FISCAL YEAR 2024-2025 ANNUAL REPORT

PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL
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Contents

Mission, Vision and Values

Mission

The core mission of the Pennsylvania Emergency Health Services Council is to serve as an independent advisory body to the Department of Health and all other appropriate agencies on matters pertaining to Emergency Medical Services. As an advocate for its diverse member organizations, the ultimate purpose of PEHSC is to foster improvements in the quality and delivery of emergency health services throughout the Commonwealth.

Vision

Pennsylvania will be a national leader in developing a unified system of high-quality emergency medical services and other health services. In partnership with other organizations statewide that are involved with emergency services, PEHSC's role includes a heightened emphasis on advocacy and legislative liaison, outcomes research, system finances and development, public education, and resources to enhance organizational management.

Core Values

- **Service**
    - PEHSC will advocate for and work to advance Pennsylvania's statewide EMS system.
- **Diversity**
    - PEHSC will be comprised of EMS agencies from across Pennsylvania and will include other organizations and stakeholders from within the emergency services and medical communities.
- **Objectivity**
    - PEHSC will generate unbiased, in-depth products that accurately reflect the needs of Pennsylvania and its EMS professionals.
- **Responsiveness**
    - PEHSC will be responsible, first and foremost, to the Council membership, and will strive to be at the forefront of new innovations.
- **Synergy**
    - PEHSC will bring together components of Pennsylvania's EMS system to explore problems and produce comprehensive solutions.

History, Funding and Function

History

PEHSC was incorporated in 1974. The Council's Board of Directors were 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.

Funding

The Council receives funding through a contract with the Pennsylvania Department of Health. PEHSC does not charge any fees or dues to its member organizations. Due to the continued economic decline of the Emergency Medical Services Operating Fund during this reporting period, Council operations were negatively impacted by the lack of available funding. Specifically, the Council's Board and committee/task forces continued to meet virtually, the staffing complement remained below normal to meet system needs and the EMSC grant agreement with the Department for the period of July 1, 2024through June 30, 2025.

Function

The Council's cornerstone is the grassroots provider network (committees and taskforces), which meet to discuss statewide issues. These grassroots providers generate recommendations for consideration by the PEHSC's Board of Directors.

These recommendations ultimately lead to the delivery of formal recommendations to the Pennsylvania Department of Health. The volunteer, grassroots participation of pre-hospital providers throughout the Commonwealth gives EMS a voice in decision making at the state level.

The volunteer involvement of providers in the PEHSC process has saved the Commonwealth thousands of dollars in personnel costs, as the PEHSC members often prepare statewide documents and/or educational programs to support recommendations. Interested providers may apply for membership to PEHSC Task Forces by completing an application. Task Forces are established either on a long-term or short-term basis and are focused on a specific issue or general topic area.

Council Membership

The Council is an organization-based, non-profit corporation consisting of 134 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.

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

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
Factoryville Fire Co. Ambulance
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
Lehighton 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

Board of Directors

Each year, the Council elects a Board of Directors comprised of 30 of the organizations represented by the Council. The Board of Directors serves as the official advisory body to the Pennsylvania Department of Health on EMS issues and meets quarterly.

Allegheny General Hospital	Robert Twaddle
Cetronia Ambulance Corps.	Robert Mateff
Chester Co Dept of Emergency Services	Harry Moore
City of Allentown EMS	Mehmet Barzev
Community Life Team	Barry Albertson
Elverson Honey Brook Area EMS	Matthew C Welch
Emergency Medical Services of Northeastern PA	Robert Carpenter
Good Fellowship Ambulance and EMS Training Institute	Chaz Brogen
Harrisburg Area Community College	John Brindle
Lehigh Valley Health Network	Jeffrey Kuklinski D.O.
Lower Allen Township EMS	Anthony Deaven
McCandles-Franklin Park Ambulance Authority	Christopher Dell
National Assoc of EMS Physicians - PA Chapter	Dr. Richard Wadas
PA Department Of Health	Anthony Martin
Pennsylvania Fire and Emergency Services Institute	William C Rigby
Penn State Milton S Hershey Medical Center	Keith McMinn
Pennsylvania ACEP	Bryan Wexler M.D.
Pennsylvania Committee On Trauma-American College of Surgeons	Susan Baro D.O.
Pennsylvania State University, The	V. Joshua Fremberg
Pennsylvania Trauma Systems Foundation	Amy Kempinski
Riddle Hospital - Main Line Health System	Keith P Laws
Southwest Ambulance Alliance	Greg Porter
Tower Health	Brad Cosgrove
UPMC Presbyterian	Myron Rickens
Uwchlan Ambulance Corps	William Wells
VFIS	Justin Eberly
Wellspan York Hospital	Dr. Avram Flamm
West Grove Fire Company	Gary Vinnacombe
Western Berks Ambulance Association	Anthony Tucci
Susquehanna Regional EMS	Mark Trueman

FY 2024-2025 Board Meeting Dates

October 16, 2024

December 11, 2024

March 19, 2025

June 25, 2025

Executive Leadership and Council Staff

Executive Committee

The Board is responsible to elect the Council officers, which include President, Vice President, Treasurer, and Secretary. The officers, two At-Large Board Members, and the Immediate Past President comprise the Council's Executive Committee.

PRESIDENT ..... Alvin Wang, DO

VICE PRESIDENT ..... Anthony Deaven

SECRETARY..... Keith Laws

TREASUERER..... Bryan Wexler, MD

MEMBER-AT-LARGE..... Justin Eberly

MEMBER -AT-LARGE..... Greg Porter

IMMEDIATE PAST PRESIDENT..... J. David Jones

Council Staff

The Council employs a staff of four, which includes a full-time Executive Director. The professional staff members have extensive experience as prehospital providers, administrators, and educators. The staff is responsible for coordinating and administering the a8tivities of the Council and its committees/task forces, as well as providing technical expertise to Pennsylvania's EMS community

Executive Director .....Janette Swade

Sr. EMS Systems Specialist .....Donald [Butch] Potter Jr.

EMS Systems Specialist.....Andrew Snavely

EMS for Children Project Manager .....Duane Spencer

Executive Offices

Pennsylvania Emergency Health Services Council
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Volunteer Hours

The dedicated professionals who volunteer their time each year are the backbone of the Council. These volunteers are comprised of council members, affiliate members and other subject matter experts from the community. The value they bring to the Council and EMS systems through their recommendations is priceless. The data below depicts the estimated volunteer hours provided by these dedicated professionals to attend meetings and other activities.

Board of Directors/Council ..... 736 hours

Executive Committee ..... 82 hours

Membership Committee ..... 18 hours

Nominating Committee ..... 34 hours

Medical Advisory Committee ..... 772 hours

Critical Care Transport Task Force ..... 149 hours

EMS for Children Committee ..... 398 hours

EMS Education Task Force ..... 74 hours

EMS Operations Committee ..... 38 hours

Special Operations Task Force ..... 44 hours

Other Activities ..... 260 hours

TOTAL ESTIMATED VOLUNTEER ACTIVITY ..... 2,605 hours

FY 2024-2025 Financial Information

Category	***Budget***	***Actual****
State Contract		
Income	$354,000.00	$264,139.00 (Note: some FY 24-25 payments from DOH still pending)
Expense	$354,000.00	$354,000.00
EMSC Contract Period: April 2024 – June 2025 ***(aligned with federal grant year)***		
Income	EMSC grant and payments from DOH still pending. Will update information when available	EMSC grant and payments from DOH still pending. Will update information when available
Expense		
EMS Conference		
Income	$48, 608.00	$48,608.00
Expense	$28,468.00	$28, 468.00 (Note: Income over expense of $20,139.00 applied to 2025 conference)

* Fiscal Year 2024-2025 amounts listed are pending the year-end audit. The complete financial audit is available upon request to the Council.

Council Consensus Statements

EMS Treatment in Place

By: PEHSC MAC Working Group, Mike Reihart, DO Chairman

Developed: February 18, 2025
Approved by MAC: April 16, 2025
Adopted by the Board of Directors June 25, 2025

Our current EMS system is encumbered by many challenges at the local, state, and national level.

One area of both concern and opportunity is to enhance EMS delivery by implementing the concept of patient “Treatment in Place” (TIP).

TIP would allow EMS providers to provide on-scene treatment and/or referral to other health facilities. This would negate the need for ambulance transport and decrease the burden on emergency department volume.

