation of less than 92% or respirations greater than 24 per minute. EHSF licensure data identified 32 of 52 EMS agencies operating at the BLS level participate in the optional CPAP program. Although there is no data on statewide voluntary CPAP use, it is reasonable to project the EHSF's high rate of participation across all licensed BLS agencies in the commonwealth.

Medical Review [Concerns]:

The medical advisory committee concurs with the EHSF's request and recommends the Department adopt the recommendation. There is ample evidence to support the efficacy of CPAP in cases of severe respiratory distress and hypoxia.. CPAP saves lives by avoiding or at least delaying the need for advanced airway placement.

Fiscal Concerns:

The EMS operations committee was consulted on this recommendation to consider of any potential operational or financial concerns. With the advent of disposable CPAP devices, the training time and financial outlay is substantially reduced thereby lessening the impact of compliance on BLS agencies. Disposable unit cost ranges between \$48 – \$80 each, however these are not high frequency use items. Unfortunately, no additional reimbursement for 3rd party payers currently exists for application of CPAP even though in some cases it results in lower healthcare costs associated with avoiding the need for positive pressure ventilation and/or ICU admission.

Educational Concerns:

Education on the use and application of CPAP is available on TRAIN PA and other multi-media resources.

Plan of Implementation:

1. Amend the current list of required equipment and supplies for EMS [BLS] vehicles.
2. Amend the inspection checklist for BLS vehicles.
3. Issue appropriate notification to all BLS agencies.

The PEHSC Committee/Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. The PEHSC Committee/Task Force specifically offers staff or member support to participate in Department deliberations regarding this recommendation in an effort to convey committee/task force discussions.

Board Meeting Comments/Concerns:

Signed:  Date December 17, 2025
President

For PEHSC Use Only – PA Department of Health Response

Accept: _____ Table: _____ Modify: _____ Reject: _____

Comments:

Date of Department Response: _____



VTR 1225-02

RECOMMENDED STANDARDS FOR WILDERNESS EMS IN PENNSYLVANIA

Developed by the PEHSC Special Operations Task Force

December 17, 2025



Executive Summary

This document describes standards recommended by the Pennsylvania Emergency Health Services Council to the Pennsylvania Department of Health to establish the Wilderness EMT in the Commonwealth. The Wilderness EMT represents a significant step in expanding the scope of practice for providers at and above the EMT level when practicing in specialized settings.

Historically, EMS was designed to deliver for short term care based on the assumption that definitive care was nearby and could be delivered quickly. Eventually there was a realization that this training, while valuable, needed to be supplemented to deal with the extended time and limited resources inherent to a medical emergency that occurs in a wilderness or backwoods setting. In the 1950's organizations began to develop training programs to address these special needs. Following a 1966 whitepaper, that led to the passage of the National Traffic and Motor Safety Act, emergency medical services as we know it today was born. The National Highway Traffic Administration was charged with creating the system's framework, including provider definitions and standardized training. The first wilderness EMT course was taught in 1976 to help EMT's in Colorado adapt their skills and knowledge when working with search and rescue teams.



The topography of Pennsylvania, while not as remote or austere as some states, can present a significant challenge to EMS providers who are called upon to provide care in a wilderness setting. The goal of this program is to build upon a provider's current certification level by introducing an expanded scope of practice and basic operational skills to provide EMS in a wilderness, backcountry or wild and uncultivated area.

Wilderness EMS training is not standardized and varies by state according to their assessed needs. In Pennsylvania, the EMS Systems Act of 2009 and accompanying regulations provides for the expanded scope of practice for providers at or above the EMT level in order to provide care when delivering the patient to definitive medical care may be delayed due to patient location. The expanded scope of practice afforded to these providers may only be utilized when functioning with an EMS agency that is licensed as a wilderness EMS Agency by the Pennsylvania Department of Health.

Sincerely,

PEHSC Medical Advisory Committee &
Special Operations Workgroup

December 17, 2025

PEHSC VTR 1225-02

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Introduction

Wilderness EMS is an emerging area of EMS practice in Pennsylvania that provides additional education and skills to experienced EMS providers at or above the EMT level to provide care in remote and sometimes austere environments where access to definitive medical care may be delayed due to distance, terrain or other factors.

Purpose

This project establishes educational standards and an expanded scope of practice for providers at or above the EMT level that will allow these providers to function safely and effectively as a component of a wilderness search and rescue operation.

Scope and Authority

Pennsylvania Department of Health (Department) possesses the statutory (Title 35, Health and Safety) and regulatory authority (Title 28, Health and Safety) to establish the Wilderness EMT and authorize their practice.

28 Pa Code § 1027.41. Special Operations EMS Services:

(a) *Generally.* A special operations EMS service provides EMS in austere environments that require specialized knowledge, equipment or vehicles to access a patient or it addresses patient care situations that differ from the routine situations that can be handled by a QRS, ambulance service or squad service, or some combination thereof. Depending upon the type of special operations EMS service and the circumstances presented, a special operations EMS service may be able to meet the EMS needs of the patient by itself, or may need to work with other EMS services to meet the EMS needs of the patient.

(b) *Special provisions.* The following apply to special operations EMS services:

(1) When providing EMS through a special operations EMS service, an EMS provider's scope of practice is expanded to include EMS skills and the use of equipment in addition to those included in the EMS provider's general scope of practice if the EMS provider has received education to perform those skills and use that equipment by having successfully completed a course approved by the Department for that type of special operations EMS service. The EMS provider is required to be able to document having received that education and to demonstrate competency in the performance of those skills and use of that equipment to the EMS agency medical director. Performance of those skills and use of that equipment by that level of EMS provider will be authorized by the Department as published in a notice in the *Pennsylvania Bulletin*. An EMS provider shall perform these skills as directed by the Statewide EMS protocols applicable to that type of special operations EMS service or as otherwise directed by a medical command physician.



System Integration

28 Pa. Code §1027.41 (d)

Wilderness EMS Service:

(1) *Purpose.* An EMS agency that provides a wilderness EMS service provides EMS in the wilderness, backcountry or other wild and uncultivated area to afford an EMS response should a person become ill or injured in that setting.

(2) *Coordination.* To secure and maintain an EMS agency license that authorizes the EMS agency to operate a wilderness EMS service, an EMS agency shall demonstrate that it has coordinated with a local, county or State emergency service or services and responds at their request.

(3) *Staffing.* An EMS agency that provides a wilderness EMS service shall be staffed by at least six EMS providers who have completed an educational program approved by the Department on wilderness EMS operations. The minimum staff when providing EMS as a wilderness EMS service is two EMS providers at or above the EMT level who meet these standards. EMS providers who provide EMS for a wilderness EMS service shall be 18 years of age or older. Shared staffing agreements or memoranda of understanding (MOU) between agencies should be permitted in order to facilitate minimum staffing if needed.

(4) *Reporting.* The EMS agency shall provide a summary report of a wilderness EMS operation response to the regional EMS council assigned to the region in which the wilderness EMS service was provided, within 30 days of the wilderness EMS operation, on a form or through an electronic process, as prescribed by the Department.

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Education Standards

Like many specialties, WEMS was created to fill a very specific need. Not surprisingly, this initially occurred with very little guidance or consistency. As more and more WEMS programs became operational it became evident that a minimum standard of practice and education was needed. In 2010, the Wilderness Medicine Education Collaborative (WMEC) was formed to develop consensus-driven standards in this specialty. In 2023 the WMEC published the "Certification Standards for Wilderness First Responder Courses" which "are intended to set clear standards for wilderness medicine certifications for the outdoor industry". As this is becoming a more widely accepted standard, the Department should ensure that any approved Wilderness EMS course meet or exceed these standards.

Course Design, Sponsorship and Approval Process

The design of the wilderness EMT course curriculum will be determined by the course sponsor and should be based on the student's intended practice environment.

The course sponsor should be accredited by the Pennsylvania Department of Health as a basic or advanced life support education institution, wilderness EMS agency or nationally recognized organization with expertise in wilderness EMS. The wilderness EMS agency or nationally recognized organization with expertise in wilderness EMS would be required to adhere to the same policies as accredited educational institutions with regard to course administration.



An educational institution or agency may not conduct a wilderness EMT course without first obtaining the approval of the Pennsylvania Department of Health. As part of its approval process the Department may require the course sponsor to submit course objectives, content outline, instructional guidelines or other information as may be needed in order for the Department, or its designee, to determine if the proposed course meets the educational standards outlined in this document.

Clinical Practicum

An EMT [or higher level provider] enrolled in a Department approved wilderness EMT course may benefit from engaging in a clinical practicum in order to gain real-life experience in both the clinical and operational aspects of wilderness medicine.

Completion of a clinical practicum is not required for a wilderness EMT endorsement by the Department, however it is highly recommended. The clinical experience may be provided as an integral part of a wilderness EMT course or may be provided by the wilderness EMS agency.

Competency Evaluation

The process to evaluate a student's entry-level mastery of the information presented in the wilderness EMT course is the responsibility of the course sponsor. This can be accomplished through the use of both cognitive and psychomotor examinations covering previously presented didactic and lab material. Course sponsors are permitted to incorporate the successful completion of a 3rd party exam as part of their course requirements, however the Department will not independently require such an exam following successful completion of an approved course as a prerequisite for expanded scope of practice.

The second level of competency evaluation, and arguably the most important, is that which is conducted by the wilderness EMS agency medical director as part of the agency's credentialing process. The medical director has the sole discretion to grant, restrict or deny [expanded] practice privileges, in total or in part, pursuant to 29 Pa. Code §1023.01 (a)(1):

(vi) Making an initial assessment of each EMS provider at or above the AEMT level to determine whether the EMS provider has the knowledge and skills to competently perform the skills within the EMS provider's scope of practice, and a commitment to adequately perform other functions relevant to the EMS provider providing EMS at that level. This subparagraph does not apply if the EMS provider was working for the EMS agency at the same level prior to the physician becoming the medical director for the EMS agency and the EMS provider was credentialed at that EMS agency within the last 12 calendar months as being able to perform at the EMS provider's certification level.

(vii) Making an assessment, within 12 calendar months of the last assessment, of each EMS provider at or above the AEMT level to determine whether the EMS provider has demonstrated competency in the knowledge and skills to perform the skills within the EMS provider's scope of practice, and a commitment to adequately perform other functions relevant to the EMS provider providing EMS at that level.

Expanded Scope of Practice Authority

The wilderness EMT will only be permitted to utilize the approved expanded scope of practice when providing care for a licensed wilderness EMS agency, or in other patient settings authorized by the Department of Health.

The wilderness EMT's expanded practice authority will be based on:

1. Completion of a Department approved education course or equivalent process.
2. The agency medical director's initial and annual review.
3. Other requirements as may be determined by the Department and/or licensed wilderness EMS agency.

Continuing Education Requirements

Continuing education requirements for providers with expanded scope of practice privileges will be determined by the EMS agency in consultation with the EMS agency medical director, who will determine the required number of continuing education hours and/or core content. Credits earned in wilderness subjects may be applied towards the Wilderness EMS provider's biannual registration requirement.

Transition to Expanded Scope of Practice

A provider, at or above the EMT level, who desires to obtain expanded scope of practice privileges to provide care on behalf of a wilderness EMS service, shall submit to the EMS agency medical director for review Documentation of successful completion of a Department approved course in wilderness EMS as posted on the Department's website.

Following approval by the EMS agency medical director, the agency will maintain a list of providers who have been granted expanded scope privileges. This list will be updated following the medical director's annual provider review and shall be made available to the Department and/or regional EMS council upon request.

Reciprocity

1. Complete the process established by the Department to obtain reciprocity as a Pennsylvania EMS provider.
2. Provide the EMS agency medical director with documentation of successful completion of a Department approved educational program in wilderness EMS as posted on the Department's website or an approved equivalent process.
3. If the EMS provider has completed a wilderness EMS course that does not appear on the Department's approved list, the provider may submit a request to the Department for review of the course for equivalency. The Department will determine the documentation required for such a review.

Providers above EMT Level

To accordance with Pennsylvania EMS regulations, providers at or above the EMT level are eligible for expanded scope of practice following completion of an approved educational program. As you review the recommended scope of practice, medication list and, in particular the education objectives, please be mindful that these standards were written to transition a provider at the EMT level.

It's important to note that establishing the educational objectives at the EMT level does not preclude higher level providers, i.e. AEMT, Paramedic, PHRN, PHPE and PHP, from completing an approved educational program and practice at an expanded scope level. The extent to which a provider's knowledge or scope of practice will be enhanced by the course is dependent on their current Pennsylvania certification.

While all provider levels will benefit from certain topics, e.g. wilderness operations and subjects related to workforce wellness/care, it's recognized that areas already within the provider's regular scope of practice will be redundant. When this is the case, the provider should view this as an opportunity to review the material previously presented in their certification course. If a sponsor conducts a course whose student composition consists of all providers above the EMT level, the sponsor may, at their discretion, change the depth and breadth of topic areas currently within the advanced provider's scope of practice.



Scope of Practice

Current Scope of Practice	Skills currently authorized for Pennsylvania EMTs. Consistent with current BLS operations, these skills would be utilized during a wilderness operation in both emergent/life threatening and non-emergent situations. An entry-level educational program will be required for the EMT to translate these skills for use in a wilderness environment. All wilderness EMTs in Pennsylvania will be required to demonstrate their ability to function safely and effectively in a wilderness environment.	Refer to current scope of practice document published in the Pennsylvania Bulletin by the Pennsylvania Department of Health, Bureau of Emergency Medical Services for a list of these skills.
Expanded Scope of Practice	OPTIONAL skills that <u>may</u> be selected and credentialed by the Wilderness EMS agency medical director Wilderness EMS providers in Pennsylvania will be required to demonstrate competency in any or all of these skills as determined by the Wilderness EMS agency medical director.	1. Epistaxis, Control of a. To include packing and commercial adjuncts 2. Joint Taping 3. Medication Administration: a. Intramuscular b. Intranasal c. Oral d. Topical 4. Wound Irrigation 5. Wound Closure - Tape a. Temporary closure only 6. Blister Incision & Drainage 7. Dental Care a. Avulsion and Fracture



Medication List

Current Scope of Practice	
Medications currently authorized for Pennsylvania EMTs. Consistent with current BLS operations, these medications would be utilized during a wilderness operation in both emergent/life threatening and non-emergent situations. An entry-level educational program will be required for the EMT to translate their use in a wilderness environment. All Wilderness EMTs Pennsylvania will be required to demonstrate their ability to function safely and effectively in a wilderness environment.	Refer to the list currently approved medications for EMS providers published in the Pennsylvania Bulletin by the Pennsylvania Department of Health, Bureau of Emergency Medical Services for these medications.
Expanded Scope of Practice Medications	
In addition to those medications approved for use in the current BLS Scope of Practice, medications from the following categories may be considered. The examples listed are not comprehensive and other may be used, provided that they fall into one of the approved classifications. All medications are considered optional and require approval by the wilderness EMS agency medical director. These medications would typically be used in an emergent or life-threatening situation. Wilderness EMTs in Pennsylvania will be required to demonstrate competency in the use of these medications to the wilderness EMS agency medical director. These medications will be administered, as appropriate, by intramuscular, subcutaneous, sublingual, intranasal, inhaled, oral or topical route.	
Glucose Elevating Agent	Glucagon (IM, IN)
Antihistamine/Decongestant	Pseudoephedrine (Sudafed) Cetirizine (Zyrtec) Fexofenadine (Allegra) Oxymetazoline (Afrin) Diphenhydramine (Benedryl)
Gastrointestinal	Antacid (Mylanta or equivalent) Loperamide (Imodium) Dimenhydrinate (Dramamine) Scopolamine
Analgesic/Anesthetic	Clove Oil
Stimulant / Anti-insomnia	Caffeine (No-Doz)

Storage and Transportation of Equipment and Supplies

A licensed wilderness EMS agency and the agency medical director are responsible to ensure all equipment and supplies used in a wilderness EMS response are stored, transported and used in a manner that complies with 28 Pa.C. §10278.5(e)(2), related to medication storage, and applicable federal requirements. The specific manner in which wilderness equipment and supplies are stored and transported may vary according to local needs.