TIP has been discussed for years and attempts to implement this initiative have not flourished for a variety of reasons. Despite TIP’s failure to be successfully implemented in the past. There is an overwhelming need for creative EMS solutions to re-engage this unique opportunity to enhance the delivery of prehospital care.

When considering TIP clinical, operational, educational and financial aspects of this initiative have their own unique challenges and opportunities which will be discussed individually.

Clinical: It is well documented many patients do not require or refuse EMS transport. In many cases a patient may have minor complaints and can be treated effectively at the scene. A classic example would be a patient with a sore throat and flu-like symptoms. The patient could be evaluated for a medical emergency and if deemed safe for EMS release, they could be treated as an outpatient and or referred to a primary care treatment facility. This would decrease the need for transport, allowing the EMS unit to return to service and decrease ED volumes for minor complaints. Another example would be for patients with mental health or drug and alcohol issues where prehospital intervention or treatment facility may be superior to an emergency department.

TIP could add to patient and provider satisfaction and help decrease the burden on EMS systems. However, TIP could become abused by patients hoping to circumvent hospital wait times. Therefore, close monitoring of potential system abuses will need to be closely monitored.

To implement this clinically there would have to be collaboration and education to the community, all first responders, EMS providers, 911 centers, health systems, pharmacies and outpatient care receiving facilities.

Operational: All regulatory agencies must approve of TIP. There also needs to be a consensus on liability with liability/malpractice insurance approval and strong physician oversight. This physician oversight could be direct or indirect and could harness technology like video conferencing. Specific supplies for TIP must be obtained and regularly stocked for deployment at the scene. These supplies could include limited prescription pharmaceutics, wound care supplies, and orthopedic splinting equipment which can be determined by the individual agency. All patients will require a written medical record as well as patient education, discharge and follow- up instructions. Patients referred to primary care may need transportation to and from the facility which could use an ambulance, EMS vehicle, public transportation, personal vehicle or taxi type transportation.

Educational: EMS providers will need formal education on the TIP process as well as any specific clinical skills, communication and documentation requirements. All parties impacted will need to be familiar with the TIP process which would include the ones mentioned above but should also include fire, police, and the media. This education will need to be closely monitored, and the core curriculum will be considered dynamic as the TIP process matures.

Financial: Of all the above considerations the fiscal component of TIP is probably the most complex and most important for success. In the current EMS reimbursement model, there is very little to no reimbursement for patients not transported. The assumption that TIP may be helpful for the patient, health system and EMS agency may actually be detrimental to downstream revenue. Therefore, a robust fiscal analysis must be obtained for the involved parties prior to implementation. Of the parties involved, third party payers will be a key component ensuring the success of TIP. While financial considerations have been listed last, this may be the first area to address while working to implement TIP.

Summary: TIP is one aspect of prehospital care which may offer improved patient satisfaction, clinical care access and EMS provider by reducing unnecessary ambulance transport. Currently in Pennsylvania, there are some TIP models mostly involving drug and mental health resources which are being used and could be a template for other TIP programs. While multiple entities have been mentioned as key to the success of TIP, our legislators will be the most powerful means to help facilitate TIP on a broad scale throughout the Commonwealth of Pennsylvania.

Recommendations to the PA Department of Health

The following recommendations, in either the form of a “VTR” (Vote to Recommend) or “CFC” (Concept for Consideration), were approved by the PEHSC Board of Directors.

December 11, 2024

VTR#: 1224-01 EMS for Children Committee

Updates to the “Prepared for Pediatrics” Program

R**ecommendation:**

The Department of Health should accept the attached **Prepared for Pediatrics** program outline of Requirements and Levels of Recognition and the Pediatric Recognition Program Equipment and Supplies as revision to the current **Pediatric Voluntary Recognition Program** (PVRP). This revised program includes a reduction of program tiers and addition of program components to meet federal guidelines and national standards.

Rationale [Background]:

The PVRP was developed over 10 years ago and based on a fundamental premise of improved readiness to care for children driven by several key components which became the singular requirement of each recognition level. Since its inception, PVRP has recognized nearly 300 EMS agencies across the state at one of five cascading levels.

The PVRP was one of the first prehospital pediatric readiness programs in the country. Since its development in 2013, national research has studied pediatric readiness and produced several publications supporting key focus areas and standards to meet the needs of pediatric patients. One of those studies put an emphasis on including a Pediatric Emergency Care Coordinator (PECC) at the EMS agency level. Pennsylvania was again at the forefront of pediatric readiness as one of seven states participating in a Learning Collaborative to study how to implement the PECC into an EMS agency. The PECC became part of PVRP in June 2019 and our first PECC’s were identified later that year. Since then, over 340 Pennsylvania EMS agencies have identified a PECC.

That same research has been an integral part of newly established federal guidelines published as part of the EMSC program and an 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 supporting an expanded engagement of families and caregivers

through the Family Advisory Network. Specifically to EMS, the Performance Measures include four key components. They are:

• Establishing a standardized Pediatric Readiness Recognition Program for prehospital EMS.

• Increase the number of Pediatric Emergency Care Coordinators in EMS agencies,

• Increase the number of prehospital EMS agencies that have a process for skills-checking on the use of pediatric equipment.

• Increased pediatric disaster readiness in prehospital EMS.

Subsequent to the Performance Measure Manual being published, the Pennsylvania EMS for Children program received a formal acknowledgement of our 10-year-old program from the Health Resources and Services Administration Division of Child, Adolescent & Family Health Maternal, Child & Health Bureau EMSC program in July of 2024 recognizing the PVRP and how it measured based on the standards listed in the manual. These standards are the current federal expectations of all prehospital pediatric recognition programs. The 10 standards used by HRSA are:

• Integration of EMS physician medical oversight

• Inclusion of policies and protocols for the safe transport of children in emergency vehicles

• Collaboration with Emergency Departments to provide pediatric readiness across the care continuum

• Inclusion of family-centered care practices

• Inclusion of pediatric considerations in disaster planning

• Inclusion of pediatric considerations in guidelines and policies

• Inclusion of practices to reduce pediatric medication errors

• Incorporation of statewide data submission, per state statute to submit NEMSIS data

• Incorporation of performance improvement practices

• Prehospital clinicians physically demonstrate the correct use of pediatric-specific equipment.

Shortly after the performance manual was published, the Pennsylvania EMS for Children program began a review of the PVRP to determine where the program was compliant and where it needed to consider revision or update to meet these newly established standards. A representative committee of EMS administrations, educators, Pediatric Emergency Care Coordinators, and EMSC program leadership began monthly meetings in January 2024 to discuss these topics, evaluate the program, and make recommendations for any changes.

The committee consensus quickly identified that a complete revision of the program was necessary to streamline and enhance program levels and requirements. This resulted in the consolidation of current PVRP requirements into a singular initial recognition level while including new requirements at all levels where appropriate. In summary, the committee recommendations addressed the following:

• Consolidate requirements over a total of three levels of recognition. A recommendation of the HRSA program review was to downgrade the number of recognition levels.

• Address the Joint Position Statement of the National Association of EMS Physicians, the American Academy of Pediatrics, the American College of Surgeons Committee on Trauma, the Emergency Nurses Association, the EMS for Children Innovation and Improvement Center, and the National Association of State EMS Officials, "**Recommended Essential Equipment for Basic Life Support and Advanced Life Support Ground Ambulances 2020**". Evaluate recommended equipment of the Joint Position Statement against the Pennsylvania Department of Health **"Vehicle, Equipment and Supply Requirements for Emergency Medical Services: Corrected Notice"** published January 27, 2024 including a crosswalk between the two documents and a cost assessment by agency licensure level for any additionally required equipment. The result is the "**Prepared for Pediatrics Pediatric Recognition Program Equipment and Supplies**" document.

• In addition to the PVRP focus areas which include having a Pediatric Emergency Care Coordinator, additional supplies and equipment, background checks, education, outreach and safe transport of children, the committee addressed focus areas from the HRSA standards involving Performance Improvement, Disaster Readiness and Family Centered Care. Other requirements of the current and updated program regarding NEMSIS data submission and EMSC survey compliance were clarified.

• Evaluate national standards as proposed by the EMS for Children Innovation and Improvement Center regarding recognition program focus areas and address implementation and sustainability considerations.

• Consider the continued inclusion of Safe Transport of Children outside of the ambulance environment as part of the program as it is not included in the current HRSA standards list.