For example, the agency may require all wilderness personnel to report to a fixed deployment point and respond to the incident in a department licensed emergency vehicles. In areas of the Commonwealth where the previously described deployment strategy would result in extended response times, the agency and its medical director may authorize certain equipment, supplies and medications to be stored upon and transported to an incident using an alternative transport method, such as a non-traditional vehicle. To ensure accountability, the EMS agency should develop policies for storage and transport of equipment, supplies and medications when using an alternative transport method.

Educational Objectives

Medical-Legal

- Understand the following legal concepts as they apply to wilderness medicine:
- Duty to Act and Good Samaritan Laws.
- Scope of practice.
- Consent and confidentiality.
- Understand the function of:
 - Certification.
 - Licensure.
 - Guidelines.
 - Standing orders.
 - Protocols.
 - Authorization (from a Medical Advisor).

Patient Assessment

Scene Survey

- Evaluate the scene and assess for safety and causes, including the need for personal protection equipment (PPE).
- Identify the obvious mechanism(s) of injury.
- Identify environmental and scene threats.
- Quickly evaluate resources.
- Consider the number of patients, the number of rescuers and their training, first aid/medical equipment, etc.



Primary Survey

- Stabilize life threats.
- Assist and support patients with their personal medications for life-threatening conditions such as epinephrine, short-acting bronchodilator, nitroglycerine, glucagon, naloxone, etc.
- Understand basic triage system with a Mass Casualty Incident (MCI).
- Assess the need and urgency of an evacuation and consider calling for medical or evacuation assistance before continuing with the Secondary Survey. Recognize when to call for an emergency evacuation for a life threat that requires additional resources and/or advanced life support (ALS).

Respiratory System

Assess:

- Patient's ability to breathe on their own.
- Quality of ventilation.
- Airway for foreign bodies or fluids. Treatment:
- Manually open, maintain and protect the airway with standard BLS techniques and the recovery position.
- Clear airway. Suction.
- Provide rescue breaths.
- Monitor and maintain airway control and breathing for people with an impaired Level of Responsiveness (LOR).

Circulatory System

Assess:

- Presence of patient's pulse at carotid artery.
- For life threatening bleeding/wounds.
- Likelihood of shock. Treatment:
- Perform CPR when indicated.
- Understand start/stop considerations for CPR in the remote context.
- Control bleeding with well-aimed direct pressure, wound packing, pressure bandage, or commercial tourniquet.

Nervous System

Assess:

- Level of Responsiveness (LOR). Know the common causes and signs and symptoms for traumatic, environmental, and medical mechanisms

Treatment:

- If LOR is depressed, attempt to identify and treat the underlying cause. Consider low blood sugar, low sodium, altitude, heat and cold illnesses, low oxygen levels, toxins, infection, etc.
- Provide ventilation ± medical oxygen for hypoxic patients.
- Identify a potential mechanism for a spine injury, and, if needed, protect the patient's spinal cord.



Core Basic Life Support skills:

- Practice and confirm practical skills via realistic simulations for adults and children:
 - Manually open airway and suction.
 - Perform rescue breathing.
 - Assess pulse at carotid artery.
 - Perform cardiopulmonary resuscitation (CPR).
 - Use AED.
 - Apply direct pressure.
 - Apply pressure bandage.
 - Maintain body temperature.
 - Understand commercial tourniquet use ± conversion.
 - Understand and consider spinal cord protection.

Elective Basic Life Support skills:

- Deliver medical oxygen via cannula or mask.
- Use airway management devices e.g. OPA, NPA, and Bag Valve Mask (BVM).
- Perform infant CPR and AED

Secondary Survey

- Perform a physical exam to identify obvious injuries or abnormalities.
- Measure and monitor vital signs: Level of Responsiveness (LOR), Heart Rate (HR), Respiratory Rate (RR), and Skin (circulation/color, temperature, wet/dry).
- Obtain a patient history.

Core secondary survey skills:

Practice and confirm practical skills via realistic simulations

- Count pulse rate (HR) at radial artery
- Count respirations (RR) and note quality
- Assess skin condition.
- Assess mental status/LOR
- Take SAMPLE history
- Complete Head-to-toe physical exam.
- Complete multiple patient SOAP notes on case-study or simulated patients

Elective secondary survey skills:

- Blood Pressure (BP) with a sphygmomanometer with or without a stethoscope
- Measure pulse oximetry
- Assessing lung sounds with a stethoscope.

Plan

- Document scene, primary, secondary survey findings, and patient information in a SOAP note.
- Develop a current and anticipated problem list.
- Develop and prioritize a treatment plan.
- Assess the need and urgency of evacuation.
- Deliver a concise, complete, and clear verbal patient report to an outside agency if requesting assistance / additional resources.
- Monitor a patient for changes over time.
- Continually reevaluate treatment and evacuation plans.

Core Plan & Evacuation skills:

- Basic improvised carries

Core Traumatic Problems

Traumatic Brain Injury

- Assessment:
 - Recognize the signs and symptoms of a minor traumatic brain injury (mTBI).
 - Recognize the signs and symptoms of increasing intracranial pressure.
- Treatment:
 - Protect the airway.
 - Protect the spinal cord.
 - Protect from environmental extremes.
 - Monitor for changes in mental status, decreased LOR and vomiting.
 - Assess the need and urgency of evacuation.

Hypovolemic Shock

- Assessment:
 - Evaluate for hypovolemic shock due to internal or external bleeding.
 - Recognize signs, symptoms, and vital sign patterns of hypovolemic shock and differentiate them from an acute stress reaction.
- Treatment:
 - Identify and manage the cause of hypovolemia
 - Keep the patient warm and protect from adverse environmental conditions
 - Provide oral fluids to maintain urine output for patients with normal mental status.
 - Stabilize injuries.
 - Minimize physical exertion.
 - Assess the need and urgency of evacuation.



Chest Trauma

- Assessment:
 - Evaluate and recognize the signs and symptoms of respiratory distress and respiratory failure due to chest trauma and subsequent lung injury.
 - Differentiate between open and closed chest injuries
 - Assess for flail chest/paradoxical chest rise
- Treatment:
 - Maintain a position that supports breathing.
 - Maintain a patent airway and support ventilation.
 - Stabilize/support injuries to the chest wall.
 - Seal an open chest wound; use a vented chest seal if feasible. Monitor.
 - Assess the need and urgency of evacuation.

Spine Injury

- Assessment:
 - Recognize a high-risk mechanism of injury for spinal cord damage.
 - Assess for potential spine injury via acceptable Focused Spine Assessment (FSA): Canadian C-spine Rule, modified NEXUS criteria, or Wilderness Medical Society FSA.
 - Consider neurogenic/vascular shock.
 - If you cannot rule out a spine injury, evaluate for vascular shock due to high (C-1 through C-4) spinal cord injury.
- Treatment:
 - Protect the airway.
 - Protect the spinal cord.
 - Use rolls, lifts, and extrication as needed to facilitate patient examination and protection.
 - Protect from adverse environmental conditions. Keep the patient warm.
 - Consider self-evacuation for ambulatory patients who fail the FSA due to low-risk column injuries.
 - Stabilize/protect and evacuate non-ambulatory patients who fail the FSA on a commercial litter, vacuum splint, or stretcher.
 - Assess the need and urgency of evacuation.

Core spine management skills:

- Know how to conduct a FSA and evaluate the type of evacuation needed.
- Know how to lift and move spine-injured patients.
- Know how to protect spine-injured patients and keep them warm.
- Know how to package spine-injured patients in (a) commercial litter(s). Examples include wire basket litter (Stokes), SKED, vacuum splint, fiberglass or plastic litters (Thompson, etc.).

Elective spine management skills:

- Improvise litters or stretchers using ropes, backboards, tarps, poles, etc.



Soft Tissue Injury

Wounds

- Assessment:
 - Recognize life-threatening bleeding.
 - Assess and communicate the need for post-exposure prophylaxis (PEP) for animal bites.
 - With an animal bite, assess and document the need for rabies prophylaxis.
 - Distinguish simple versus high-risk wounds.
- Treatment:
 - Control bleeding with direct pressure, pressure/clot enhancing bandage, or commercial tourniquet. Consider conversion.
 - Clean wounds by removing debris and pressure irrigation/debridement.
 - Dress and bandage wounds. For large wounds, deep puncture wounds, consider wet-to-dry dressings. Dress abdominal eviscerations with moist gauze and keep the patient warm.
 - Manage blisters, splinters, and fish hook injuries.
 - Remove impaled objects unless met with increased bleeding, pain, or resistance. Do not remove objects impaled in the globe of the eye, neck, or torso.
 - Manage amputations (control bleeding, wrap amputated part in moist gauze, place in a plastic bag, and keep cool while protecting from drying and freezing).
 - Assess the need and urgency of evacuation.

Infections

- Assessment:
 - Recognize signs and symptoms of local versus systemic infection.
- Treatment:
 - Hot compresses (avoid scalding the patient) promote drainage, and monitor.
 - Assess the need and urgency of evacuation. Begin an urgent evacuation for patients with signs and symptoms of a systemic infection.
- Prevention:
 - Understand prevention: drug-resistant infections and bloodborne pathogen awareness. Wound cleaning is preemptive

Burns

- Assessment:
 - Recognize the common causes of wilderness burns—hot water burns, grease burns, etc.—and take steps to mitigate them.
 - Assess depth: superficial, partial, or full thickness.
 - Approximate percent of body surface area involved.
 - Identify high-risk anatomical areas (e.g., airway, face, hands, feet, and genitals).



- Treatment:
 - Cool burns and protect with a clean, non-adherent bandage.
 - Understand that most burns are evacuated due to patient comfort, inability to travel or participate, or lack of appropriate dressing.
 - Assess the need and urgency of evacuation.

Musculoskeletal Injury

- Assessment:
 - Recognize signs and symptoms of musculoskeletal injury.
 - Differentiate between stable and unstable extremity injuries.
 - Recognize signs and symptoms of high-risk problems associated with musculoskeletal injuries (e.g., fractures of the femur or pelvis, open fractures, compartment syndrome, joint infections, and persistent ischemia).
- Treatment:
 - Treat stable extremity injuries with supportive and anti-inflammatory treatment.
 - Treat unstable and angulated long-bone extremity injuries with gentle traction into anatomical position.
 - Reposition unstable joint extremity injuries toward mid-range anatomical position if there is impaired circulation, sensation, and motor skills (CSM) or if splinting in position is impossible.
 - Splint unstable extremity injuries. Splints should provide adequate stabilization, be comfortable during extended evacuations, and allow for ongoing assessment of CSM.
 - Irrigate the wound and clean bone ends before applying traction to and splinting an open fracture.
 - Assess the need and urgency of evacuation.

Core musculoskeletal injury treatment skills:

- Understand the principles and practice improvised long bone and joint splints.
- Apply circumferential pelvic wrap (pelvic binder) for suspected pelvic fractures.

Elective musculoskeletal injury treatment skills:

- Apply commercial traction splints for femur fractures.

Core Environmental Problems

Contact Allergic Reactions (Poison Ivy, Oak, Sumac, etc.)

- Recognize signs and symptoms of contact allergic dermatitis.
- Treatment:
 - Wash affected area with soap and cool water to remove oily plant resin (urushiol)
 - Manage itching with cool compresses and topical corticosteroids.
 - Monitor for anaphylaxis.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies.
 - Consider patient history and individual management plan.

Sunburn

- Assessment:
 - Recognize signs and symptoms of a sunburn (superficial to partial).
- Treatment:
 - Consider the application of over the counter (OTC) medications or aloe.
 - Maintain hydration.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Understand the role of ultraviolet barriers, sunscreen and clothing.

Snow Blindness (photokeratitis)

- Assessment:
 - Recognize the signs and symptoms of photokeratitis.
- Treatment:
 - Remove from sunlight until signs and symptoms resolve.
 - Use cool compresses to mitigate pain.
 - Improvise slit sunglasses if goggles or sunglasses are unavailable.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Wear goggles or dark glasses with side protection to minimize ultraviolet (UV) exposure in bright sun, and on snow or water (due to reflection).

Dehydration

- Assessment:
 - Recognize common causes and spectrum of signs and symptoms for mild to severe dehydration.

- Treatment:
 - Provide oral fluids and electrolytes to satisfy thirst. Know how to improvise an effective oral electrolyte solution.
 - Identify and treat the underlying cause.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider fitness for the activity, hydration status, environmental temperatures, exertion levels, altitude, etc.

Heat Exhaustion

- Assessment:
 - Recognize signs and symptoms of heat exhaustion.
- Treatment:
 - Stop activity, remove insulative clothing, and find a cooler area.
 - Provide oral fluids to satisfy thirst.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider fitness, environmental temperatures, exertion levels, work/ rest ratios, hydration status, underlying medical conditions, physical conditioning, and predisposing medications (e.g., prescriptions, OTC, herbs, and dietary supplements)

Heat Stroke

- Assessment:
 - Recognize signs and symptoms of heat stroke.
- Treatment:
 - Aggressive, immediate core cooling as per available resources: Consider cool/cold water immersion, misting, fanning, shade, etc.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider environmental temperatures, exertion levels, hydration status, underlying medical conditions, physical conditioning, and predisposing medications (e.g., prescriptions, OTC, herbs, dietary supplements/ stimulants).

Exercise Associated Hyponatremia

- Assessment:
 - Recognize the spectrum of signs and symptoms for mild to severe exercise associated (exertional) hyponatremia

- Treatment:
 - Provide sodium and initiate fluid restriction.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider hydration status and amount of water consumed relative to sodium consumption.

Rhabdomyolysis

- Assessment:
 - Recognize the signs and symptoms of Rhabdomyolysis as a result of exertion, and heat stroke.
- Treatment:
 - Stop exertion and cool the patient as necessary.
 - Administer fluids (with electrolytes).
 - Assess the need and urgency of evacuation.
- Prevention:
 - Consider hydration status, environmental temperatures, exertion levels, and physical conditioning.

Hypothermia

- Assessment:
 - Recognize the spectrum of signs and symptoms for mild to severe hypothermia.
- Treatment:
 - Mild Hypothermia:
 - Give oral fluids and calories and protect from the environment. Consider a hypothermia wrap.
 - Moderate Hypothermia:
 - Handle gently and place supine in hypothermia wrap ± added heat.
 - Severe Hypothermia:
 - Handle gently and place supine in hypothermia wrap with added heat.
 - Assess the need and urgency of evacuation.
 - Perform rescue breathing or CPR when indicated.
- Prevention:
 - Identify and manage predisposing environmental and clinical conditions to prevent hypothermia. Consider environmental temperatures, wind, rain or snow, exertion levels (exhaustion), hydration status, available calories, shelter, and clothing.
 - *Core hypothermia treatment skills:*
- Practice and demonstrate how to build and move a patient into a hypothermia wrap.



Frostbite

- Assessment:
 - Recognize signs and symptoms of superficial to full thickness frostbite.
- Treatment:
 - Assess pros and cons of field thawing versus evacuation on frozen limb(s); manage for the best patient and group care:
 - Ideally, field thaw superficial frostbite in a warm water bath. Practically, this may need to be skin-to-skin.
 - Avoid refreezing affected areas.
 - Assess the need and urgency of evacuation.
 - Consider evacuating a patient with frozen extremities if evacuation time is 24 hours or less, when navigating technical terrain, or when resources are unavailable to properly thaw in the field.
- Prevention:
 - Recognize predisposing environmental and clinical conditions. Consider environmental temperatures, wind, snow, rain, exertion levels (exhaustion), hydration status, available calories, shelter, and clothing choice and fit (avoid local constriction).

Non-Freezing Cold Injuries

- Assessment:
 - Recognize signs and symptoms of nonfreezing cold injuries immersion foot, Raynaud's disease, and chilblains
 - Treatment immersion foot:
 - Passively rewarm the afflicted area (pat or air dry); the use of external heat sources to rewarm are contraindicated.
 - Elevate to reduce pain and swelling.
 - Understand that patients with swollen feet should not walk. If walking is unavoidable, protect feet and wear non-constricting footwear.
 - Treatment Raynaud's disease and chilblains foot:
 - Gently rewarm the afflicted area.
 - Avoid continued exposure.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Recognize predisposing environmental and clinical conditions; avoidance equals prevention. For immersion, consider immersion time in cold water, sweat, and clothing choice.



Drowning

- **Assessment:**
 - Recognize the spectrum of signs and symptoms for fatal and non-fatal drowning.
- **Treatment:**
 - When indicated, removal from the water should include practical respiratory support and spinal protection. When possible, maintain potentially severely hypothermic patients in a horizontal position during removal from the cold water as well as immediately after extrication from the water.
 - Provide rescue breathing or CPR as needed; if present, breathe through any foam issuing from the patient's mouth or nose.
 - Treat for hypothermia as necessary.
 - Assess the need and urgency of evacuation.
- **Prevention:**
 - Know the factors that contribute to drowning. For example, alcohol, not wearing a personal floatation device, cold water, group think, altered mental status (due to trauma, substances that alter mental status, medical problem, etc.), lack of skill, etc.
 - Recognize and manage high-risk environmental conditions designed to prevent extended immersion and submersion times.

Lightning

- **Assessment:**
 - Know the common mechanisms of lightning injury and common presentation of injury (cardiovascular, neurological, burns, and potential for traumatic injuries).
- **Treatment:**
 - Prioritize treating apneic and pulseless patients.
 - Perform rescue breathing or CPR when indicated.
 - Triage and treat any traumatic injuries.
- **Prevention:**
 - Recognize high-risk locations and weather conditions to minimize the risk of lightning strikes.

Altitude-Related Problems

- **Assessment:**
 - Recognize signs and symptoms of Acute Mountain Sickness (AMS).
 - Recognize signs and symptoms of High Altitude Cerebral Edema (HACE) and High Altitude Pulmonary Edema (HAPE).
 - Recognize patients who need to stop ascent and acclimatize or descend/evacuate.

- Treatment.
 - Stop ascent if symptomatic.
 - Descend if no improvement.
 - Descend immediately in presence of shortness of breath (HAPE) and ataxia and/or mental status changes (HACE).
 - Consider prescription medications.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and mitigation/prevention strategies. Consider preventative medications, acclimatization, and rate of ascent.

Arthropod Bites & Stings (insects, arachnids e.g., scorpions, spiders)

- Assessment:
 - Recognize the signs and symptoms of common arthropod bites and stings.
- Treatment:
 - Clean bites. Monitor for infection and necrosis.
 - Monitor for respiratory distress or failure and provide rescue breathing as needed.
 - Remove embedded ticks.
 - Assess the need and urgency of evacuation. If signs and symptoms of a tick-borne illness appear, evacuate.
- Prevention:
 - Understand the role and importance of avoidance, clothing, netting, repellents, and insecticides in the prevention of disease transmission.

Snakebites

- Assessment:
 - Recognize the signs and symptoms of cytotoxic, hemotoxic, and neurotoxic envenomations.
- Treatment:
 - Evacuate all suspected venomous snake bites.
 - Follow locally medically endorsed treatment practices for regional snakes.
- Prevention:
 - Identify common human behaviors that are factors in snakebite incidents.
 - Research snake behavior and habitat before entering venomous snake territory.

Core Medical Problems

Heart Disease

- Assessment:
 - Recognize signs and symptoms of a cardiac emergency.
- Treatment:
 - Stop activity. Keep the patient calm and in a position of comfort, typically sitting or semi-reclining.
 - For chest pain/pressure: administer low-dose aspirin or one regular aspirin dissolved in water and assist with their personal medications (e.g. prescribed nitroglycerine).
 - Perform CPR when indicated.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider patient history—including prescription medications—risk factors, and physical demands of the activity

Cerebral Vascular Accident (Stroke)

- Assessment:
 - Recognize signs and symptoms of a cerebral vascular accident (CVA) and be familiar with methods (e.g., FAST assessment) to assess a patient exhibiting these signs and symptoms.
- Treatment:
 - Keep the patient calm and offer reassurance.
 - Determine when the patient was last seen as “normal.”
 - Perform rescue breathing or CPR when indicated.
 - Aspirin is contraindicated.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider patient history—including prescription medications—and physical demands of the activity.

Seizures

- Assessment:
 - Recognize the signs and symptoms of partial and generalized seizures.
- Treatment:
 - During a seizure: Protect the patient from injury but do not restrain or put anything in the patient’s mouth.
 - Post-seizure: Keep the patient calm and provide reassurance. Protect and manage the airway and provide rescue breathing when needed.
 - Assess and treat any traumatic injuries incurred during the seizure.
 - Assess the need and urgency of evacuation.

- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider patient history, including seizures, past traumatic brain injuries, and prescription medications.

Problems with Sugar

- Assessment:
 - Recognize signs and symptoms of hypoglycemia and hyperglycemia in people with diabetes.
 - Recognize the possibility of non-life threatening hypoglycemia in people who do not have diabetes.
- Treatment for hypoglycemia:
 - Administer oral glucose tabs/sugar (honey, maple syrup, hard candy, juice) to all awake patients. Keep hydrated.
 - Consider administering glucagon (IM or nasal spray) in unresponsive patients. If unavailable, rub oral glucose/sugar paste—honey and maple syrup work—on the oral mucosa of all voice-responsive, pain-responsive, and unresponsive patients while they are lying on their side to protect their airway.
 - If intervention is successful, give a complex carbohydrate and protein meal.
 - Assess the need and urgency of evacuation.
- Treatment for hyperglycemia:
 - Keep the patient hydrated and assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider patient history, including prescription medications, and individual diabetes management plan.
 - Awareness that acute onset of illness (e.g., influenza, COVID-19) may affect glucose levels in persons with diabetes.

Toxic Reactions

- Assessment:
 - Recognize the signs and symptoms of toxic reactions and poisons commonly encountered in a wilderness environment.
 - Understand general principles of ingested, inhaled, and absorbed poison management.
- Treatment:
 - If possible, consult with a local poison control center (PCC) with the type of toxin/chemical, how much, when (time), where, and the patient's weight.
 - Treat for anaphylaxis if present.
 - Perform rescue breathing or CPR when indicated.
 - Ingested Poisons:
 - Supportive care and evacuation.
 - Inhaled Poisons:(commonly carbon monoxide , occasionally other gasses e.g., volcanic fumes, smoke, carbon dioxide, etc.)



- Scene safety. Remove from exposure.
 - Administer O2, if indicated and available.
 - Absorbed Poisons:
 - Remove contaminated clothing.
 - Flush the area with water and wash with soap.
 - Suspected opioid overdose:
 - Administer naloxone. Repeat as necessary.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Prior to the trip, research potential wilderness toxins; avoidance equals prevention.

Local and Mild Allergic Reactions

- Assessment:
 - Recognize signs and symptoms of local and mild allergic reactions.
- Initiate treatment:
 - Identify and remove the allergen or trigger when possible.
 - Treat local allergic reactions with cool compresses, a topical corticosteroid, and an oral antihistamine.
 - Monitor for anaphylaxis.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider patient history, triggers, and individual management plans.

Anaphylaxis

- Assessment:
 - Recognize signs and symptoms of anaphylactic reactions.
- Treatment:
 - Administer epinephrine as the first-line treatment for all anaphylactic reactions.
 - Administer an oral antihistamine as adjunctive treatment
 - Monitor for a second phase anaphylactic reaction and treat with epinephrine as described above.
 - Take steps to avoid repeated exposure to the allergen or trigger.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider patient history, triggers, and individual management plans.

Core anaphylaxis treatment skills:

- Practice and demonstrate how to use an epinephrine auto-injector.

Elective anaphylaxis treatment skills:



- Practice and demonstrate how to manually inject via a syringe ± draw from a vial or ampule.

Asthma

- Assessment:
 - Recognize signs and symptoms of mild to moderate asthma flare-ups and severe reactions.
- Treatment:
 - Identify and remove triggers when possible.
 - Assist patient into a position of comfort that supports breathing. Mild to moderate flare-ups:
 - Stop activity, rest, and calm the patient.
 - Assist the patient with their personal medications (prescribed short-acting bronchodilator)
 - Severe reactions:
 - Administer epinephrine. Once normal breathing has been restored, assist with short-acting bronchodilators.
 - Consider corticosteroids.
 - Provide respiratory support—rescue breathing, oxygen, or nebulized medication if available—when breathing becomes inadequate.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider patient history, including prescription medications, and individual asthma management plan.
 - Be familiar with the common triggers (cold, exercise, allergy, and stress) and emergency medications (short acting bronchodilators, epinephrine).

Respiratory Infections

- Assessment:
 - Recognize signs and symptoms of upper and lower respiratory infections.
 - Sinus infection: runny nose, sinus congestion, colored discharge, ± headache, sinus pain
 - Throat infection: sore throat, dry cough, ± fever, swollen lymph glands
 - Lower airway infection: fever, cough, chest tightness, and shortness of breath
- Treatment:
 - Rest.
 - Focus on adequate hydration.

- Treat symptomatically:
 - Sinus infection: Consider salt water flush, a local or systemic OTC decongestant; do not use antihistamines.
 - Throat infection: Consider salt water gargle, OTC cough suppressant or cough drops, consider zinc lozenges, and evacuate if strep is suspected.
 - Lower airway infection: consider using a OTC expectorant during the day and a OTC cough suppressant before bed, steam inhalation may ease episodes of respiratory distress
 - Quarantine as needed
- Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider camp hygiene, hand washing, mask use, and isolation of participants with potential airborne diseases (COVID, SARS, etc.).

Flu-like Illness

- Assessment:
 - Recognize signs and symptoms of flu-like illness (nausea/vomiting, diarrhea, fever, cough, upper respiratory involvement)
- Treatment:
 - Rest.
 - Focus on adequate hydration. Treat symptomatically using OTC medications.
 - Quarantine as needed
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider camp hygiene, hand washing, mask use, and isolation of participants with potential airborne diseases (COVID, SARS, etc.).

Genitourinary Issues

- Assessment:
 - Recognize signs and symptoms of vaginal yeast infections, urinary tract infections (UTI), testicular pain (e.g., torsion and epididymitis), atypical vaginal bleeding (i.e. miscarriage or menorrhagia), ectopic pregnancy.
- Treatment:
 - Treat vaginal yeast infections (Candidiasis) symptomatically with OTC medications. Consider prescription medications.
 - Treat UTIs with hydration and improved hygiene. Consider prescription medications.
 - In the event of testicular torsion, have the patient attempt a field correction by unweighting the scrotum.
 - Treat suspected epididymis with OTC medications and ice to control pain, definitive treatment typically requires antibiotics.



- For atypical vaginal bleeding, provide supportive care and fluids, evacuate as needed.
- For ectopic pregnancy, see abdominal pain and acute abdomen.
- Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider medical history, prescription medications, hydration status, and hygiene.

Abdominal Pain (including Gastrointestinal Illnesses)

- Assessment:
 - Recognize the signs and symptoms of abdominal pain commonly encountered during wilderness travel: bloating, gas, constipation, diarrhea, and nausea/vomiting.
 - Recognize signs and symptoms of an acute abdomen that require an urgent evacuation: rigid abdominal muscles, guarding, rebound pain, and generalized abdominal pain that becomes specific.
- Treatment:
 - Rest. Position of comfort.
 - Consider treating symptomatically with OTC medication. Focus on adequate hydration and adjust diet as needed.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Prevention focuses on diet, camp hygiene, hand washing, food choice and preparation, and water disinfection.

Eye Problems

- Assessment:
 - Recognize signs and symptoms of small foreign bodies (dirt, insects) in the eye and infection.
- Treatment:
 - Gently irrigate to remove small foreign bodies or pus from a bacterial infection. Do not remove impaled objects from the globe of the eye.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider hygiene, contact lenses and solution, and back-up glasses.

Ear Problems

- Assessment:
 - Recognize the signs and symptoms of objects in the ear, ear infections, and punctured or ruptured eardrum.
- Treatment:
 - Insect (or loose objects) in ear
 - Ear infections: Evacuate.



- Ruptured eardrum: Evacuate. Do not flush with water.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider the patient's history of ear infections, swimming, and water activities.

Nosebleeds (epistaxis)

- Assessment:
 - Recognize signs and symptoms of an anterior nosebleed.
- Treatment:
 - Gently blow nose, firmly pinch bridge of nose and lean forward. Consider packing the nose with gauze.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider the patient's history, cold, dry air, and high altitude.

Dental Emergencies

- Assessment:
 - Recognize signs and symptoms of lost crown/fillings, broken teeth, avulsed teeth, and dental infections.
 - If facial trauma is present, assess for a traumatic brain injury.
- Treatment:
 - Cover lost fillings and repair broken crowns with dental cement.
 - Attempt to preserve avulsed teeth if the evacuation is less than one hour.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions and prevention strategies. Consider facial trauma, poor hygiene, dental history, and lack of pre-trip screening.

Motion Sickness

- Assessment:
 - Recognize the causes and signs and symptoms of motion sickness.
- Treatment:
 - If possible, remove the underlying cause.
 - Consider OTC and prescription antiemetic medications.
 - Assess the need and urgency of evacuation.
- Prevention:
 - Identify predisposing environmental and clinical conditions. Consider fresh air, focusing on the horizon, OTC or prescription medications, and acupressure points.



Medical Director Requirements

The medical director serves as the chief medical officer for an EMS Agency. In this role the physician performs a variety of tasks to ensure patient care is delivered in a timely, safe and competent manner. Although a medical director may delegate some of the more routine tasks to physician or non-physician subordinates, it is essential the physician be engaged as an integral part of the prehospital healthcare delivery system.

In wilderness medicine, the physician medical director's role takes on added significance due to the complexity associated with providing advanced level care in an austere environment. The wilderness EMT represents the best of their profession, but can only provide optimal care when the agency medical director is prepared to guide and support their practice.

In Pennsylvania, the EMS Act (Act 37 of 2009) requires all licensed EMS agencies to have a medical director. The statute further provides requirements for physician qualifications and outlines their roles and responsibilities.

Recommended Best Practices Recommendation:

In addition to the requirements set forth in statute, the wilderness EMS agency medical director should assume the following responsibilities:

- a. Roles and responsibilities:
 1. Provide medical guidance, advice and continuing education [didactic, skills, scenario, etc.] to the wilderness EMS agency.
 2. Perform medical audits of Wilderness EMS provided by the wilderness EMS agency's EMS providers.
 3. Review the Statewide EMS and wilderness protocols and Department-approved regional EMS protocols that are applicable to the wilderness EMS agency and ensuring that its wilderness Medics and other relevant personnel are familiar with the protocols applicable to the wilderness EMS agency.
 4. Participate in and reviewing quality improvement and peer reviews of wilderness EMS provided by the wilderness EMS agency.
 5. Review regional mass casualty and disaster plans and providing guidance to the wilderness EMS agency regarding its provision of wilderness EMS under those plans.
 6. Provide guidance to the wilderness EMS agency, when applicable, with respect to the ordering, stocking and replacement of medications and devices, and compliance with laws and regulations impacting upon the wilderness EMS agency's acquisition, storage and use of those medications.