• Address the missing ePCR data from select QRS units currently not required to submit

Specific to the HRSA standards, several are already met at the state level as pediatric considerations in clinical guidelines and policies and safe transport of children in ambulances are already addressed in statewide protocols. While the requirement for an EMS agency medical director at the agency level is met through statute and licensing. The collaboration with Emergency Departments will occur through the newly developed EMSC **Partners in Pediatrics** program which will tie prehospital agencies and emergency departments together through developing PECC relationships and focus on collaboration and communications between EMS and ED's regarding pediatric care. Having these components of the HRSA standards covered allows the recognition program to concentrate on family centered care, disaster planning, performance improvement and provider competencies as additional focus areas.

Fiscal Concerns:

There are no direct fees for an EMS agency to apply for recognition and the program is voluntary in participation. Specific agency costs are dependent on current agency practices and readiness to care for children in comparison to the program requirements. Specific to the additional equipment list above that which is required by regulation, items vary across licensure level with many are already carried by agencies when allowed by scope of practice despite not being a requirement of licensure. These costs are nominal and well below a single investment of $500.00 per license for disposable and non- disposable items and primarily at the BLS-QRS licensure levels with lower costs at subsequent higher licensure levels.

Educational Concerns:

A comprehensive communications plan and marketing materials will be developed before the proposed Go-Live date to educate agencies and other stakeholders about program changes, requirements, and processes. Additional and ongoing education on the program will be made available at statewide activities such as EMS conferences or via direct consultation with the EMSC Program Manager. The quarterly PECC Learning Session will continue in 2025. The PECC sessions will include emergency department PECC's in the future as a component of the Partners in Pediatrics program to support collaboration and communication between EMS and ED's.

Plan of Implementation:

After nearly one year of committee activity, including two updates to the EMS for Children Advisory Committee, the attached proposed **Prepared for Pediatrics** Program Requirements and Levels of Recognition outline and Pediatric Recognition Program Equipment and Supplies document have been approved by the EMSC Advisory Committee and are being submitted to the Department of Health for

consideration in support of prehospital pediatric readiness and the HRSA EMSC Performance Manual measures and standards. Supplemental to these items will be the following program support documents.

• Prepared for Pediatrics Program Administrative Handbook for EMS agencies

• Prepared for Pediatrics Program Application in both a digital and web-based format for submission

• Prepared for Pediatrics Program support materials including forms and attestations in support of requirement areas and levels of recognition.

• Prepared for Pediatrics Program Recognition Process Guidelines to support the required site visit activities and the additional required equipment inspections

These program documents will be finalized in partnership with the Bureau of EMS to facilitate process, ensure consistency in language and effort, and address EMS agency and EMSC program capacity to support a functionally efficient product. All program documents will be available for access on the Pennsylvania EMSC website @ www.paemsc.org.

Once program approval has been received, a statewide marketing blitz is planned to communicate the programs requirements, educate EMS agencies on the changes and additions, identify documents and processes, and allow feedback to support assessing program implementation. Presently there are four EMS agencies waiting to be given program documentation as beta test sites to assess process and clarity of program materials.

A Frequently Asked Questions (FAQ) document will be developed from these beta test agencies and expanded with feedback from new agency applications after the program is live. The FAQ documentation will be available on the EMSC website.

Currently recognized EMS agencies who are participating in the PVRP will need to apply for a new recognition of the Prepared for Pediatrics program as detailed in the Prepared for Pediatrics Program Administrative Handbook for EMS agencies. Recognition terms will coincide with the agency licensure expiration date at which time the agency must submit a renewal application and support documents as detailed in the handbook to remain recognized by the program.

All EMS agencies recognized by the Prepared for Pediatric program will be provided with program level decals to be placed on the EMS agency licensed vehicles. Recognized agencies will also be listed on the Pennsylvania EMS for Children website. Materials to support agency communications with the public will be available upon successful recognition.

June 25, 2025

VTR#: 0625-01 **EMS Operations Committee**

Shared Staffing Between EMS Agencies

Recommendation:

The Pennsylvania Department of Health, Bureau of EMS, should reinstate the practice of the on-scene combination of personnel from different EMS agencies to form a complete and legally compliant crew capable of delivering emergency care and transportation at the appropriate level (BLS or ALS), as determined by the responding personnel, provided that all minimum staffing requirements are met at the time of transport

Rationale [Background]:

The EMS system across Pennsylvania is currently grappling with a severe workforce shortage, significantly impacting its ability to respond promptly and reliably to emergency service requests. While recruitment and retention initiatives are important and can yield long-term benefits, they are often complex and slow to deliver immediate results. In the meantime, agencies should be empowered to adopt creative and non-traditional operational models tailored to their specific local needs.

One such model—once frequently utilized—is the practice of allowing multiple understaffed EMS agencies to respond to an incident and combine their personnel on-scene to form a complete and qualified crew. Since the inception of EMS in Pennsylvania, this approach has been seen as a practical solution in many parts of the Commonwealth, particularly in expansive rural and suburban areas that rely on a tiered response system. **Not intended to be changed during the EMS Act revision process in 2009 and being not expressly prohibited by statute, this practice continued, without complication, until new guidance was published in 2017.**

EMS Information Bulletin 2017-06 – "Minimum Staffing" – further complicated and often discouraged the practice of shared staffing by imposing restrictions based on the licensure level of the transporting vehicle. These limitations intensified existing operational challenges, increased response times, and in some cases, resulted in the discontinuation of local EMS services across parts of the Commonwealth.

Additionally, EMS IB 2017-06 mandates detailed written agreements that must be approved by the Department. While these agreements reflect industry best practices, the decision to implement them should remain at the discretion of individual agencies rather than be enforced through regulatory requirements.

In the summer of 2022, the PEHSC Board of Directors voted to submit CFC 0622-01, requesting that the Department review EMS IB 2017-06 and consider revising its position. To date, no official response has been received, and no action has been taken.

This unresolved issue continues to create operational challenges across the Commonwealth. Since the submission, numerous organizations and stakeholders have expressed their support for the concept of shared staffing on the scene.

Statutory and Regulatory Review:

There are numerous EMS System Act statutes and regulations that specifically state that people may arrive at the scene separately as long as there is a full crew during the transport. There is absolutely no language anywhere that says that the full crew can only consist of rostered personnel of one ambulance service. Rather, the Regulations specifically give permission for an intermediate ALS or ALS provider from another EMS agency to board the BLS vehicle and provide care on board the BLS vehicle during transport. These providers are certainly not on the BLS roster.

Current regulation permits the formation of a crew on the scene of an incident. As stated in Title 28 §1027.33 (2), referring to BLS ambulances, "*Responding ambulance crew members may arrive at the scene separately, but the ambulance shall be fully staffed at or above the required minimum staffing level before transporting a patient."* Similar language is present in §1027.34 and §1027.35 when referring to IALS and ALS ambulances. The is no specific requirement that these crew members are required to be employed by the same agency.

Further, when discussing ALS ambulance and ALS squad interaction, Title 28 §1027.35 (c)(2) and §1027.38 (c)(2) state that *"If the lower-level EMS vehicle is used to transport the patient, that EMS provider shall use the equipment and supplies on the lower-level EMS vehicle, supplemented with the additional equipment and supplies, including medications, from the ALS ambulance (squad)."* The same can be said for IALS resources.

Additional statutory language, noted below, also supports the concept of forming complete crews after arrival at the scene:

• 35 Pa.C.S. § 8133(c)(1) – Basic life support ambulances: "The minimum staffing requirements at the time of transport for a BLS ambulance to provide EMS is an EMS vehicle operator and an EMS provider at or above the level of an EMT." There would be no need to include the language "at the time of transport" if the staffing requirement

applied at all times. But, 35 Pa.C.S. § 8133(c)(2) indicates that this subjection expires on April 29, 2027.

• 35 Pa.C.S. § 8130(b)(1) - Advanced life support ambulances: “If a member of the ambulance crew arrives at the scene before another crew member, that person shall begin providing EMS to the patient at that person’s skill level.

• 35 Pa.C.S. § 8129(l) – Emergency medical services agencies: Permits the Department of Health to revise the staffing standards for ambulance by Regulation.

In its publication of EMS Information Bulletin 2017-06, the Department outlines requirements for minimum staffing level of an EMS agency. The bulletin states, “if minimum staffing for an ambulance is achieved utilizing personnel from different agencies a response plan, staffing plan and staffing agreement between the agencies must be in place in advance of the response.”