7. Make an initial assessment of each wilderness medic at or above the EMT level to determine whether the wilderness EMS provider has the knowledge and skills to competently perform the skills within the wilderness provider's scope of practice, and a commitment to adequately perform other functions relevant to the wilderness provider providing EMS at that level. This subparagraph does not apply if the wilderness EMS provider was working for the wilderness EMS agency at the same level prior to the physician becoming the wilderness medical director for the wilderness EMS agency and the wilderness EMS provider was credentialed at that wilderness EMS agency within the last 12 calendar months as being able to perform at the wilderness provider's certification level.
 8. Make an assessment, within 12 calendar months of the last assessment, of each wilderness EMS provider at or above the EMT level to determine whether the wilderness EMS provider has demonstrated competency in the knowledge and skills to perform the skills within the wilderness provider's scope of practice, and a commitment to adequately perform other functions relevant to the wilderness provider providing wilderness EMS at that level.
 9. Recommend to the wilderness EMS agency that a wilderness EMS provider not be permitted to provide wilderness EMS at the wilderness provider's certification level if the wilderness EMS medical director determines that the wilderness EMS provider has not demonstrated competency in the knowledge and skills to perform the skills within the wilderness provider's scope of practice, or a commitment to adequately perform other functions relevant to the wilderness provider's providing wilderness EMS at that level, and recommending restrictions on the wilderness provider's practice for the wilderness EMS agency, if appropriate, to ensure patient safety.
 10. Provide medical direction and availability for wilderness medical command for the wilderness medic or wilderness EMS agency dispatch center if the wilderness EMS agency operates a wilderness EMS agency dispatch center.
 11. Maintain a liaison with the regional EMS medical director.
 12. Participate in the regional and Statewide quality improvement programs, participate in affiliated law enforcement agencies training and quality improvement programs and cooperate with regional, State and federal agencies as needed.
 13. Recommend to the relevant regional EMS council, when appropriate, wilderness EMS protocols for inclusion in the Statewide and regional wilderness EMS protocols.
 14. Recommend to the Department the supervision, revocation or restriction of a wilderness provider's certification.
- b. Minimum qualifications:
1. Be a physician with an unrestricted license to practice medicine in Pennsylvania.
 2. Have successfully completed an emergency medicine residency accredited by a residency program crediting body recognized by the State Board of Medicine or the State Board of Osteopathic Medicine and/or be board certified or board eligible in emergency medicine by an emergency medicine certifying board recognized by the State Board of Medicine or the State Board of Osteopathic Medicine. The physician should also have successfully completed or



taught the ACLS course within the preceding 2 years and have completed, the ATLS course and PALS course or APLS course, or other programs determined by the Department to meet or exceed the standards of these programs and maintain the certifications. The physician should have successfully completed and maintain certification as a Pre-Hospital Physician as recognized by the Department, or;

1. Have successfully completed a residency program in surgery, internal medicine, family medicine, pediatrics or anesthesiology, accredited by a residency accrediting body recognized by the State Board of Medicine or the State Board of Osteopathic Medicine. The physician should also have successfully completed or taught the ACLS course within the preceding 2 years and have completed, the ATLS course and PALS course or APLS course, or other programs determined by the Department to meet or exceed the standards of these programs and maintain the certifications. The physician should be able to meet the same educational competencies as the prehospital providers they supervise regarding medical care, mission planning and support.
3. Have successfully completed and maintain certification as a Pre-Hospital Physician as recognized by the Department.
4. Is an active medical command physician and has successfully completed the medical command course as recognized by the Department and serves or served as an ALS agency medical director having completed an EMS agency medical director course as recognized by the Department or has served as an ALS medical director under the Emergency Medical Services Act [35 P.S. & 6921-6938] [repealed by the act of August 18, 2009 [P.L.308, No. 37]] prior to February 16, 2010.
5. Have a valid Drug Enforcement Agency number.
6. Have completed an EMS agency medical director course or an EMS fellowship or other EMS training program that is determined by the Department to be equivalent. This training will ensure that the EMS agency medical director has knowledge of:
 - i. The scope of practice of the EMS providers.
 - ii. The provision of the EMS under the Statewide EMS protocols.
 - iii. The interface between EMS providers and medical command physicians.
 - iv. Quality improvement and peer review principles.
 - v. Emergency medical dispatch principles and EMS agency communication capabilities.
 - vi. EMS system design and operation.
 - vii. Federal and State laws and regulations regarding EMS.
 - viii. Regional and State mass casualty and disaster plans.
 - ix. Patient and EMS provider safety principles.

Medical Command

The licensed wilderness EMS agency should establish, by agreement, a relationship with a PA DOH accredited medical command facility(s) to provide primary online medical direction to its wilderness EMTs. Such an agreement(s) will ensure that physicians providing online medical direction are familiar with the expanded scope of practice capabilities of a wilderness EMT. This does not preclude the wilderness EMT from establishing contact with a local medical command facility if contact cannot be made with the primary medical command facility(s). The wilderness EMS should be in possession of a device, such as a satellite phone or similar, that will provide guaranteed communication link regardless of environment or location.

Statewide Wilderness EMS Protocols

The workgroup envisions the development of statewide wilderness EMS protocols to follow a similar path to that of the current statewide ALS protocols. These protocols should, when possible, be evidence based and developed with stakeholder input and in consultation with the PEHSC Medical Advisory Committee.

Board Meeting Comments/Concerns:

Signed: _____
President



Date December 17, 2025

For PEHSC Use Only – PA Department of Health Response

Accept: _____ Table: _____ Modify: _____ Reject: _____

Comments:

Date of Department Response: _____

December 17, 2025

PEHSC VTR 1225-02

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RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: December 17, 2025

Subject: Establishing the Prepared for Pediatrics - Emergency Department Program in Pennsylvania

VTR#: 1225-03

Committee/Task Force: EMS for Children Advisory Committee

☐ Recommended Goal

☒ Recommended Policy Change

☒ Other:

Recommendation: The Department of Health should accept the attached **Prepared for Pediatrics – ED Tier Requirements** and the **Prepared for Pediatrics’ ED Equipment, Supplies and Medications** as framework for a new pediatric readiness recognition program focused on the capacity of emergency departments across the Commonwealth to care for children in the event of an emergency. The recognition program is designed to support stabilizing the pediatric patient in the event of an emergency.

The program is a partner to the **Prepared for Pediatrics - EMS** program and supports the continuum of care as a resource destination for EMS agencies, families, and caregivers. The program is designed for communities to obtain local primary emergent care resources to treat and stabilize pediatric patients while supporting the subsequent (as necessary) transfer to higher levels of care available throughout state. Recognized emergency departments should not be presumed to have specialized capabilities. Pennsylvania has a depth of pediatric healthcare resources well beyond that of most other states, including specialized Children’s Hospitals and dedicated pediatric emergency departments to support access to pediatric care above that needed during the initial emergent situation.

While many adult patients arrive in the emergency department via the EMS system, the frequency of pediatric transport via EMS is less due to factors including the ease of (and sometimes lack of wanting to wait) parental transport via personal vehicle. The perceived or real urgency of care often leads patients to arrive at a local community hospital emergency department by virtue of proximity, and therefore the need to ensure all emergency departments across the Commonwealth are prepared for pediatric patients regardless of their location, respective to specialized pediatric care.

The program was designed based on federal guidelines and national standards.

Rationale [Background]:

Pediatric readiness in Pennsylvania and the EMS for Children Pediatric Voluntary Recognition Program (PVRP) for prehospital EMS agencies was developed in 2013 and was based on a fundamental premise of improved readiness to care for children driven by several key components, for which each became the singular requirement of five progressive recognition levels. Since then, the PVRP has been revised and a new **Prepared for Pediatrics – EMS** program for prehospital EMS agencies across the Commonwealth was implemented in July 2025.

RECOMMENDATION FOR CONSIDERATION - Establishing the Prepared for Pediatrics in Emergency Departments

As a parallel to our prehospital efforts and to maintain a continuum of pediatric care as EMS agencies discharge their patients to emergency departments throughout the state, we have utilized federal performance measures and national industry recommendations to develop the **Prepared for Pediatrics – ED** program. Program development employed the industry expertise of a representative steering committee including the Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Trauma Systems Foundation, pediatric emergency care physicians, nurses, and educators, Regional EMS Councils, Critical Access Hospitals, the Pennsylvania Office of Rural Health, Health Care Coalitions and the Public Health Management Corporation, the Bureau of Emergency Preparedness and Response, the Bureau of EMS, and Pennsylvania EMS for Children staff.

National research (Ames SG, 2019) has noted improved outcomes when emergency departments are better prepared to care for children. Additionally, the joint policy statement (Pediatric Readiness in the Emergency Department, 2018) also identified key areas of focus for improved readiness to care for this population. That research has been an integral part of newly established federal guidelines published as part of the EMSC program and the April 2023 **Implementation Manual for State Partnership Grants**. The manual includes guidance through a set of Performance Measures supporting pediatric readiness in Emergency Departments and EMS agencies and an expanded engagement of families and caregivers through the Family Advisory Network. Specifically to emergency departments, the Performance Measures include four key components. They are:

- To increase the percent of hospitals with an ED recognized through a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric emergencies.
- To increase the percent of hospitals with an ED that have a designated nurse, physician, or both who coordinates pediatric emergency care.
- To increase the percent of hospitals with an ED that weigh and record children in kilograms.
- To increase the percent of hospitals with an ED that have a disaster plan that addresses the needs of children.

Subsequent to the Performance Measure Manual being published, the Pennsylvania EMS for Children program established a steering committee and began work on developing a program outline and addressing key focus areas linked to improved pediatric care. These focus areas were then addressed in more detail with a combined team consisting of the steering committee and representatives from nine pilot facilities. The pilot facilities represented critical access hospitals, community hospitals, small and large health systems, a dedicated children's hospital, pediatric emergency departments, hospitals without inpatient pediatric care, and rural facilities. The focus areas and their specific requirements became the framework for the recognition program requirements and were then divided into two parts, with primary expectations and basic standards of practice integrated into the Tier 1 level and higher expectations or specialized levels of care or support set at the Tier 2 level.

Focus Areas:

- | | |
|---|---|
| • Pediatric Emergency Care Coordinator | • Care Team Competencies |
| • Patient Safety & Family Centered Care | • Communications and Collaboration Across Systems of Care |
| • Equipment, Supplies, and Medications | • Quality Improvement |
| • Policies and Procedures | |

Federal performance measures standards and expectations of all emergency department pediatric recognition programs are:

- Include, at a minimum, (in any tier/level), the following criteria:
 - A designated nurse and physician PECC,
 - Weigh pediatric patients in kilograms only,
 - Record pediatric patients' weight in kilograms only, and
 - A disaster plan that addresses the needs of children



RECOMMENDATION FOR CONSIDERATION - Establishing the Prepared for Pediatrics in Emergency Departments

- The program should have a verification process to validate that the facility meets program requirements, including a site visit that may be in-person or virtual.
- Additionally, the federal implementation manual specifically mentions and strongly encourages the inclusion of as many recommendations as possible from the most current version of the AAP/ACEP/ENA joint policy statement (Pediatric Readiness in the Emergency Department, 2018) along with participation in the National Pediatric Readiness Assessment as a requirement of each level.

The joint team reviewed recommended equipment, Supplies, and Medications and published a parallel list to the focus areas representing Equipment, Supplies, and Medications requirements for the Tier 1 and Tier 2 levels.

Together, the **Prepared for Pediatrics – ED Tier Requirements** and the **Prepared for Pediatrics’ ED Equipment, Supplies and Medications** function as framework for the new **Prepared for Pediatrics – ED** pediatric readiness recognition program focused on the capacity of emergency departments across the Commonwealth to stabilize and/or manage pediatric emergencies.

Recognition levels encompass a combination of program and equipment, supplies, and medication (ESM) tier requirements. Although specific nomenclature for the levels has not been finalized, the composition for each has.

Recognition Level	Program Requirements	ESM Requirements
Initial	All Tier 1 focus area requirements	All Tier 1
Secondary	All Tier 1, Tier 2 PECC, and 3 of 6 remaining Tier 2 focus areas	All Tier 1 and 2
Tertiary	All Tier 1 and 2 focus area requirements	All Tier 1 and 2

Medical Review [Concerns]:

No concerns. Physician, and specifically pediatric physician, input and considerations have been included in program development.

Fiscal Concerns:

The Pennsylvania EMS for Children State Partnership program is 100% funded by a federal grant issued by the Health Resources Services Administration and its Maternal & Child Health Bureau. The EMSC State Partnership program funding has historically been a fixed amount with each of 57 state partnerships across the nation receiving the same financial support amount despite differences in demand and effort of the program to meet grant expectations. Pennsylvania’s over 1200 EMS agencies and over 170 emergency departments are far greater in number than most other states or territories while our funding amount does not reflect this inequality.

The **Prepared for Pediatrics – ED** program is voluntary in participation. There are no direct fees for an emergency department to apply for recognition. However, any significant volume of application activity may require an application fee to offset program costs primarily associated with site visit expenses.

Specific facility costs are dependent on current practices and readiness to care for children in comparison to the program requirements. Specific to the additional equipment, supplies, and medications list above that which is required by regulation, items vary across tiers with many items already utilized by many facilities. Additional costs are nominal and widely dependent on facility practices in place prior to becoming recognized.

Nationally, research into the cost benefit of pediatric readiness and its associated reduction of in-hospital mortality does not specifically identify a measurable dollar value but does identify a specific reduction in deaths that can be associated with reduced healthcare costs and an improvement in quality of life. (Newgard CD, 2023), (Newgard CD L. A.-F., 2024).

RECOMMENDATION FOR CONSIDERATION - Establishing the Prepared for Pediatrics in Emergency Departments

Educational Concerns:

A comprehensive communications plan and marketing materials will be developed before the proposed Go-Live date to educate perspective healthcare facilities about the program requirements and processes. Additional and ongoing education on the program will be made available at statewide activities such as conferences or via direct consultation with the EMSC Program Manager. Quarterly PECC Learning Sessions will resume in 2026 and support facilities developing the role and the recognition program. The PECC sessions will include emergency department PECC's and prehospital EMS PECC's as components of the Partners in Pediatrics program to support collaboration and communication between EMS and ED's.

Plan of Implementation:

After over two years of steering committee activity and pilot facility engagement, the attached **Prepared for Pediatrics – Emergency Department Tier Requirements** and **Prepared for Pediatrics – ED Equipment, Supplies, and Medications** documents form the framework of a new emergency department pediatric readiness program, having been approved by the EMSC Advisory Committee, are being submitted to the Department of Health for consideration in support of emergency department pediatric readiness, the HRSA EMSC Performance Manual measures, and industry policy standards. Supplemental to these items will be the following program support documents.

- Prepared for Pediatrics – ED Program Administrative Handbook
- Prepared for Pediatrics – ED Program Application
- Prepared for Pediatrics – ED Program support materials including all necessary forms and attestations in support of requirement areas and levels of recognition
- Prepared for Pediatrics – ED Program Recognition Process Guidelines to support the required site visit activities and the additional required equipment inspections



These program documents will be developed to facilitate process, ensure consistency in language and effort, and address hospital emergency department and EMSC program capacity to support a functionally efficient readiness product. All program documents will be available for access on the Pennsylvania EMSC website @ www.paemsc.org.

Once DOH program approval has been received and program materials have been developed, a statewide marketing blitz is planned to communicate the programs requirements, provide education on the programs intent and benefit, identify the application process, and allow feedback to support assessing program implementation. Pilot facilities who participated in the planning process will be offered the first opportunity to become recognized through the new program. A July 1, 2026 Go-Live date is proposed to start accepting new applications to the statewide program.

A Frequently Asked Questions (FAQ) document will be developed from these pilot facilities and expanded with feedback from future applications after the program is live to support facility decisions to apply and application questions as they occur. The FAQ documentation will be available on the EMSC website.

All hospitals recognized by the Prepared for Pediatrics – ED program will be provided with program level certificates and additional media content support to share their efforts and readiness to care for children throughout their patient population communities. Recognized facilities will also be listed on the Pennsylvania EMS for Children website.

A plan for community education will follow and utilize the Family Advisory Network and Steering Committee teams as resources for information, targeted audiences, and communications portals.

The PEHSC Committee/Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. The PEHSC Committee/Task Force specifically offers staff or member support to participate in Department deliberations regarding this recommendation in an effort to convey committee/task force discussions.

RECOMMENDATION FOR CONSIDERATION - Establishing the Prepared for Pediatrics in Emergency Departments

Board Meeting Comments/Concerns:

Signed: Alvin Wang Date 12/17/2025
President

For PEHSC Use Only – PA Department of Health Response

Accept: _____ Table: _____ Modify: _____ Reject: _____

Comments:

Date of Department Response: _____

References

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Newgard CD, L. A. (2023). Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care. *JAMA Netw Open.*, 6(1):e2250941. doi:10.1001/jamanetworkopen.2022.50941

Newgard CD, L. A.-F. (2024). State and National Estimates of the Cost of Emergency Department Pediatric Readiness and Lives Saved. *JAMA Netw Open.*, 7(11):e2442154. doi:10.1001/jamanetworkopen.2024.42154

Pediatric Readiness in the Emergency Department. (2018). *Pediatrics*, 142 (5) e20182459. Retrieved from <https://doi.org/10.1542/peds.2018-2459>



Prepared for Pediatrics – Emergency Department – Tier Requirements

*** Version 3.1 ***



Tier 1 Requirement	Tier 2 Requirement
Pediatric Emergency Care Coordinator	
The emergency department will identify either a Nurse or Physician Pediatric Emergency Care Coordinator (PECC). This individual will meet the role requirements published separately. This individual may be part of a system-wide effort, but facilities should consider a local, on-site, person to facilitate the role and utilize regional health-system resources where applicable	The emergency department will identify both a Nurse and Physician Pediatric Emergency Care Coordinator (PECC). These individuals will meet the role requirements published separately. These individuals may be part of a system-wide effort but facilities must implement local, on-site, people to facilitate the role and utilize regional health-system resources where applicable
An advanced practice provider may serve in either of these roles.	
Patient Safety & Family Centered Care	
Pediatric patients are weighed in kilograms	All Tier 1 requirements plus:
Weights are recorded in kilograms (lb's conversion in EHR allowed)	Pediatric patients are weighed in kg only . Scales do not record lbs.!
For children who require emergency stabilization, a standard method for estimating weight in kilograms is used(e.g., a length-based system)	Weights are recorded in kilograms only . No documentation of weight in pounds is present.
The emergency department has a family centered care policy and staff receive regular education on including families in all levels of decision-making. This involves working with patients and families rather than providing care to or for them.	CO2 monitoring for children of all ages when indicated
Infants and children have a full set of vital signs recorded. A full set of vital signs includes temperature, heart rate, respiratory rate, pulse oximetry, blood pressure, pain, and mental status, when indicated, in the medical record	Timely tracking and reporting of pediatric patient safety events
Process for safe medication delivery that includes: prescribing, administration, and disposal, and pre-calculated drug dosing and formulation guides are available.	Processes are in place for safe pediatric interfacility transfer

Prepared for Pediatrics – Emergency Department – Tier Requirements

*** Version 3.1 ***



Tier 1 Requirement	Tier 2 Requirement
24/7 access to interpreter services in the ED	Provide for and support caregiver presence during ED visit, including resuscitation.
	Facility promotes a culture of non-punitive patient safety
Equipment, Supplies, and Medications	
Pediatric Equipment is referenced from the 2024 version of Pediatric Readiness in the Emergency Department Checklist based on the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEPP), and Emergency Nurses Association (ENA) 2018 Joint Policy Statement “Pediatric Readiness in the Emergency Department”. Changes to the Checklist, future publication so the joint policy statement, or revisions recommended by Pennsylvania Stakeholder will be reflected in the Prepared for Pediatric ED Equipment, Supplies, and Medications document.	
All Tier 1 items listed in the Prepared for Pediatric ED Equipment, Supplies, and Medications document.	All Tier 1 And Tier 2 items listed in the Prepared for Pediatric ED Equipment, Supplies, and Medications document.
Policies and Procedures	
Illness and injury triage	All Policies and Procedures required in Tier 1 plus:
Pediatric patient assessment and reassessment	Immunization assessment and management of the under-immunized patient
Consent, including when parent or legal guardian is not immediately available	Sedation and analgesia, for procedures including medical imaging
Physical or chemical restraint of patients	Social and behavioral health issues
Child maltreatment reporting and assessment	Children with special health care needs
Death of the child in the ED	Family and guardian presence during all aspects of emergency care, including resuscitation
Do not resuscitate (DNR) orders	Patient, family, guardian, and caregiver education
Discharge planning and instruction	Bereavement counseling
	Communication with the patient’s medical home or primary care provider as needed
	Telehealth and telecommunications

P4P ED Version 3.1 full program outline.docx last updated November 25, 2025

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Prepared for Pediatrics – Emergency Department – Tier Requirements

*** Version 3.1 ***



Tier 1 Requirement	Tier 2 Requirement
A written all-hazard disaster preparedness plan that addresses pediatric specific needs including: *Medications, vaccines, equipment, supplies and trained providers for children in disasters *Pediatric surge capacity for injured and non-injured children *Minimization of parent-child separation *Tracking and reunification for children and families *Access to specific behavioral health therapies and social services for children *Disaster drills include a pediatric mass casualty incident at least every two years Written pediatric interfacility transfer agreements There is a written Interfacility Transfer Guideline that includes: *Criteria for transfers (e.g., specialty services) *Criteria for selection of appropriate transport service *Process for initiation of transfer *Plan for transfer of patient information	A written all-hazard disaster preparedness plan that includes all requirements in Tier 1 plus: *Decontamination, isolation, and quarantine of families and children of all ages *Care of children with special health care needs Evidence-based clinical pathways, order sets or decision support available to providers in real time There is a written Interfacility Transfer Guideline that includes all requirements in Tier 1 plus: *Integration of family-centered care *Integration of telehealth/telecommunications
Care Team Competencies	
Nurses and other key support staff receive annual pediatric competency evaluations to assure knowledge around and use of required equipment, supplies, medications, and policies and procedures of the program. The facility provides pediatric annual training opportunities for all emergency department staff involved in the care of pediatric patients	All Care Team Competencies required in Tier 1 plus: The facility requires pediatric competencies for all emergency department physicians by policy or has a plan in place and approved by the medical board (or facility equivalent) to address pediatric physician competencies



Prepared for Pediatrics – Emergency Department – Tier Requirements

*** Version 3.1 ***



Tier 1 Requirement	Tier 2 Requirement
All emergency department nursing staff caring for the pediatric patient are certified in PALS (or equivalent)	All advanced practice providers caring for pediatric patients are certified in PALS (or equivalent)
4 hours of pediatric continuing education is required for all nursing, advanced practice providers, and non-boarded EM or PEM physicians every two years	4 hours of CME specific to pediatrics are required for board certified Physicians every two years
Communications and Collaboration Across Systems of Care	
A plan for best practices of communications and collaboration across systems of care that support the care of children in the emergency department.	All components of Communications and Collaboration Across Systems of Care in Tier 1 plus:
All efforts made to transfer completed images when a patient is transferred from one facility to another	Medical imaging capabilities and protocols address age- or weight-appropriate dose reductions for children
Collaboration with radiology, laboratory and other ED support services to ensure the needs of children in the community are met	
Quality Improvement	
The facility has a Quality Improvement program that includes pediatric-specific measures	All Quality Improvement requirements in Tier 1 plus:
Active participation in the NPRQI program.	System changes are based on performance assessment through the Quality Improvement program
Reports out on at least 2 of the 7 focused clinical conditions of the National Pediatric Readiness Quality Initiative (NPRQI) Measures. Assessment, Interfacility Transfer, Blunt Head Trauma, Seizures, Respiratory Complaints, Vomiting, and Suicidality.	There is a program of ongoing monitoring of system performance that integrates with the Quality Improvement program
	Reports out on at least 4 of the 7 focused clinical conditions of the National Pediatric Readiness Quality Initiative (NPRQI) Measures.

Prepared for Pediatrics ED Equipment, Supplies, and Medications

*** Version 2 ***



	Tier 1 Requirement	Tier 2 Requirement
Pediatric Equipment is referenced from the 2024 version of Pediatric Readiness in the Emergency Department Checklist based on the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEPP), and Emergency Nurses Association (ENA) 2018 Joint Policy Statement “Pediatric Readiness in the Emergency Department”. Changes to the Checklist, future publication so the joint policy statement, or revisions recommended by Pennsylvania Stakeholder will be reflected in the Prepared for Pediatric ED Equipment, Supplies, and Medications document.		
Guidelines for Medication, Equipment, and Supplies	A pediatric emergency equipment (crash cart/bag) in the ED is accessible and easily obtained.	Daily method in place to verify the proper location and function of pediatric equipment and supplies
	ED staff are educated on the location of all items	
	Medication chart, length-based tape, medical software, or other systems is readily available to ensure proper sizing of resuscitation equipment and proper dosing of medications	
	Standardized chart or tool used to estimate weight in kilograms if resuscitation precludes the use of a weight scale(e.g., length-based tape)	
Medications	Analgesics (oral, intranasal, and parenteral)	All Tier 1 Items and the following additional Tier 2 items.
	Antidotes (common antidotes should be accessible to the ED, e.g., naloxone)	Anesthetics (eutectic mixture of local anesthetics; lidocaine 2.5% and prilocaine 2.5%; lidocaine, epinephrine, and tetracaine; and LMX 4 [4% lidocaine])
	Antipyretics (acetaminophen and ibuprofen)	Antipsychotics (olanzapine and haloperidol)
	Antiemetics (ondansetron and prochlorperazine)	
	Antihypertensives (labetalol, nicardipine, and sodium nitroprusside)	
	Antimicrobials (parenteral and oral)	
	Benzodiazepines (midazolam and lorazepam)	

Prepared for Pediatric ED Equipment, Supplies, and Medications_ver2.docx last updated November 25, 2025

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Prepared for Pediatrics ED Equipment, Supplies, and Medications

*** Version 2 ***



	Tier 1 Requirement	Tier 2 Requirement
Medications	Bronchodilators	
	Calcium chloride and/or calcium gluconate	
	Corticosteroids (dexamethasone, methylprednisolone, and hydrocortisone)	
	Cardiac medications (adenosine, amiodarone, atropine, procainamide, and lidocaine)	
	Hypoglycemic interventions (dextrose, oral glucose)	
	Diphenhydramine	
	Epinephrine (1mg/mL and 0.1 mg/mL solutions)	
	Furosemide	
	Glucagon Insulin	
	Magnesium sulfate	
	Intracranial hypertension medications (mannitol, 3% hypertonic saline)	
	Neuromuscular blockers (rocuronium and succinylcholine)	
	Sucrose solutions for pain control in infants	
	Sedation medications (midazolam, etomidate and ketamine)	
	Sodium bicarbonate (4.2%)	
	Vasopressor agents (dopamine, epinephrine and norepinephrine)	
	Vaccines (tetanus)	



Prepared for Pediatrics ED Equipment, Supplies, and Medications

*** Version 2 ***



	Tier 1 Requirement	Tier 2 Requirement
General Equipment	Restraint device	All Tier 1 Supplies and the following additional Tier 2 items.
	Weight scale, in kilograms only (no opportunity to weigh or report in pounds), for infants and children	Patient warming device (infant warmer)
	Tool or chart that relies on weight (kilograms) used to assist physicians and nurses in determining equipment size and correct drug dosing (by weight and total volume)	IV blood and/or fluid warmer
	Pain scale assessment tools that are appropriate for age	
	Rigid boards for use in CPR	
	Pediatric-specific AED pads	
	Atomizer for intranasal administration of medication	
Vascular Access	Arm boards: infant and child	All Tier 1 Items
	Catheter-over-the-needle device: 22 gauge and 24 gauge	
	Intraosseous needles or device: pediatric	
	IV administration sets with calibrated chambers and extension tubing and/or infusion devices with the ability to regulate the rate and volume of infusion devices (including low volumes)	
	IV solutions: Normal saline, Dextrose 5% in 0.45% normal saline, Lactated Ringer's solution, Dextrose 10% in water	
	Extremity splints (including femur splints) for pediatric pt's	
	Cervical collar: infant and child	



Prepared for Pediatrics ED Equipment, Supplies, and Medications

*** Version 2 ***



	Tier 1 Requirement	Tier 2 Requirement
Monitoring Equipment	Blood pressure cuffs: Neonatal, infant, and child	All Tier 1 Items
	Doppler ultrasonography devices	
	ECG monitor and/or defibrillator with pediatric and adult capabilities, including pediatric-sized pads and/or paddles	
	Pulse oximeter with pediatric and adult probes	
	Continuous end-tidal CO2 monitoring	
Respiratory	Endotracheal tubes: uncuffed 2.5 mm, uncuffed 3.0 mm, cuffed or uncuffed 3.5 mm, 4.0 mm, 4.5 mm, 5.0 mm, 5.5 mm, and cuffed 6.0 mm	All Tier 1 Items
	Feeding tubes: 5F and 8F	
	Laryngoscope blades: straight#0, straight #1 & #2, curved #2	
	Magill forceps: pediatric	
	Nasopharyngeal airways: infant and child sizes	
	Oropharyngeal airways: sizes 0, 1, 2, and 3	
	Stylets for endotracheal tubes: pediatric and infant	
	Suction catheters: infant (6-8F) and child (10-12F)	
	Rigid suction device: pediatric	
	Bag-mask device, self-inflating: infant (250 ml) & child (450-500 ml)	
	Non-rebreather masks: infant and child	
	Clear oxygen masks (std, nonrebreathing, and with adapter for nebulized medications) for an infant, child, and adult	
	Masks to fit bag-mask device: Neonatal, infant, and child	
	Nasal cannula: infant and child	
	Gastric tubes: infant (8F) and child (10F)	

Prepared for Pediatric ED Equipment, Supplies, and Medications_ver2.docx last updated November 25, 2025

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Prepared for Pediatrics ED Equipment, Supplies, and Medications

*** Version 2 ***



	Tier 1 Requirement	Tier 2 Requirement
Specialized Pediatric Trays or Kits	Newborn delivery kit (including equipment for initial resuscitation of a newborn infant), umbilical clamp, Scissors, bulb syringe, and towel	All Tier 1 Items and the following additional Tier 2 items.
	Urinary catheterization kits and urinary (indwelling) catheters: infant and child	Difficult airway supplies and/or kit: Contents to be based on pediatric patients served at the hospital and may include some or all of the following: supraglottic airways of all sizes, needle cricothyrotomy supplies, surgical cricothyrotomy kit video laryngoscopy
High Volume ED Additional Requirements	N/A	Alprostadil (prostaglandin E1)
		Central venous catheters: 4.0F, 5.0F, 6.0F, 7.0F
		Chest tubes: infant (8–12F catheter), child (14–22F catheter), adult (24–40F catheter) OR pigtail catheter kit (8.5–14F cath)
		Hypothermia thermometer
		Inotropic agents (e.g., digoxin and milrinone)
		Laryngoscope blade: size 00
		Lumbar puncture tray, spinal needles: infant and child
		Noninvasive ventilation: continuous positive airway pressure OR high-flow nasal cannula
		Self-inflating bag-mask device: pediatric
		Tube thoracostomy tray
		Tracheostomy tubes: sizes 3.5mm, 4.0mm, 4.5mm, 5.0mm, and 5.5mm
		Umbilical vein catheters: 3.5F and 5.0F
		Video laryngoscopy



RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: March 11, 2026

Subject: Amending Equipment Requirements for Prehospital Capture and Transmission of 12-lead ECG by Basic Life Support Agencies

VTR#: 0326-01

Committee/Task Force: Medical Advisory

☐ Recommended Goal

☐ Recommended Policy Change

☒ Other: Equipment List

Recommendation:

The PEHSC Medical Advisory Committee recommends the Department of Health amend the Vehicle, Equipment and Supply Requirements for Emergency Medical Services Agencies [54 Pa.B. 476], 12-Lead ECG, to read “paper print out and/or digital display, and transmit capabilities” and assist BLS agencies in obtaining equipment through the EMS Operating Fund.

Rationale [Background]:

American Heart Association Statement

The use of 12-lead electrocardiograms (ECGs) by Emergency Medical Services (EMS) plays a crucial role in the early detection and management of cardiac emergencies, particularly acute myocardial infarctions. The American Heart Association (AHA) emphasizes the importance of rapid diagnosis and intervention to improve patient outcomes, and the integration of 12-lead ECGs into pre-hospital care aligns with these goals.

Current AHA guidelines recommend that EMS providers be trained and equipped to perform 12-lead ECGs promptly upon suspicion of cardiac ischemia or infarction. The timely acquisition and transmission of these ECGs to receiving hospitals facilitate early diagnosis, enable pre-hospital activation of cardiac care teams, and reduce door-to-balloon times in patients with ST-elevation myocardial infarction (STEMI).