This document is not simply conveying information to EMS agencies, by its very content and tone, it is attempting to communicate Department policy on this issue.

Two questions arise:

1) there is no reference to an EMS Information Bulletin in statute or regulation, therefore are the requirements set forth therein enforceable?

2) Does the Department possess the authority to require a staffing agreement and define its contents when such an agreement is not referenced in statute or regulation? While the Department has clear authority to define EMS vehicle staffing levels in terms of the number required providers at a given certification level, there is no clear authority to dictate the source of those providers, which is an EMS agency responsibility in compliance with 28 Pa.C. §1027.31(7) related to general standards for providing EMS.

Fiscal Concerns:

There are minimal fiscal concerns associated with the proposed shared staffing model. In fact, this approach has the potential to enhance operational efficiency and reduce costs in EMS systems already under financial and workforce stress. Although considerations related to billing, reimbursement, insurance, liability, and workers' compensation exist, these are not governed by the EMS Act and fall outside the regulatory scope of the Department. Nevertheless, addressing these considerations through inter-agency agreements is a widely accepted best practice and should be encouraged for the protection of both agencies and their personnel.

Operational Concerns

The shared staffing model offers several key operational benefits. It allows for faster response times by enabling partially staffed crews to initiate a response and then form

a complete and legally compliant crew upon arrival at the scene. This model enhances system efficiency and improves access to care by reducing turnaround times, particularly within tiered BLS and ALS response frameworks.

These benefits are especially pronounced in rural areas, where EMS resources are often limited and response coverage is challenging. By maximizing available personnel across neighboring agencies, the model helps fill service gaps and ensure timely patient care.

To ensure safe and effective implementation, agencies should establish clear policies and procedures that confirm adequate staffing can be formed on-scene prior to response. Additionally, operational elements such as documentation responsibilities should be explicitly defined in advance to maintain accountability and clarity during joint responses.

Clinical Concerns:

While the shared staffing model presents significant operational advantages, it is critical to address several clinical concerns to ensure the delivery of safe and effective patient care. Agencies should have formal medical direction agreements in place that explicitly cover shared staffing arrangements, protecting both the organizations involved and the individual providers. Policies should clearly define who is responsible for clinical oversight during shared responses to avoid ambiguity and ensure consistent medical supervision.

Furthermore, agencies should implement systems to track clinical data related to shared staffing incidents. This will allow for ongoing quality assurance, performance improvement, and identification of any clinical trends or issues. Adherence to all applicable treatment protocols must be monitored and confirmed, regardless of the originating agency of each provider. By proactively addressing these clinical elements, the model can be implemented without compromising patient safety or care standards.

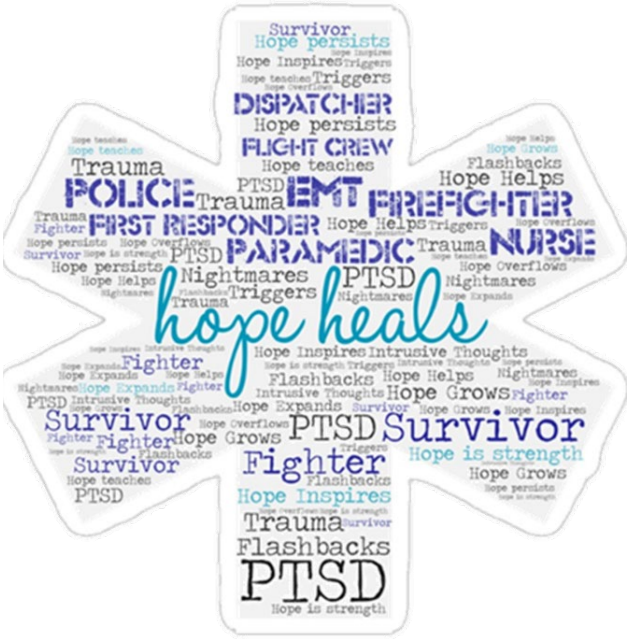
Plan of Implementation:

The Pennsylvania Department of Health, Bureau of EMS, should begin implementation by immediately rescinding EMS IB 2017-06, which currently limits the use of shared staffing models. In its place, the Department should issue updated guidance explicitly permitting the practice of shared staffing at all levels of care— BLS, IALS, and ALS provided that minimum staffing and equipment requirements are met at the time of transport.

In a separate document, additional guidance could also include a set of recommended best practices to assist EMS agencies in responsibly implementing shared staffing models. These recommendations could cover areas such as inter-agency agreements,

documentation responsibilities, medical oversight, and coordination of care. It should be clearly communicated that these are recommendations—not mandates—and do not impose new regulatory requirements beyond those already established in the EMS Act.

Creation of this additional guidance should not delay the cancellation of EMS IB 2017-06. This approach will support local flexibility, improve system efficiency, and ensure that legal and financial responsibilities are appropriately managed at the agency level.



Research and Pilot Program Recommendations

The following research or pilot projects were recommended to the Department of Health for approval by the PEHSC Medical Advisory Committee.

Tranexamic Acid and Calcium in Prehospital Patients

Penn Medicine – Lancaster General Hospital

MAC Recommendation: Approval by the Department of Health

1 Background and Study Rationale

This study is a retrospective research study/chart review and prospective, observation study that will be reviewed and approved by the IRB. This study will be conducted in accordance with all applicable University of Pennsylvania human subjects research requirements as well as applicable federal regulations.

1.1 Study Introduction

Hemorrhagic shock as a result of trauma accounts for more than 60,000 deaths in the United States and 1.5 million deaths worldwide each year.1 The management and treatment of prehospital hemorrhage are critical concerns for emergency service providers, as 91% of prehospital deaths are linked to sources of bleeding. Additionally, 20% of hemorrhagic prehospital deaths involved survivable injuries if the correct medical care was administered.

Hemorrhage that goes without treatment leads to hemorrhagic shock, which causes vasoconstriction with hypoperfusion, leading to end-organ damage in patients. Severe hemorrhagic shock can lead to cerebral anoxia and fatal arrhythmias, ultimately leading to death

However, the use of calcium chloride and tranexamic acid (TXA) are two of many interventions used in the prehospital setting to combat hemorrhage and hemorrhagic shock in trauma patients and reduce mortality rates in trauma patients.

Using calcium chloride to manage hemorrhage is advantageous as calcium is an essential component of the coagulation cascade. Calcium contributes to activating clotting factor X and thrombin, which are essential steps that form a secondary hemostatic plug. Intravenous administration of calcium chloride in the case of hemorrhage is beneficial as it increases hemostatic plug formation and decreases blood loss. Administration of calcium chloride as an anti-hemorrhagic intervention in a prehospital setting is generally supported based on the demonstrated association between hypocalcemia, mortality, and the need for blood transfusions

and on the demonstrated decreased risk of mortality from major traumas with calcium supplementation.

TXA can also be used to manage hemorrhage, as it extends the life of existing hemostatic plugs. TXA is an antifibrinolytic agent that acts as a competitive inhibitor that binds plasmin, the enzyme responsible for binding and cleaving fibrin to result in the degradation of hemostatic plugs.2 Thus, in the presence of TXA, plasmin cannot bind and degrade hemostatic plugs; thus, existing hemostatic plugs persist for longer periods than normal, resulting in reduced blood loss. Several studies have clearly demonstrated that prehospital TXA administration is associated with reduced mortality and the need for blood transfusions.

Both TXA and calcium chloride have been used in a prehospital setting to combat hemorrhage in trauma patients. However, there is a lack of literature surrounding the relationship between co-administering TXA and calcium chloride to trauma patients prior to their arrival at the hospital. We seek to find clarity on this gap in the current research using our own data from our trauma registry by looking at trauma patients 16 and older who fit the inclusion criterion. We hypothesize that administering TXA and calcium chloride in a prehospital setting will result in better outcomes than solely administering TXA and administering TXA in a prehospital setting will have better outcomes than no administration of TXA.

2 Study Objectives

The purpose of this study is to find clarity on the administration of TXA and calcium chloride in a pre-hospital setting in trauma patients.

2.1 Primary Objective

The primary objective of this study is to determine the effects of the co-administration of TXA and calcium chloride on trauma patient’s mortality and blood transfusion rates.

3 Study Design and Methods

3.1 General Study Design

This study is a retrospective, cohort study and a prospective, observational study.

3.1.1 Total Number of Subjects

The study will enroll a total of approximately 5,000 subjects who will meet inclusion criteria. This study serves to determine the incidence rates of patients receiving TXA, Calcium Chloride, or TXA and Calcium Chloride pre-hospital for hemorrhagic shock. Further, it serves to determine the association between the administration of TXA and Calcium Chloride and trauma patients’ mortality and blood transfusion rates. Rates of many outcomes/covariates are low, so optimizing sample size by including all cases over the time frame is the best way to estimate and study those parameters. When we do calculate rates of outcomes or incidences, we want our reported results from the study to match the registry and not be a sample which can vary.

3.2 Study Population

3.2.1 Inclusion Criteria

- Patients 16+ years of age presenting to Lancaster General Hospital by EMS
- Patients who meet both of the following:
- Significant blood loss related to traumatic injury (blunt or penetrating) with
- suspected uncontrolled bleeding
- Shock index greater than or equal to 1 OR systolic blood pressure < 90 mmHg

3.2.2 Exclusion Criteria

- Patients younger than 16 years of age
- Patients who have died before presentation to the hospital
- Burn patients
- Hypersensitivity or allergy to TXA
- Time elapsed from injury greater than 3 hours
- Isolated closed head injury

Pregnancy greater than or equal to 24 weeks

Beyond Reversal: Enhancing Opioid Overdose Outcomes Through EMS Delivered Buprenorphine in the Field

Wellspan Health System – Wellspan EMS

MAC Recommendation: Approval by the Department of Health

Purpose:

Multidisciplinary approach to initiating MAT therapy in the field for patients that suffer from opioid use disorder

Goal and Objective:

Provide a prehospital MAT initiation option for patients suffered from opioid use disorder and were given naloxone by prehospital providers to reduce the risk of deadly opioid overdose.

Proposal:

Wellspan Community paramedicine and/or specially trained paramedicine respond to 911 calls concerning opioid overdoses. After evaluation of the patient and providing naloxone, paramedics would conduct a discussion about the patient's substance use history, current MAT therapies and discuss the option for prehospital initiation of buprenorphine- naloxone. Patients, if consenting, would receive treatment by EMS and options for further management.

Situation (S)

• **Patient Population:** Patients suffering from opioid use disorder

• **Current Condition:** Currently, patients suffering from overdoses can receive naloxone in the field, only to leave the patients in withdrawal. This increases the risk of additional overdoses if the patients decline transport to the Emergency Department.

Background (B)

• **Medical History:**

- Known opioid use disorder with history of overdose.
- Previous treatments or medications: No methadone > 48 hours

Prehospital Event:

- Initial call details: EMS 911 call for overdose or unconscious/unresponsive patient requiring naloxone..
- Bystander information: Strong suspicion for opioid use and subsequent overdose

Assessment (A)

• **Inclusion Criteria:** Patients 18 years or older with current opioid use disorder;

requiring naloxone by EMS; provide name and date of birth; able to participate in consent process

• **Exclusion Criteria:** Pediatric patients; methadone use within 48 hours; pregnancy; imprisoned patients; altered mental status (non AOx4, unable to have conversation of consent, verbalize benefits and risks, understand the process)

• **Physical Examination Findings:**
- Vital signs: Bradypnea and/or hypoxia resolved with naloxone administration
- Mental status: AOx4 after naloxone administration
- Symptoms: Signs of withdrawal, COWS score documentation

Interventions by EMS:
- Patient received naloxone by EMS, patient in withdrawal
- Initial COWS score documented (> 7)
- Call online Medical command for approval of buprenorphine administration
- Administer 16 mg buprenorphine and 4 mg IM ondansetron PRN
- Reassess after 10 minutes, Repeat COWS score
- Administer additional 8 mg buprenorphine, if still symptomatic (COWS
- score > 7)
- Reassess after 10 minutes, Repeat COWS score
- Transport patient to hospital or accept patient refusal of transport
- Provide information for outpatient addiction services

Transport decision: Patient consent to transport for further care. If the patient declines transport, EMS protocol for refusal to be followed. If the patient is not stable or demonstrating capacity to refuse transportation, patent is to be to the emergency department as per protocol.

Recommendation (R)

• **Immediate Needs:**
- Permission from the PA State EMS Council for a pilot program
- Wellspan Service Line Support for Prehospital EMS efforts
- Outpatient follow up with Wellspan Primary Care and Addiction Services to ensure continuity of care
- Funding (small community grant)

• **Proposed Timeline (Subject to Boards and Departments for scheduling):**
- Month 1 to 4: Submit proposal to Regional and State EMS board for
- prehospital buprenorphine approval
- Month 4 to 6: Obtain approvals and collaborate with Administration for appropriate management and handling of controlled substances. Paramedic Education through didactics, simulations and conferences
- Month 6: Initiation of field application of the intervention
- Monthly chart reviews and Review of Educational material every 4 months

Council Activities

As reported to the PEHSC Board of Directors

2025 Unified Statewide EMS Treatment Protocol Project

The Department of Health, Bureau of EMS, has indicated its desire to combine the current Statewide BLS, iALS and ALS treatment protocols into a single unified document. This unification will improve the continuity of care and improve provider satisfaction.

It's important to note that this project is not simply copying and pasting the information from 3 different documents into one master treatment protocol. To do so would result in a work product that would be very large and not user friendly. With the support of the Bureau of EMS, PEHSC forwarded a workgroup to make recommendations on the building and review process; document format and approximate timeline for completion. The workgroup reviewed a number of existing unified formats from around the country, pulling elements from several to create a unified protocol template for Pennsylvania.

In some cases, elements from the current protocols could easily be combined to create one unified protocol, however, simple transcription is not practical for every protocol topic and will require more time and effort to deliver a user-friendly product. The writing process also provides an opportunity to ensure the protocols are evidence-based and reflective of the current standards of practice.

To manage the size of the document, duplication of some elements of care have been combined into a stand-alone protocol that connects to and complements other complaint-based protocols. An excellent example of this is pain management, which is currently addressed based on the root cause of the discomfort, e.g., traumatic or non-traumatic in addition to which pain management is addressed in other protocols, e.g., suspected acute coronary syndrome. With BEMS support, the workgroup is developing a single protocol that addresses the various causes of pain the prescribes appropriate pain control using both narcotic and non-narcotic medications.

Category	Protocol Number & Title:	Last Update:
Assessment		
Signs and Symptoms	Differential	