Supporting the use of 12-lead ECGs in EMS is based on several key points:

- **Enhanced Diagnostic Accuracy:** 12-lead ECGs provide comprehensive cardiac electrical activity data, allowing for accurate identification of ischemic changes and infarction patterns.
- **Rapid Decision-Making:** Early ECG interpretation helps EMS personnel make informed decisions regarding patient triage, destination hospital selection, and pre-hospital interventions.
- **Improved Patient Outcomes:** Studies have demonstrated that early ECG acquisition and transmission are associated with reduced treatment delays and improved survival rates in acute coronary syndromes.
- **Alignment with Guidelines:** The AHA recommends the routine use of 12-lead ECGs in suspected cardiac emergencies, emphasizing the importance of pre-hospital ECGs as part of comprehensive emergency care.

In Pennsylvania's EMS System, the optional use of BLS acquisition and transmission of a 12-lead ECG is currently supported by the Scope of Practice for EMS document (published 12/30/2023). EMTs with authorization and training by the agency Medical Director, may acquire and transmit a 12-lead ECG.

The December Scope document and PA Statewide BLS Protocol 250 (12-lead Electrocardiography) [OPTIONAL] allows BLS agencies to carry 12-Lead ECG devices for use by appropriately trained and credentialed EMTs in the agency. Once captured, the 12—lead ECG should be transmitted as soon as possible to the receiving facility for interpretation.

PA Statewide BLS Protocol #501 (Chest Pain/Suspected ACS: Treatment: "[OPTIONAL] If patient has chest pain that may be of cardiac origin, obtain and transmit 12-lead ECG if BLS agency has this capability. See Protocol #250."

Medical Review:

Currently, the Vehicle, Equipment and Supply Requirements for Emergency Medical Services Agencies [54 Pa.B. 476] states that, at a minimum, any 12-lead ECG device selected for IALS (and optional BLS) use must be battery powered, 12-lead electrocardiogram capable printing, on paper a full diagnostic-quality 12-lead ECG tracing. The capability for immediate transmission of full diagnostic 12-lead ECG waveforms is required.

Footnote: Diagnostic quality 12-lead ECG display and transmission means that the waveforms are presented with standard calibration parameters in a manner that is readily suited for physician interpretation. Products which display or transmit only quantitative measurements or automated interpretive statements without supporting waveform transmission are not acceptable.

As IALS practice is confined to the acquisition and transmission of 12-lead ECG tracings, interpretation remains outside the current IALS/BLS scope. The primary role of a paper printout is to confirm tracing clarity—verifying minimal artifact and ensuring diagnostic quality for interpretation by the receiving physician. Devices with high-quality digital displays similarly allow providers to assess clarity prior to transmission, thereby supporting the delivery of diagnostic-quality ECGs to receiving facilities. Furthermore, Given that the BLS scope of practice for 12-lead ECG acquisition and transmission mirrors that of IALS, it is reasonable to extend the established basic equipment standards to encompass BLS operations in this context.

Fiscal Concerns:

The cost of 12-lead ECG technology varies widely based on capabilities (standalone acquisition/transmission devices versus integrated monitor-defibrillator platforms), warranties/service contracts, connectivity requirements, and replacement electrodes/batteries. For many BLS agencies, this may reasonably be treated as a capital purchase.

Product selection will be agency-dependent, guided by the agency medical director's clinical and quality requirements and the agency's operational capacity to implement and sustain the system (training, maintenance, connectivity, documentation, and CQA/QI). Because BLS 12-lead ECG transmission relies on receiving-facility workflows for timely physician interpretation, receiving facilities should be engaged early as stakeholders in product selection.

The Commonwealth's 2025–26 budget included a **\$6 million EMSOF investment**, intended to support training and education, recruitment, and the purchase of new medical equipment for ambulances. **The PEHSC Medical Advisory Committee supports consideration of BLS 12-lead ECG capability as one of the appropriate priority areas for distribution of these funds.**

Educational Concerns:

The agency medical director is responsible for training and authorizing BLS providers in the use of the selected device, including correct lead placement, acquisition, troubleshooting artifact, transmission workflow, documentation, and protocol-compliant integration into patient care and destination planning. To do this safely and consistently, the agency medical director must have adequate operational and administrative support (e.g., training infrastructure, CQA/QI capacity, IT/connectivity support, and coordination with receiving facilities) to implement, monitor, and sustain this capability.

Plan of Implementation:

Consistent with existing guidance and protocol development, it is recommended that the Department publish, via the PA Bulletin, an amendment to the Vehicle, Equipment, and Supply Requirements for Emergency Medical Services Agencies. This amendment should specify that 12-lead ECG devices intended for use by BLS agencies electing to implement the optional BLS Protocol 250 (12-lead Electrocardiography) may provide either a paper printout, a digital display, or both, to ensure flexibility in device selection and operational workflow.

While this recommendation is directed toward BLS acquisition of 12-lead ECG capability, it is recognized that these amendments may reasonably be extended to Intermediate Advanced Life Support (IALS) requirements, given that the scope and function of BLS and IALS providers is identical for this protocol.

The PEHSC Medical Advisory Committee and Education Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. In addition, PEHSC offers staff and member support to participate in Departmental deliberations or implementation regarding this recommendation.

Board Meeting Comments/Concerns:

Signed:  Date March 11, 2026
President

For PEHSC Use Only – PA Department of Health Response

Accept: _____ Table: _____ Modify: _____ Reject: _____

Comments:

Date of Department Response: _____





RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: March 11, 2026

Subject: Student Minimum Competencies (SMCs) for BLS Education Programs

VTR#: 0326-02

Committee/Task Force: PEHSC EMS Education Task Force

☒ Recommended Goal

☐ Recommended Policy Change

☐ Other:

Recommendation:

The PEHSC EMS Education Task Force recommends that the Pennsylvania Department of Health, Bureau of EMS, proceed with the development and phased implementation of Student Minimum Competencies (SMCs) for BLS-level certification programs, including EMR and EMT education. The task force also suggests revisions to the Department's draft SMCs, as outlined below.

The Task Force supports the use of SMCs as a replacement for traditional psychomotor testing models, with flexibility in how competencies and clinical exposures are achieved and documented.

Rationale [Background]:

At the request of the Pennsylvania Department of Health, Bureau of EMS, the PEHSC EMS Education Task Force convened a subgroup to review a draft proposal outlining Student Minimum Competencies (SMCs) for BLS education programs. This review was intended to provide high-level feedback on the feasibility, structure, and implementation considerations associated with adopting an SMC-based educational model in Pennsylvania.

The subgroup discussed national and state trends toward competency-based education and recognized that SMCs are increasingly being used to replace traditional psychomotor skills testing. There was general agreement that an SMC framework could improve educational consistency while allowing programs flexibility to meet learning objectives through multiple instructional pathways.

Medical Review [Concerns]:

The subgroup reviewed proposed exposure minimums of 30 patient exposures for EMT students and 15 exposures for EMR students. Members expressed concern regarding the clinical feasibility of meeting certain exposure categories, particularly pediatric encounters, which were reported to represent less than one percent of call volume in some systems. Although there were some reservations, the group accepts the proposed numbers as a practical baseline. However, questions persist about how these figures were determined. The Task Force requests a clear explanation regarding the foundation of the proposed Student Minimum Competencies (SMCs). Specifically, clarification is needed as to whether these competencies were established in accordance with national guidelines,

derived from published studies, adapted from Advanced Life Support (ALS) program standards, or created by combining elements from these sources. Understanding the basis for the SMCs is critical to ensure the adopted framework is credible and appropriate for BLS education programs.

The Task Force also highlighted the need to maintain various pathways for exposure, such as live patient interactions and simulations, to address challenges in clinical access and ensure flexibility across programs. Going forward, "Exposure" should have a clear definition, emphasizing that the total number of exposures can be achieved through any mix of live contacts (via field or hospital/clinical experiences) OR simulation. Furthermore, comprehensive guidelines outlining what qualifies as acceptable "high fidelity" simulation should be developed, with PEHSC input, and clearly communicated.

Fiscal Concerns:

Members observed that implementing SMCs may pose significant challenges for smaller training institutions with limited access to clinical sites, simulation resources, or documentation systems. Additional concerns were identified regarding heightened competition for regional training resources and potential downstream effects on paramedic program access to clinical experiences. These factors highlight the importance of adopting a flexible, phased approach to minimize unforeseen fiscal and operational strains. Furthermore, depending on specific student activities, liability insurance considerations and associated costs may become relevant. Educational institutions may be required to provide such coverage and furnish proof to precepting sites. It is doubtful that any time of clinical site will permit an EMR or EMT to participate in direct or supervised patient care activities without appropriate risk exposure coverage being addressed.

Educational Concerns:

The subgroup reviewed multiple components of the proposed EMT skills list and identified areas where updates would better align with current field practice.

The task force recommends the following changes:

- Airway/Ventilation
 - Either eliminate "Manual Airway Manipulation" or leave it as a header only, instead just focusing on the individual techniques (head-tilt-chin-lift, etc.)
 - Remove "Administering Oxygen by Venturi Mask" as this is very uncommon
- Patient Assessment Skills
 - Remove "Obtain Automated Blood Pressure"; this task is equipment-specific and better handled by agencies during onboarding and internal training, rather than being required for initial certification. Including it as a SMC could also require EMS Education Institutes to buy costly equipment.
- Medical Skills
 - Remove "Mechanical CPR Device" and "Pediatric Restraint Device for Stretcher" for the same reasons as noted above for Automated Blood Pressure Monitoring
- Trauma Skills
 - Move "Perform emergency moves for endangered patient" to the Misc. Operations section
- Misc. Operations
 - Add "PPE donning and doffing" as a SMC

The Task Force further supports flexibility in how exposure requirements are distributed across patient categories, recognizing that a single patient encounter may satisfy multiple competency areas. The concept of recommended versus required exposure numbers was discussed as a potential mechanism to support smaller programs.

Plan of Implementation:

The Task Force advocates for a phased implementation of Student Minimum Competencies instead of immediate mandatory adoption. Members emphasize that effective execution will necessitate comprehensive guidance from the Bureau of EMS concerning timelines, accepted verification procedures, and documentation standards. Dedicating substantial time to these matters, along with other critical details, is essential before specific competency or exposure requirements are finalized or enforced. The PEHSC EMS Education Task Force requests ongoing participation in the development of this process.

The PEHSC Committee/Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. The PEHSC Committee/Task Force specifically offers staff or member support to participate in Department deliberations regarding this recommendation in an effort to convey committee/task force discussions.

Board Meeting Comments/Concerns:

Signed:  Date March 11, 2026
President

For PEHSC Use Only – PA Department of Health Response

Accept: _____ Table: _____ Modify: _____ Reject: _____

Comments:

Date of Department Response: _____



RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: June 24, 2026

Subject: Proposed Pennsylvania Standards for EVOC Program Sponsors and Authorized Training Sites

VTR#: 0626-01

Committee/Task Force: EMS Education

☐ Recommended Goal

☒ Recommended Policy Change

☐ Other:

Recommendation:

The Pennsylvania Emergency Health Services Council (PEHSC) recommends that the Department of Health adopt minimum approval standards for Emergency Vehicle Operator Course (EVOC) program sponsors and authorized training sites whose courses are used to satisfy EMS Vehicle Operator (EMSVO) certification requirements in Pennsylvania, and that the Department use these standards as the basis for EVOC program sponsor approval, authorized training site oversight, and corrective action.

Background / Need for Action:

EMSVO training presents a distinct regulatory concern because ambulance operation is among the most frequent and consequential activities performed in EMS practice, yet the standards supporting approval of EVOC programs have not kept pace with modern course delivery models. As a result, the Department and Regional Councils may be left to evaluate a wide variety of EVOC program sponsor practices, authorized training site practices, and paper certificates without a sufficiently uniform framework for determining whether a Department-approved EVOC course has been delivered with appropriate oversight and consistency.

The primary national EVOC curriculum used as a reference point is now decades old. While it remains useful as a baseline framework for core EVOC knowledge and skills, its age underscores the need for clear EVOC program sponsor standards that require curriculum review, current operational relevance, consistent delivery, and accountability unless and until broader national standards are revised.

For purposes of these standards, an **EVOC program sponsor** is the organization that owns, develops, licenses, maintains, or is otherwise responsible for the approved EVOC curriculum and the integrity of its delivery, including curriculum currency, instructor authorization, quality assurance, certificate control, and records sufficient to verify course completion. An **authorized training site** is an agency, institution, or local host approved by the EVOC program sponsor to conduct or coordinate delivery of the sponsor's approved course. An authorized training site may provide facilities, vehicles, instructors, scheduling, or local administration, but operates under the EVOC program sponsor's standards and oversight. For example, a national EVOC provider may serve as the program sponsor, while an individual EMS agency conducting the class locally may serve as the authorized training site.

Statutory Context:

This recommendation is consistent with the statutory and regulatory framework governing EMSVO certification in Pennsylvania. Under 35 Pa. § 8122 and 28 Pa. Code § 1023.22, an applicant for EMSVO certification must demonstrate successful completion of a Department-approved emergency vehicle operator course. For purposes of these standards, a **Department-approved EVOC course** refers to an emergency vehicle operator course approved by the Department for use in satisfying EMSVO certification requirements. The issue, therefore, is not whether EVOC training is required, but whether the standards used to approve and oversee those courses are sufficiently defined to ensure consistent quality, accountability, and documentation across EVOC program sponsors and authorized training sites. This Vote to Recommend is intended to support that statutory requirement by establishing clearer standards for the approval and oversight of EVOC program sponsors, authorized training sites, and the courses they administer.

Policy Rationale:

Establishing standards for EVOC program sponsors and authorized training sites will improve consistency, accountability, and administrative clarity across EVOC programs while preserving flexibility in course delivery. An EVOC program sponsor-based approval model addresses identified gaps in instructor preparation, program oversight, authorized training site accountability, and certificate control without creating unnecessary state micromanagement of individual classes.

Policy Recommendations:

1. Scope and Applicability

1.1 Applicability. These standards apply to EVOC program sponsors and authorized training sites involved in EMS Vehicle Operator (EMSVO) training used to satisfy the requirement to complete a Department-approved Emergency Vehicle Operator Course (EVOC). They are not intended to govern fire apparatus driver/operator qualification programs, law enforcement emergency vehicle or pursuit training, or other non-EMS emergency vehicle operations.

These standards govern EVOC program sponsor responsibilities, authorized training site operations under an approved sponsor, and the authorization of instructors who deliver or evaluate the sponsor's approved course.

2. EVOC Program Sponsor Eligibility and Responsibility

2.1 EVOC Program Sponsor Responsibility. An EVOC program sponsor must be the organization accountable for curriculum content and version control, instructor authorization, instructor training and discipline, course delivery standards, authorized training site approval and oversight, quality assurance and compliance monitoring, and certificate issuance and record retention.

2.2 Authority Requirement. The EVOC program sponsor must demonstrate the authority and operational ability to approve and remove instructors, approve and monitor authorized training sites, and enforce corrective actions when noncompliance is identified.

Any EVOC course used to satisfy EMSVO certification requirements must be conducted under an EVOC program sponsor that expressly accepts responsibility for the course and its instructors, authorized training sites, records, and certificates.

3. Curriculum Standards (Content Requirements)

3.1 Curriculum Alignment. The EVOC program sponsor's EVOC curriculum must, at a minimum, meet or exceed the objectives of the USDOT EVOC (Ambulance) National Standard Curriculum and must supplement those objectives as necessary to address current EMS vehicle operations, risk management, safety practices, and course delivery expectations.

EVOC program sponsors must be able to demonstrate equivalency through a documented curriculum outline showing how required knowledge and skills objectives are met.

3.2 Required Topic Areas. At a minimum, the curriculum must include instruction and assessment in legal principles and due regard in EMS vehicle operation; EMS vehicle operator roles, responsibilities, and communications; defensive driving and EMS vehicle dynamics; emergency response and non-emergency operations; intersection approach and other high-risk roadway environments; vehicle inspection, readiness, and operator safety checks; fatigue, distraction, impairment, and other human factors; and crash prevention and post-collision actions.

3.3 Practical / Behind-the-Wheel Training. The EVOC program sponsor must require a mandatory behind-the-wheel practical component that includes closed-course vehicle maneuvering, backing procedures with spotter communication, and an objective determination of operator proficiency using clearly defined evaluation criteria.