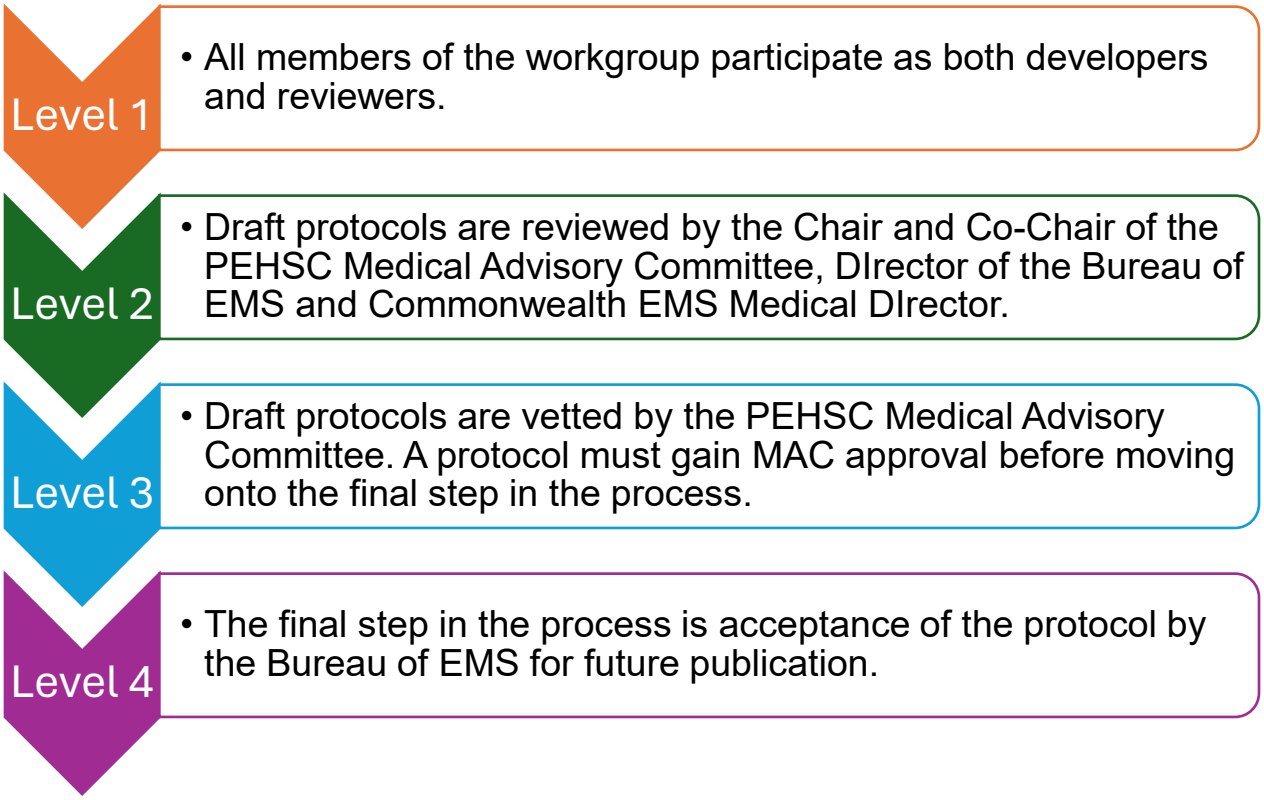
BLS	
IALS	
ALS	

MEDICAL COMMAND – BLS	
IALS	
ALS	

Clinical Pearls:

QA/QI INDICATORS – BLS	
IALS	
ALS	

The protocol development process has several levels of review and involves a physician-led multidisciplinary group that includes medical directors, providers, managers, educators, regional councils and representatives of the Ambulance Association of PA. We are pleased to report that the Bureau of EMS is an active participant in the workgroup through the Bureau Director, Commonwealth EMS Medical Director and staff.



Project Timeline:

The normal protocol update cycle begins in the spring of the year, progresses throughout the year, concluding that fall/winter. During the first quarter of the succeeding year, the Bureau of EMS develops a protocol update education module, then publishes the updated protocols for provider and medical director familiarization.

The education modules are posted on TRAIN PA; all providers will be required to view this education. When a date for mandatory implementation is announced, some providers may utilize the new protocols upon completing the education and with agency medical director approval.

That is the “normal” process, this project is anything but normal in terms of the depth and breadth of its scope. While the intent is to follow the standard timeline as close as possible, a project of this significance cannot be rushed just to simply hit a benchmark, the process with continue until all parties agree that a quality product has been produced.

Additional Council Committee/Task Force Activities

Medical Advisory Committee:

August 14, 2024

The meeting was held at the Pennsylvania Emergency Management Agency. The incoming class of EMS fellows from around the Commonwealth attended this meeting to gain a better understanding of the EMS system and advisory role of PEHSC.

Department of Health Report:

Dr. Bledsoe reported that numerous pilot programs have been approved by the Department. He also reported the BEMS is reviewing the current EMS Agency Medical Director's course.

Director Martin offered clarification on EMSIB# 2024-13 regarding use of mechanical CPR devices. The intent of the update was to allow for QRS agencies to use the devices. An unintended consequence is that with ePCR and data reporting requirements for QRS agencies differing from those of BLS agencies, this has actually made things potentially more restrictive.

Pilot Programs;

Dr. Derek Isenberg presented a pilot project, OPUS REACH-I. This study aims to optimize the current prehospital stroke algorithm when triaging patients to an appropriate stroke center. The study has now received IRB approval and is in the process of obtaining funding. The MAC voted to recommend the Department approve the project.

Dr Chris Berry, Associate EMSNP Regional Medical Director, presented a joint pilot project between Greater Valley EMS and the regional council. The proposed pilot would allow for adjustment of the minimum staffing for ALS transport units (MICU's) to a single ALS provider and a single EMSVO certified individual. Current statute requires a crew of a single ALS provider and a single BLS provider. This is in response to significant staffing difficulties in a rural region coupled with prolonged mutual aid. The MAC voted to recommend the Department approve the pilot project.

Dr. Alvin Wang presented the FASTEST Study. The study is a currently running national study involving mobile stroke units (MSU's) and the identification and treatment of intracranial hemorrhage. Dr. Wang would like to enroll the Bensalem Jefferson MSU in this study. The MAC voted to recommend the Department approve the study. Dr. Alex Rosenau announced his retirement to the group. The

members expressed their appreciation for his years of dedicated service to the EMS system and as member of the MAC.

2025 Protocol Development Workgroup:

The workgroup has developed a template for the unified 2025 treatment protocols. It is a compilation of several existing state and large agency documents and supports POC by limiting content to the most relevant information. It provides “clinical pearls” to support provider critical decision making. The draft template was shared with the MAC who supports the design.

RSI Task Force:

Progress on the project continues. The task force is developing a participant guide to provide agencies with information on requirements and expectations; the application and approval process; clinical guidelines; data and QA activities. All information in the guide was derived from previously reviewed/approved source documents.

Special Operations Task Force:

The group has continued to work on Wilderness EMS Service recommendations and has reached consensus on most items such as scope of practice, course/education content, medical director, and medical command content. The only outstanding item is a recommended formulary.

The task force reviewed and offered support on a proposal for Outdoor Emergency Care (OEC) to EMT bridge program

EMS Education Task Force:

In response to questions about the accreditation/reaccreditation of EMS Education Institutes, a best practices survey was drafted and sent to stakeholders. The results were presented as follows: 30 responses (40%) with 11 regions represented A meeting will be planned to review results and continue development of related recommendations

EMS for Children Committee:

2024 Prehospital Pediatric Readiness Project assessment is in progress.

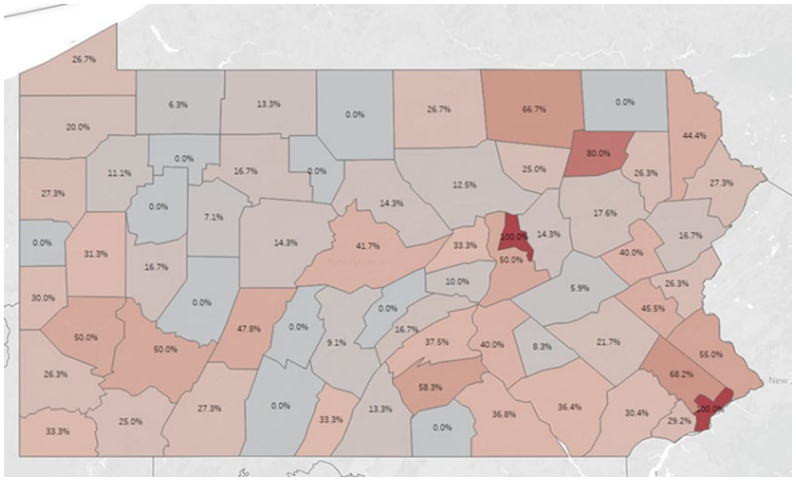
Pediatric Readiness Recognition Program - ED (PRRP-ED) is in the pilot program phase that includes eight facilities. Engagement over the seven focus areas of the program to develop each level’s requirement

Pediatric Readiness Recognition Program - ED (PRRP-EMS) has been discussed and new program outline finalized.

2024 National Prehospital Pediatric Readiness Assessment has a 28% response rate in Pennsylvania (6th most responses nationwide). New Jersey had 100%, North Carolina 40%, Ohio 60%, Indiana 82%, Texas 37%, California 55%, Iowa 41%, and Illinois 46%.

2024 National Prehospital Pediatric Readiness Assessment. Darker colors represent higher % response rate. Montour (1) and Philadelphia (2) Adams (5), Bedford (8), Blair (4), Cameron (2), Clarion (7), Forest (7), Indiana (1), Lawrence (9), Mifflin (4), Potter (9), & Susquehanna (13)

- Represents number of 911 agencies surveyed in the county



Pennsylvania Response Statistics

Agency Licensure level:

- ALS 58.4%, IALS 1.6%, and BLS 39.9% response rate

Agency Transport level: Transport capable 79.4% response rate of all respondents. Non-transport 20.6% response rate, Agency licensing level will drive reporting Detailed report is expected in late 2024.

Pediatric Readiness Recognition Program - ED (PRRP-EMS)

<u>Current Program Components</u>

1. Equipment and Supplies
2. Background checks
3. Education
4. Community Outreach
5. CPST and Safe Transport
6. EMSC Survey Participation

Additional Components

1. Pediatric Emergency Care Coordinator (PECC) all levels
2. Performance Improvement
3. Disaster Readiness
4. Family Centered Care
5. NEMSIS

December 11, 2024

Medical Advisory Committee:

The MAC held a virtual meeting on November 11, 2024

Department of Health Report:

Director Martin requested the MAC's consultation on a draft letter regarding a proposed ALS staffing pilot in the Northeastern PA region. The BEMS is not in favor of the proposed staffing pilot.