4. Instructor Standards

4.1 Instructor Eligibility.

EVOC program sponsors must require, verify, and document that EVOC instructors are at least 18 years of age, hold a valid driver's license, and meet EVOC program sponsor-defined prerequisites related to emergency vehicle operations or training.

Instructor authorization may not be based solely on payment of fees or purchase of instructional materials.

4.2 Instructor Training and Preparation.

EVOC program sponsors must also require instructor training in adult learning principles, facilitation techniques, practical skills evaluation and documentation, remediation and re-evaluation procedures, safety controls for driving exercises, and course documentation and recordkeeping. Instructor preparation must address how to teach, not merely how to present course content.

4.3 Instructor Currency and Oversight.

EVOC program sponsors must maintain a current roster of active, expired, and suspended instructors, establish update or renewal requirements when course content changes, and maintain a process to suspend or revoke instructor authorization for noncompliance.

5. Course Delivery Standards

5.1 Didactic Delivery. EVOC program sponsors must define minimum instructional requirements for didactic delivery, including required content coverage, assessment methods and passing criteria, and remediation processes for unsuccessful students.

5.2 Practical Evaluation. EVOC program sponsors must define objective performance standards for practical driving skills, establish pass/fail or scoring criteria, and require documentation sufficient to support evaluator observations and final decisions.

6. Quality Assurance and Compliance Monitoring

6.1 EVOC Program Sponsor QA Plan. Each EVOC program sponsor must maintain a written Quality Assurance (QA) plan addressing instructor authorization and monitoring, authorized training site approval and oversight, course delivery compliance, complaint intake and investigation, corrective action, and documentation and record retention.

6.2 Monitoring Activities. EVOC program sponsors must implement at least two QA mechanisms, such as periodic audits of course records, review of student rosters and assessment results, observation of instructors or authorized training sites, monitoring through a learning management or training management system, or formal complaint tracking and resolution.

6.3 Corrective Action. EVOC program sponsors must maintain a graduated corrective action process that may include required remediation, probation, suspension, or revocation of instructor or authorized training site authorization.

7. Certificates of Completion and Documentation

7.1 Certificates of Completion. EVOC program sponsors shall issue certificates of completion only to students who have successfully met all requirements established by the EVOC program sponsor for the approved EVOC course. Each certificate must be supported by documentation sufficient to verify the student's identity, identify the approved course and EVOC program sponsor, identify any authorized training site involved in course delivery, confirm successful completion of both required didactic and practical components, and record the date or dates of course completion.

7.2 Certificate Control. EVOC program sponsors shall maintain controls over the issuance and format of certificates to ensure consistency with the approved course and to protect against inaccurate, incomplete, or misleading documentation. EVOC program sponsors remain responsible for the integrity of all certificates issued in their name, including certificates issued through or on behalf of authorized training sites.

7.3 Records Retention. EVOC program sponsors shall retain records necessary to validate student attendance and course completion and to support Department audit, review, or other compliance verification of approved course activity, including activity conducted through authorized training sites. Records must be maintained in a manner that allows the EVOC program sponsor to promptly respond to Department requests and demonstrate that certificates of completion were issued appropriately.

8. Department Oversight and Enforcement Framework

8.1 Department Approval Authority. The Department may approve EVOC educational programs and associated EVOC program sponsors under its existing authority to approve courses of instruction. In exercising that authority, the Department may establish and apply approval criteria, including documentation requirements related to curriculum compliance, instructor oversight, authorized training site oversight, quality assurance processes, and sponsor administration.

8.2 Oversight Focus. Department oversight should be limited to confirming that an approved EVOC program sponsor maintains the minimum standards necessary to support EMSVO certification, including curriculum alignment,

instructor authorization, authorized training site oversight, practical evaluation, certificate control, and record retention. These standards are intended to establish baseline approval and compliance expectations for EVOC program sponsors and authorized training sites, not to authorize routine Department management of individual classes, day-to-day instructional decisions, or sponsor operations. Additional review of a specific class, instructor, authorized training site, or record should occur only when supported by a complaint, audit finding, documentation concern, or other articulable compliance issue.

8.3 Corrective Authority. The Department retains authority to require corrective action when an approved course or EVOC program sponsor fails to meet established approval standards. When noncompliance involves an authorized training site, corrective action should generally be directed through the responsible EVOC program sponsor, unless direct Department action is necessary to address an immediate or systemic compliance concern. The Department may modify, suspend, or revoke course approval when systemic deficiencies demonstrate noncompliance with Department requirements.

8.4 Transition for Currently Approved Courses. The Department may continue to recognize EVOC courses and EVOC program sponsors that are already approved, as well as authorized training sites operating under an approved sponsor, at the time these standards are adopted, provided that the responsible EVOC program sponsor demonstrates a good-faith effort to comply and comes into substantial alignment with the new standards within a reasonable period established by the Department. During that transition period, the Department may require submission of a compliance plan, updated sponsor documentation, authorized training site documentation, or other materials necessary to verify progress toward full compliance.

The PEHSC Committee/Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. Prior to implementation, PEHSC recommends that EVOC program sponsors and authorized training sites be provided an opportunity to review these standards and submit comments for Department consideration. Should additional revision be warranted, PEHSC offers ongoing support. The PEHSC Committee/Task Force specifically offers staff or member support to participate in Department deliberations regarding this recommendation in an effort to convey committee/task force discussions.

Board Meeting Comments/Concerns:

Signed:  President Date 7/7/2026

For PEHSC Use Only – PA Department of Health Response

Accept: _____ Table: _____ Modify: _____ Reject: _____

Comments:

Date of Department Response: _____





RECOMMENDATION FOR CONSIDERATION

Board Meeting Date: June 24, 2026

Subject: Modification of Minimum Required Equipment List – 12Lead ECG Printing Capability (ALS)

VTR#: 0626-02

Committee/Task Force: Medical Advisory

☐ Recommended Goal

☒ Recommended Policy Change

☐ Other:

Recommendation:

The Department should consider revising the current 12-lead ECG paper printout requirement to make paper printing optional for EMS vehicles equipped with ECG devices capable of capturing, displaying, storing, retaining, and transmitting full diagnostic-quality 12-lead ECG data. For any 12-lead ECG device that is not capable of electronically displaying and readily transmitting a full diagnostic-quality 12-lead ECG, paper printout capability should remain required.

Rationale [Background]:

This recommendation was originally received by the Department from one of the regional EMS partners. With advances in prehospital cardiac monitor technology, many ECG monitors used in the EMS setting are now capable of displaying full diagnostic-quality 12-lead ECGs on the device's screen, storing the ECG record electronically, and transmitting the tracing to a hospital receiving center. These capabilities reduce the need for a mandatory paper printout in every EMS vehicle.

The option to purchase or deploy ECG monitors without integrated printing capability should be left to the judgment of the EMS agency medical director, provided that the device meets the required clinical, documentation, quality assurance, and transmission standards.

This recommendation is consistent with the previous Medical Advisory Committee recommendation regarding devices used by intermediate advanced life support and basic life support units, specifically related to paper printout capability, VTR #0326-01.

Note that this recommendation does not eliminate the requirement that the ECG device be capable of transmitting 12-lead ECG data to a hospital receiving center. It also does not eliminate the requirement for the complete ECG record to be available for clinical review, patient care documentation, quality assurance, and medical record purposes.

Medical Review [Concerns]:

The Medical Advisory Committee supports this recommendation, if all of the following conditions are met:

1. The device is capable of capturing a full diagnostic-quality 12-lead ECG.
 2. The captured waveforms are visually presented on the screen with standard calibration parameters in a manner that is readily suited for clinician interpretation of the waveforms.
- Products which display or transmit only quantitative measurements or provide automated

interpretative statements without supporting waveform display or transmission are not acceptable.

3. The device can transmit the full, diagnostic-quality ECG to hospitals to which patients are transported by the EMS agency.
4. EMS agencies using monitors without printout capabilities should make all reasonable efforts to transmit the full 12-lead ECG upon hospital arrival as part of the patient transfer-of-care process for medical record review and possible comparison with subsequent 12-lead ECGs.
5. The device is capable of storing and retrieving the full diagnostic-quality 12-lead ECG for clinical documentation, quality assurance, and medical record review.
6. The EMS agency medical director approves the use of the device without paper printout capability.

Fiscal Concerns:

Based on current pricing, removing the requirement for a dedicated ECG printer may reduce the overall device cost by \$3,000 - \$4,000.

Educational Concerns

Any procedural change will be addressed by the agency's management team, including the medical director.

Plan of Implementation:

The Department should publish this recommended change with the next printing of the required equipment and supplies list in the Pennsylvania bulletin.

The PEHSC Committee/Task Force offers consultation to the Department in regard to the content of this Vote to Recommend (VTR) and its attached documents. The PEHSC Committee/Task Force specifically offers staff or member support to participate in Department deliberations regarding this recommendation to convey committee/task force discussions.

Board Meeting Comments/Concerns:

Signed:  Date 7/7/2026
President

For PEHSC Use Only – PA Department of Health Response

Accept: _____ Table: _____ Modify: _____ Reject: _____

Comments:

Date of Department Response: _____

Appendix B

Conference





PROJECT REPORT

48TH ANNUAL PENNSYLVANIA EMS CONFERENCE



SUMMARY

The annual Pennsylvania State EMS Conference continues to serve as a leading source of continuing education for the emergency medical services community. Building on the success and sustained growth of recent years, the 2025 conference maintained a largely consistent format while incorporating targeted refinements to enhance the overall educational experience.

As in prior years, the conference was conducted in a fully virtual format. Live educational sessions were held over a four-day period from September 2–5, 2025, with all sessions recorded and made available for on-demand viewing through November 30, 2025. This structure continued to provide broad access to high-quality education while allowing participants the flexibility to engage with content around work and personal schedules.

The 2025 agenda placed a heavier emphasis on clinical education than in previous years, reflecting ongoing interest in patient-focused content and evidence-based practice. A diverse range of nationally recognized presenters delivered sessions spanning multiple clinical disciplines, supporting continuing education needs across certification levels and professional roles.

The most notable operational change for 2025 was the adoption of a new virtual conference software platform. The platform performed well and supported reliable live streaming, interactive participation, and on-demand access, contributing to a positive attendee experience.

Now in its 48th year, the Pennsylvania EMS Conference is co-sponsored by the Pennsylvania Department of Health, Bureau of Emergency Medical Services, and the Pennsylvania Emergency Health Services Council.

OBJECTIVES

- Provide participants with a variety of clinical and non-clinical topics to improve and educate them about Pennsylvania’s EMS system and the delivery of clinical care
- Provide participants with pediatric-specific educational content in conjunction with the PA EMS for Children Program
- Create opportunities for industry partners and vendors to interact with potential partners in a non-traditional environment
- Expand the participant base to include not only EMS providers but also registered nurses, emergency preparedness personnel, agency and regional leaders, fire department personnel, and hospital staff
- Provide an opportunity for professional networking among the EMS community.

CONFERENCE HIGHLIGHTS

- Numerous nationally recognized presenters participated from across the United States, delivering a diverse and high-quality educational program.
- A total of 21 educational sessions were offered, providing EMS continuing education credits in the following categories:
 - Clinical Patient Care – 17.5 hours
 - Other – 7.5 hours
 - EMSVO – 1.0 hour
- Sessions were offered live over a four-day period via an online streaming platform, allowing for real-time interaction between presenters and attendees similar to a traditional in-person conference.
- All sessions were recorded and made available in an on-demand format through November 30, 2025, significantly expanding access and allowing participants to engage with content on a flexible schedule.
- A new virtual conference software platform was utilized for the 2025 program. The platform performed well and supported a reliable user experience, interactive features, and on-demand access.
- Lower operational costs and generous sponsor support continued to allow the conference to be offered at a nominal registration fee, maintaining affordability and accessibility for a broad audience.

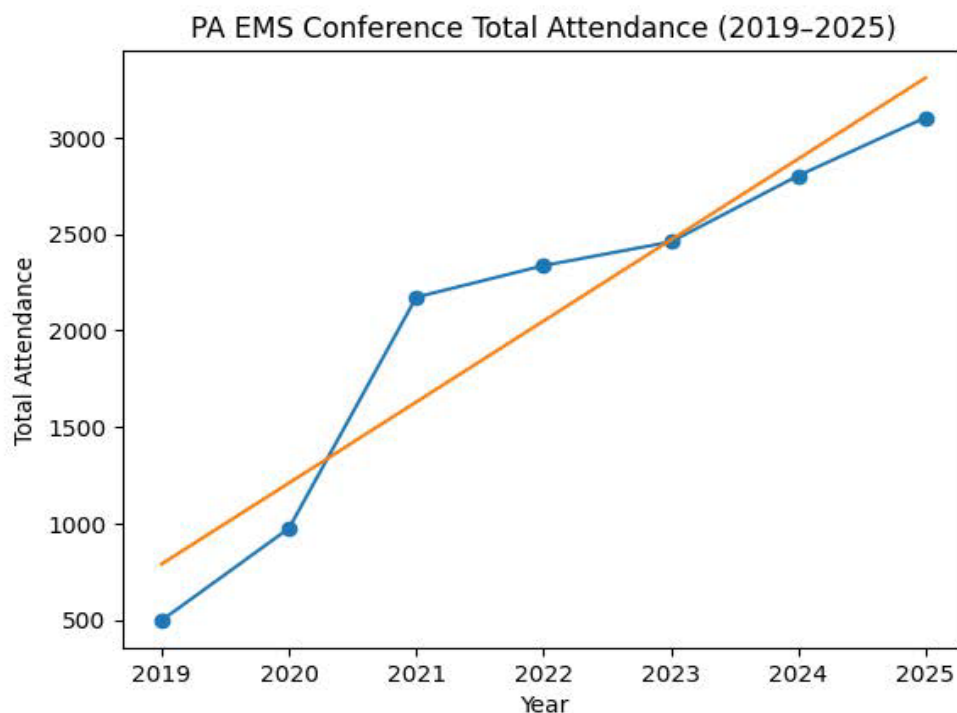
ATTENDANCE

Total attendance for the 2025 Pennsylvania EMS Conference was 3,103 participants, representing individuals who viewed at least one live or on-demand session during the conference period.

Historical Comparison – Total Attendance	
<i>Year</i>	<i>Attendance</i>
2019	497
2020	974
2021	2172
2022	2336
2023	2459
2024	2802
2025	3103

*Individuals viewing at least one session. Includes both live and recorded viewing windows.

Since transitioning to a virtual format, the conference has experienced sustained growth in overall participation. As a result, attendance reporting for 2025 focused exclusively on total participation, as prior sub-metrics such as single-day attendance, exhibitor attendance, and pre-conference participation are no longer applicable in the virtual environment.



Total conference attendance has increased steadily each year since the transition to a virtual format in 2020. The 2025 conference achieved the highest participation to date, reflecting sustained interest in accessible, high-quality continuing education and the continued effectiveness of the virtual delivery model in reaching a broad statewide and out-of-state audience.

Registration by Certification Level	
Highest Certification	Total
Emergency Medical Responder (EMR)	73
Emergency Medical Technician (EMT)	1815
Advanced Emergency Medical Technician (AEMT)	209
Paramedic	1182
Prehospital Registered Nurse (PHRN)	206
Prehospital Physician Extender (PHPE)	4
Prehospital EMS Physician (PHP)	25
Other	87

Registration data indicate that the 2025 Pennsylvania EMS Conference continued to attract a broad cross-section of the prehospital workforce, with participation dominated by front-line providers. Emergency Medical Technicians (EMTs) and Paramedics accounted for the majority of registrants, reflecting the conference’s strong emphasis on clinically relevant content applicable to day-to-day patient care.

Advanced practice and specialty roles, including Prehospital Registered Nurses, advanced practice providers, and physician-level providers, were also represented, supporting the conference’s objective of engaging a multidisciplinary audience. Participation by Emergency Medical Responders and individuals categorized as “Other” further demonstrates the conference’s reach across varying levels of certification, experience, and professional focus within Pennsylvania’s EMS system.