The BEMS is working on new guidelines for conducting pilot programs or research. The current guidelines are over 20 years old

Pilot Program:

Dr. Bledsoe, acting as the Community LifeTeam Medical Director, presented a pilot program for the direct transport of mental health patients to a walk-in mental health facility in the City of Harrisburg. The MAC recommended the BEMS approve this project.

Neighborhood (aka micro hospitals):

Dr. Rick Wadas led a discussion on EMS transport of 911 patients to "microhospitals" aka neighborhood hospitals base on their experience in the Pittsburgh area. Their experience overall has been positive, with no major issues The sponsoring health systems provided education to EMS agencies prior to opening facilities. Some facilities can provide destination medical command. The rate of re-triage and transfer to a tertiary care facility has not been overwhelming, however, if possible, facilities should ID EMS resources in advance to avoid using 911 system.

Intranasal Epinephrine:

Dr. Myers asked the MAC to consider permitting EMTs to utilize the recently approved intra-nasal epinephrine spray. The MAC requested additional information to consider this request at their January 2025 meeting.

Nalmafene:

Butch Potter updated the committee on the legislative lobbying efforts to expand the available opioid antagonists to include Nalmefene on the DOH blanket order. The national clinical toxicology groups currently do not support this initiative.

Subgroup Formed:

A subgroup of MAC will be formed to discuss and potentially make recommendations on topics including, but not limited to:

1. Treatment in place (TIP)
2. Transport to alternate destinations (TAD)
3. ED “wall time” waiting
4. Medical command orders for placing patient in restraints at the request of law enforcement.

2025 Protocol Development Workgroup:

The workgroup has begun the process of reviewing draft protocols as submitted by group members. The BEMS reaffirmed their desire to draft Sections 1&2 as some protocols involve matters of regulation. The group will forward blocks of protocols forward to the MAC rather than the entire protocol book.

Critical Care Transport Task Force:

Awaiting a response from the BEMS on recommendations:

1. To update the CCT medication and scope of practice lists as submitted by the group.
2. To permit the development and use of agency-level protocols by ground CCT and special operations EMS agencies.

The task force reviewed the current required equipment list and made several recommendations, which will be combined with reviews by the EMSC and EMS Operations committees.

There was continued discussion on the expansion of the statewide CCT protocols. Consensus reached that the additional protocols should be created if a gap assessment reveals patient conditions for which there is not a CCT protocol or; If the patient condition is not addressed in the current statewide ALS protocols. The TF member will gather source documents to assist in the creation of needed protocols. The CCT protocols will not be included in the concurrent initiative to unify the other statewide protocols in order to keep both documents user-friendly.

EMS Operations Committee:

Revisited CFC 0622-01 - Shared staffing operations between ALS and BLS agencies. Verbal response received from BEMS voicing support for the concept and has requested additional recommendation on how to proceed. The committee is also drafting a VTR and possibly a best practices document

At the request of MAC the committee is reviewing required ambulance equipment list for changes/updates

EMS for Children Committee:

There are new advisory committee members from ENA and Penn State Hershey Medical Center – welcome!

A revised contract from the DOH has been received.

The committee is reviewing current pediatric protocols in support of the 2025 protocol update.

Spring Symposium still needs committee support before any planning can proceed

Committee workplan includes:

1. Prehospital Pediatric Recognition Program for EMS presentation and approval.
2. VTR, program outline of Requirements and Levels of Recognition, and the Pediatric Recognition Program Equipment and Supplies
3. Pediatric Voluntary Recognition Program (PVRP) 10 years old
4. Addition of Pediatric Emergency Care Coordinators in 2019
5. HRSA Performance Measures - 2023 Implementation Manual for State Partnership Grantees
6. Establishing a standardized Pediatric Readiness Recognition Program for prehospital EMS.
7. HRSA July 2024 program review with recommendations

HRSA Standards based on "Pediatric Readiness in Emergency Medical Systems" joint policy statement and technical report

1. Integration of EMS physician medical oversight – Statute and Regulation
2. Inclusion of policies and protocols for the safe transport of children in emergency vehicles - Protocols
3. Collaboration with Emergency Departments to provide pediatric readiness across the care continuum – Partners in Pediatrics program
4. Inclusion of family-centered care practices
5. Inclusion of pediatric considerations in disaster planning
6. Inclusion of pediatric considerations in guidelines and policies - Protocols
7. Inclusion of practices to reduce pediatric medication errors - Protocols
8. Incorporation of statewide data submission, per state statute to submit NEMSIS data
9. Incorporation of performance improvement practices
10. Prehospital clinicians physically demonstrate the correct use of pediatric-specific equipment.

Review Committee

1. Consolidate and expand levels
2. "Recommended Essential Equipment for Basic Life Support and Advanced Life Support Ground Ambulances 2020"
3. Maintain PECC, Background Checks, Education, Outreach, and Safe Transport in the program
4. Add focus areas on Performance Improvement, Disaster Readiness, Family Centered Care, and Provider Competencies to the program
5. Clarify survey participation and NEMSIS data submission

Program Level Expectations from Performance Manual

1. Be monitored by a governing body
2. Have an application
3. Verification process including a site review, virtual or in person
4. Meet the 10 standards
5. Track recognized agencies

Implementation Plan

Department of Health Approval

Communications and Marketing Plan

Go-Live projected for April 1st

Supplemental support documents including:

1. Prepared for Pediatrics Program Administrative Handbook for EMS agencies
2. Prepared for Pediatrics Program Application in both a digital and web-based format for submission
3. Prepared for Pediatrics Program support materials including forms and attestations in support of requirement areas and levels of recognition.
4. Prepared for Pediatrics Program Recognition Process Guidelines to support the required site visit activities and the additional required equipment inspections
5. Transition currently recognized agencies includes submitting a New Application for the new program
6. 3-year term based on agency licensure expiration date, renewal required to maintain recognition
7. FAQ document to address transition and new program key requirements
8. Program level decals for all agency licensed vehicle
9. Media support for communicating recognition accomplishment
10. All materials hosted on PA EMSC website

March 19, 2025

Medical Advisory Committee:

The MAC met virtually on January 15th.
Dr Wang provided an update on the 2025 Protocol Update Workgroup. There is steady progress with the group members submitting protocol drafts for review.

Dr. Stephanie Costa, EMS Physician, Wellspan Health, presented a pilot project for EMS personnel to administer Buprenorphine to patients with suspected of opioid abuse. The project is slightly different from those already in progress. The MAC voted to recommend the BEMS approve the pilot.

The committee reviewed and discussed the recommended changes to the required equipment and supply list. Commented that agencies utilizing video laryngoscope should continue to carry direct laryngoscope as a back up.

Dr. Reihart convened the first meeting of the TIP/TAD MAC subcommittee. The group discussed the opportunities and challenges with treating patients in-place and transport of 911 patients to alternate destinations for further care.

Dr. Reihart authored at draft consensus statement on **Treatment in Place**, which is currently under review by the subcommittee. After which it will be presented to the MAC at their April meeting and if approved, will come to the Board for consideration at their June meeting.

Special Operations Workgroup:

The final draft of the Wilderness EMS Agency Recommendations has been completed and will be presented to MAC at the April 2025 meeting. Regarding the Tactical EMS Agency Recommendations, the group is awaiting further guidance from BEMS on next steps

EMS Education Task Force:

The group has continuing work to support EMS Education Institutes by developing best practice guidance. A survey was distributed in Summer 2024, which yielded inconclusive results. Continuing to solicit feedback from regional partners and other stakeholders and sharing with BEMS. Awaiting copy of “Draft Guidance for Document Checklist for Educational Institutes” for committee review

EMS Operations Committee:

The group continues work on revisiting CFC 0622-01 0 Shared Staffing Between ALS and BLS Agencies – and drafting a formal recommendation to the Department.

June 25, 2025

Medical Advisory Committee:

Dr Wang provided an update on the 2025 Protocol Update Workgroup. There is steady progress with the group members submitting protocol drafts for review.