Registration by EMS Region	
EMS Region	Total
Bucks County EMS Council	155
Chester County EMS Council	161
Delaware County EHS Council, Inc.	159
Eastern PA EMS Council, Inc.	323
EHS Federation, Inc.	657
EMMCO West	147
EMS of Northeastern Pennsylvania Inc.	559
EMS WEST	431
LTS EMS Council	90
Montgomery County EMS Council	164
Out-of-State (or unspecified)	153
Philadelphia Regional EMS	204
Seven Mountains EMS Council Inc.	238
Southern Alleghenies EMS Council Inc.	160

Conference registrations were broadly distributed across all Pennsylvania EMS regions, indicating strong statewide engagement. The highest participation came from EHS Federation, Inc. (657), EMS of Northeastern Pennsylvania (559), and EMS WEST (431), together accounting for a substantial share of total attendance. Eastern PA EMS Council (323) and Seven Mountains EMS Council (238) also demonstrated solid representation.

Moderate participation was observed among county-based councils and smaller regions, while Out-of-State or unspecified registrations (153) reflect continued interest beyond Pennsylvania, consistent with the accessibility of the virtual format. Overall, the data suggest that the conference maintained a well-balanced regional reach, with particularly strong engagement from larger, multi-county EMS regions and sustained participation across all councils.

SUPPORTING ORGANIZATIONS

Corporate Sponsors		
Silver Sponsor	Wellspan Health	
Bronze Sponsors	Glick Fire Equipment	
	Penn State Health	

AGENDA SUMMARY

Session	Presenter	Clinical	Other	EMSVO
The Powers of Peers and Partnership – A Novel Response to Patients with SUD	Dr. Alvin Wang, et.al.	0	1	0
Bumps, Births, and Bleeding: Managing Out-of-Hospital OB/GYN Emergencies	Cassandra Crouse	1	0	0
Driving Reflection: Empowering Safer Habits Through the Drive Cam Program	Dawn Ray	0	1	1
Patient Consent Issues for Prehospital Care Providers	David Goroff	1	0	0
Understanding the EMS Compact: Changing the Landscape of Interstate Licensure	Donnie Woodyard	0	1	0

Session	Presenter	Clinical	Other	EMSVO
Tube it or Lose it: a Crash Course in Airway Management For PA EMS Providers	Dr. Lily Roth	2	0	0
Angioedema: Are We Overreacting?	Dr. Avram Flamm	1	0	0
Life-Threatening Causes of Syncope	Dr. Brian Risavi	1	0	0
EMS Patients- Are the cases we see today like the cases we saw 20 years ago?	Paul Werfel	1.5	0	0
Medically Fragile and High Tech Kids	Mark Ford	1.5	0	0

Session	Presenter	Clinical	Other	EMSVO
Livin' DaVita Loca	Jonathon Jenkins	1	0	0
Geriatric Trauma with Case Reviews	David Sanko	1.5	0	0
Does the End of the Call Have to Be the End of the Ride?	Dr. R. Daniel Bledsoe	1	0	0
Recognition and Transport Tips for the Infectious Diseases Patient	Mollie Lauck	1	0	0
Combating the Hidden Dangers of Shock in Trauma	A.J. Heightman	1	0	0
PA Dept of Health, Bureau of EMS Update	Anthony Martin	0	1	0

Session	Presenter	Clinical	Other	EMSVO
The Sinister Six	Chris Ebright	1.5	0	0
Sip, Swallow, Stuff and Sputter: Pediatric Foreign Body Ingestion	Joyce Foresman-Capuzzi	1	0	0
Peer Support in a Hoodie: Building Connections with Type-A First Responders	Nick Carson	0	1	0
Medical Directors Panel Discussion	Alvin Wang, et. al.	0	1.5	0
Event Medical Services: Planning for Success	Gary Vinnacombe	0	1	0

Views By Session	
Session	Total
Bumps, Births, and Bleeding: Managing Out-of-Hospital OB/GYN Emergencies	3461
Driving Reflection: Empowering Safer Habits Through the Drive Cam Program	3391
Patient Consent Issues for Prehospital Care Providers	3152
Understanding the EMS Compact: Changing the Landscape of Interstate Licensure	3020
Tube it or Lose it: a Crash Course in Airway Management For PA EMS Providers	2892
The Powers of Peers and Partnership – A Novel Response to Patients with OUD	2795
Medically Fragile and High Tech Kids	2714
Combating the Hidden Dangers of Shock in Trauma	2602
Life-Threatening Causes of Syncope	2503
EMS Patients- Are the cases we see today like the cases we saw 20 years ago	2358
Angioedema: Are We Overreacting?	2318
Geriatric Trauma with Case Reviews	2202
PA Department of Health, Bureau of EMS Update	2104
Livin' DaVita Loca	2086
Recognition and Transport Tips for the Infectious Diseases Patient	2068
Does the End of the Call Have to Be the End of the Ride?	2015
The Sinister Six	1966
Sip, Swallow, Stuff and Sputter: Pediatric Foreign Body Ingestion	1892
Event Medical Services: Planning for Success	1533
Medical Director's Panel Discussion	1377
Peer Support in a Hoodie: Building Connections with Type-A First Responders	1365

Session view counts were strong across the program, with clear emphasis on high-risk clinical topics and provider-relevant legal/operational issues. The most viewed sessions focused on OB/GYN emergencies, provider safety, consent and legal considerations, airway management, and interstate licensure, suggesting sustained demand for content that directly impacts day-to-day clinical decision-making and professional practice. Behavioral health, pediatrics, geriatrics, and trauma topics also performed consistently well, indicating broad interest across patient populations and care environments.

Overall, the distribution of views reflects a balanced appetite for core clinical education, emerging system-level issues, and provider wellness and support, reinforcing the value of maintaining a clinically weighted agenda while continuing to include regulatory, operational, and peer-support content.

FINANCIALS

Income	
Registration Fees	\$28,679.42
Sponsors	\$10,500.00
Agency Registrations	\$490.00
Total	\$39,669.42

Expenses	
Faculty	\$1,550.00
Software	\$14,932.50
Miscellaneous	\$249.80
Total	\$16,732.30

Income over Expense	\$22,937.12
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The 2025 Pennsylvania EMS Conference generated total revenue of \$39,669.42, primarily from registration fees and corporate sponsorships, while total expenses totaled \$16,732.30. The resulting net surplus of \$22,937.12 reflects the continued cost-efficiency of the virtual conference model and strong sponsor support. Consistent with prior years, net income from the conference will be applied to support future Pennsylvania EMS Conference programming, helping to ensure the long-term sustainability and accessibility of the event.

FEEDBACK

Overall, session evaluations were exceptionally strong, with all sessions rated between 4.44 and 4.84 out of 5, indicating a consistently high level of attendee satisfaction across the program.

The highest-rated sessions clustered at the top end of the scale (4.8+), with Combating the Hidden Dangers of Shock in Trauma leading all sessions (4.84). Several additional clinical and pediatric-focused sessions closely followed, reflecting strong participant interest in high-acuity clinical content.

The majority of sessions (approximately three-quarters) received ratings of 4.70 or higher, demonstrating broad approval across clinical, operational, leadership, and regulatory topics. Even the lowest-rated session (Driving Reflection: Empowering Safer Habits Through the Drive Cam Program, 4.44) remained well above average, suggesting no significant outliers or poorly received offerings.

Taken together, the ratings indicate that the conference delivered consistently high-quality educational content, with particularly strong performance in trauma, airway management, pediatrics, and complex medical decision-making topics.

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Presenter evaluations were uniformly strong, with ratings ranging from 4.40 to 4.81 out of 5, indicating a high level of satisfaction with speaker expertise, delivery, and relevance across the conference.

The highest-rated presenters were those delivering advanced clinical and high-impact educational content. A.J. Heightman received the top presenter rating (4.81) for Combating the Hidden Dangers of Shock in Trauma, reinforcing the strong alignment between clinical depth and attendee engagement. Several other presenters clustered closely behind (4.79–4.78), including sessions focused on airway management, pediatric care, peer support, and OB/GYN emergencies.

The majority of presenters (approximately 80%) received ratings of 4.65 or higher, reflecting consistent instructional quality across a wide range of topic areas, including trauma, pediatrics, behavioral health, regulatory issues, and systems-level EMS topics. Panel-based sessions, such as the Medical Directors Panel and OUD-focused discussions, also performed well, demonstrating effective facilitation and perceived value despite their broader discussion-based formats.

The lowest-rated presenter (Driving Reflection: Empowering Safer Habits Through the Drive Cam Program, 4.40) still scored solidly above average, suggesting that even sessions with comparatively lower ratings were well received and met participant expectations.

Overall, presenter feedback indicates that the conference successfully attracted high-caliber speakers capable of delivering relevant, engaging, and practical content. The narrow spread of ratings further suggests a consistently strong presenter selection and vetting process, with particularly strong performance in clinically focused and experience-driven presentations.

Overall Feedback Summary

Overall, narrative feedback across all conference sessions was overwhelmingly positive, reinforcing the strong quantitative ratings. Attendees consistently highlighted speaker expertise, practical relevance, and immediate applicability to field practice as major strengths of the program.

Common Positive Themes

High speaker credibility and real-world experience

Participants frequently commented that presenters were knowledgeable, engaging, and clearly experienced in the subject matter. Speakers such as A.J. Heightman, David Sanko, Jonathon Jenkins, Dr. Avram Flamm, Dr. Brian Risavi, Chris Ebright, and Nick Carson were repeatedly cited for delivering content that was both authoritative and relatable to everyday EMS operations.

Practical, field-focused education

Many comments emphasized appreciation for sessions that provided:

- Clear clinical decision-making guidance
- Case-based examples
- “What to do differently on the next call” takeaways

Trauma, airway management, pediatrics, consent/legal issues, and special populations (e.g., medically fragile children, geriatric patients) were especially well received.

Balanced mix of clinical and system-level content

Attendees noted strong value in sessions that went beyond clinical skills to address:

- Provider wellness and peer support (e.g., *Peer Support in a Hoodie*)
- Regulatory and policy updates (e.g., *Bureau of EMS Update*, *EMS Compact*)
- Risk management, documentation, and consent issues

Panel discussions, including the Medical Directors Panel and OUD-focused sessions, were praised for offering diverse perspectives and practical insights.

Engaging delivery and clear communication

Speakers who were described as conversational, energetic, or story-driven received particularly favorable comments. Attendees frequently noted that sessions were easy to follow, appropriately paced, and well organized.

Recurring Constructive Feedback

Desire for deeper dives or longer sessions

Some attendees expressed interest in:

- More time for Q&A
- Expanded coverage of complex topics
- Follow-up or advanced versions of popular sessions

This was especially common for high-interest clinical topics and legal/regulatory discussions.

Variability in engagement for operational/technology topics

While still positively received, a small number of comments suggested that technology- or program-focused sessions (e.g., driver monitoring systems) were less universally applicable depending on agency size or resources.

Overall Interpretation

Narrative feedback strongly supports the conclusion that the conference delivered high-quality, relevant, and well-presented education. Attendees consistently valued speakers who combined subject-matter expertise with practical experience and real-world examples. The comments reinforce the effectiveness of the current speaker selection and topic mix, particularly for clinically focused, case-based, and experience-driven sessions, while also highlighting opportunities for future expansion of high-interest topics.

SUMMARY

The 48th Annual Pennsylvania EMS Conference successfully continued its role as a premier source of continuing education for the Commonwealth's EMS community. The 2025 program demonstrated sustained growth in participation, strong statewide and out-of-state engagement, and consistently high attendee satisfaction across all educational offerings. The virtual format remained effective in delivering accessible, high-quality education while maintaining financial sustainability and operational efficiency.

Evaluation data and narrative feedback reinforce the value of a clinically focused, case-based agenda supported by experienced and engaging presenters. The strong performance of the conference across attendance, financial outcomes, and participant satisfaction affirms the continued viability of the current model and provides a solid foundation for future planning. Collectively, these outcomes position the Pennsylvania EMS Conference to continue meeting the evolving educational needs of EMS professionals while supporting the long-term success of the program.

Appendix C

Initiatives





EMS & Municipal Leaders – Meeting Outline Reference Document

1. Overview of EMS Role in the Community

- EMS is a 24/7 public safety service, operating alongside police and fire.
- Local operations: staffing model, call volume, and coverage area.
- EMS differs from other services: constant readiness, advanced medical capabilities, and patient transport responsibilities.
- Services provided: emergency, non-emergency, critical care, disaster management, community standby.
- Key facts: staffing levels, qualifications, hours of coverage, performance benchmarks.

2. Current Challenges (National & Local)

- Staffing Shortages – recruitment/retention, overtime reliance, burnout, volunteer decline.
- Funding Gaps – reimbursement rarely covers readiness costs; no payment for non-transport calls; flat rates.
- Call Volume Trends – increasing demand, aging population, and mutual aid reliance.
- Hospital Offload Delays – extended ER wait times reduce unit availability.
- Aging Equipment & Vehicles – replacement cycles misaligned with budgets.
- Training & Certification Costs – barriers for new EMS providers.

3. Impact on Public Safety & Health

- Turnout Time Trends – longer delays impact outcomes; response time no longer sole standard.
- Service Reductions – fewer staffed ambulances and gaps in coverage.
- Mutual Aid Strain – neighboring towns also under pressure.
- Resident Risk – delayed care in time-sensitive emergencies (cardiac arrest, trauma, stroke).

4. Financial Realities

- High cost of readiness (personnel, facilities, equipment).
- Gap between reimbursements and actual costs.
- Comparison: EMS often underfunded relative to police/fire.
- Solutions: shared services, cost-sharing agreements, or dedicated funding streams.

5. Opportunities for Partnership

- Municipal contribution models: budget allocations, cost-per-capita, service contracts.
- Grants requiring municipal sponsorship or matching funds.
- Joint planning with fire/police for integrated response.
- Community paramedicine & preventative health programs to reduce 911 burden.

6. Legislative & Regulatory Factors

- Acts 7, 8, 9 of 2008 – municipalities must ensure EMS coverage.
- Federal rules: Medicaid/Medicare reimbursement limitations.
- Pending or potential state legislation affecting EMS funding or authority.
- Local ordinances (e.g., EMS service fees) that can sustain operations.

7. Call to Action

- Identify short-term needs (staffing support, equipment replacement).
- Propose a working group or EMS advisory committee.
- Establish a timeline for funding and operational planning.
- Invite municipal leaders to observe EMS firsthand (ride-alongs).

Municipal Leaders Meeting Prep Sheet for EMS



PENNSYLVANIA EMERGENCY
HEALTH SERVICES COUNCIL
Your Voice In EMS

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EMS – Preparatory Information

Be knowledgeable of the following information prior to meeting with your local government leaders

1. Build the Relationship

- Establish regular communication (reports, meeting attendance, public safety committees).
- Offer ride-alongs and participate in community events.
- Share articles for municipal websites/newsletters.

2. Understand Legal Authority

- Acts 7, 8, 9 of 2008 – Municipalities must ensure EMS coverage and may designate a primary EMS agency.
- Must consult with EMS providers and require annual expenditure reports if providing funds.

3. Funding & Subsidy Options

- None – No municipal contribution.
- Partial/In-kind – Fuel, insurance, utilities, volunteer workers comp.
- Direct – Annual donation or budget line item.
- Taxes/Fees – EMS tax (max ½ mill), local services tax, special EMS fee.

4. Examples of Funding Models

- Ross/West View EMS – Special ambulance fee replacing subscriptions.
- MESA (Lancaster County) – Joint municipal EMS authority with property-based fees.
- Pike County – Matching grant program doubling municipal contributions.

5. EMS Services Provided

- Emergency & non-emergency transports
- Critical care, disaster management, rescue, tactical ops
- Public training & community event standby

6. Challenges to Share

- Staffing shortages & declining volunteers





- Increased costs (equipment, training, technology)
- Low reimbursement rates, especially for non-transport calls
- Heavy mutual aid demand

7. Data Municipal Leaders Need

- Cost per call & per hour
- Budget trends & financial projections
- “Cost of readiness” for 24/7 coverage

8. Best Practices for Meetings

- Be honest about strengths & weaknesses
- Present clear, concise facts
- Suggest solutions, not just problems
- Set realistic goals & prepare for pushback
- Keep communication ongoing