Dr. Siberski provided an overview of the proposed education standards for the Wilderness EMS Provider. The MAC provided feedback, and the Spec Ops group will consider the recommended changes, then resubmit the document to the MAC.

The BEMS requested the MAC reaffirm their previous recommendation on use of IV pumps for vasoactive medications, and the ability for CCT and Special Ops medical directors to create and utilize BEMS-approved agency level protocols. Both recommendations were reaffirmed.

Dr Larry Anderson, Chester Co Regional Medical Director, presented a draft regional protocol for the alternative transportation and destination for mental health patients based on resources available within that region. The MAC recommended the BEMS approve the protocol.

Dr. Brandon Mulcahy, Penn Medicine-LGH, presented an IRB approve study for the use of TXA combined with Calcium Chloride in Prehospital Patients. The MAC recommended the BEMS approve this study, which will take place in Lancaster Co.

The committee discussed the implications of hospital ED’s contacting a PSAP for an emergent response to the ED for interfacility transfers. Also, does the EMS agency have a duty to act on such a 911 dispatch and be forced to perform the transfer? More information is needed from both the hospital and EMS aspect of this issue.

Critical Care Transport Task Force**:**

A discussion was held the expansion of the current statewide CCT protocols covering clinical care situations that are not [adequately] addressed in the current CCT or ALS protocols.

The anticipated approval and development of BEMS-approved, agency-level protocols for ground CCT and Special Operations may impact their development. It's important to note, agency-level protocols are an OPTION for medical directors, therefore statewide CCT protocols will still be needed.

The group discussed the current scope of the task force's focus. While originally developed to discuss air medical, the ground CCT related issues, recently more topics related to transports performed by BLS, iALS and ALS units. The question was raised, if the group should be rebranded as the *'Interfacility Transport Task Force?"* No consensus reached – more discussion needed.

With the changes to the EMS provider scope of practice, e.g., blood administration and the anticipated update to the CCT medication list. It may be time to revisit and interfacility transport guide, which was jointly developed by PEHSC and PACEP.

EMS Special Operations Workgroup:

A final draft of the Wilderness EMS Agency Recommendations was presented to MAC at April 2025 meeting. Additional revisions were recommended and the document will be routed back to committee for further revision.

Regarding the Tactical EMS Agency Recommendations, the group is still awaiting further guidance from BEMS on next steps.

EMS Education Task Force:

BEMS presented a draft document checklist for accreditation/reaccreditations of EMS Education Institutes with request for TF comments. Document distributed to TF with minimal responses to date, review ongoing

EMS Operations Committee:

VTR 0625-01 – Shared Staffing Operations Between Agencies

Follow-up to PEHSC CFC 0622-01. Recommends that the Department rescind EMS IB 2017-06 which limits that ability of EMS agencies to share staff and form crews on the scene of an incident

EMS for Children Committee:
An update was provided regarding the grant program status and funding.

Prepared for Pediatrics - ED update
The committee discussed the current pilot program activity, further program development and targets.

Prepared for Pediatrics - EMS implementation
The PVRP program has been revised and the pilot group reviewed program materials.

Prepared for Pediatrics - EMS implementation
Scheduled for July 1st . rollout This includes social media, website, direct mailing, and email correspondence. There will be FAQ's, document access and a program handbook. There will be a focus on existing and additional areas of readiness including, the PECC, Equip & Supplies, Background Checks, Education, Outreach, Safe Transport, NEMSIS, Surveys, performance improvement, including disaster Readiness and Family Centered Care.

New Member Spotlight

During FY 2024-2025 the following organization became a PEHSC member:

Washington Hose Company No. 1 Coatesville, PA

Contributions

- PEMA 911 Advisory Board - PEHSC continues to hold a seat on the advisory board to provide EMS insight into dispatch and communications matters.
- PA Trauma Systems Foundation - PEHSC continues to hold a seat on the Board of Directors of the Foundation to provide EMS field insight into discussions.
- Farm Safety Board - PEHSC continues to hold a seat on the Farm Safety Board
- State Fire Commissioner's Office - Volunteer Loan Assistance Program
  PEHSC continues to hold a seat on the loan committee.

Professional Development and Outreach

- Ambulance Association of Pennsylvania
- HRSA Atlantic Region EMSC Council
- National Association of State EMS Officials (NASEMSO) EAST Region, Highway Incident and Transportation Systems (HITS) Committee, Substance Misuse, Assessment, Recovery, Treatment, & Surveillance (SMARTS) Committee, National EMS Quality Alliance liaison, and Pediatric Emergency Care Council
- Pediatric Emergency Care Applied Research Network (PECARN) GLACiER and PRIME nodes.
- EMSC Innovation and Improvement Center (EIIC) Trauma and Advocacy Domain representation, Pediatric Readiness Recognition Programs Collaborative, and State Partnership Advisory Council.
- Pennsylvania Fire & Emergency Services Institute Statewide Advisory Board Meetings
- 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:** PEHSC is legislatively recognized as the primary advisory council for EMS in Pennsylvania, providing expert input to shape regulations, policies, and statewide EMS initiatives. This role has been established in statute since 1985.

- **Representation and Engagement:** Comprised of over 230 member organizations—including EMS agencies, hospitals, medical professionals, training institutions, and advocacy groups—PEHSC ensures that all EMS system components have a voice in system planning and development.

- **Policy and System Development:** PEHSC leads and facilitates workgroups and task forces to develop clinical, operational, and educational recommendations that inform the Department of Health's actions.

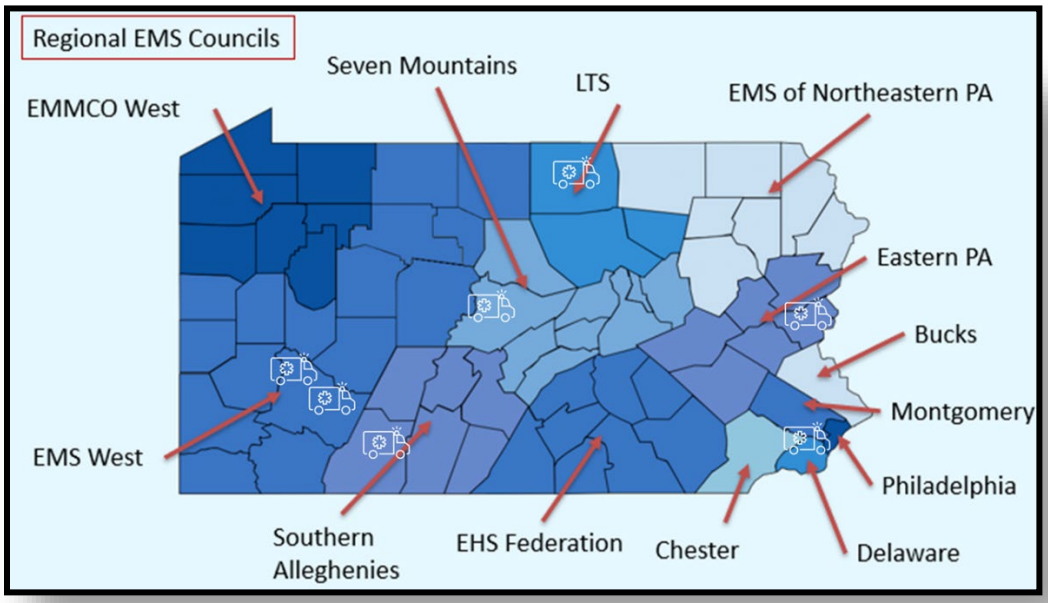
As a 501(c)(3) Organization
PEHSC is an independent nonprofit, not a state agency, allowing it to operate free of political influence while fulfilling its public advisory mission**. PEHSC does not lobby for specific legislation or candidates.** It provides neutral, educational briefings and recommendations to support informed legislative decisions.

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.


LEGISLATION
JURIDICAL
LAW
COURTHOUSE
LEGAL
JUSTICE
LAWYER
DOCUMENT
RIGHTS
CRIME
JUDGEMENT
PUNISHMENT
VERDICT

2025 Pennsylvania EMS Awards

The 2025 Pennsylvania State EMS Award are individuals and organizations that have demonstrated dedication and excellence in their communities and embody the ideals of the Commonwealth's EMS system.



BLS Practitioner of the Year

Kayla Hurler – Clymer Township Volunteer Hose Company

ALS Practitioner of the Year

Guy Kuklentz – Suburban EMS

EMS Educator of the Year

Fred Ferguson – Moshannon Valley EMS

Amanda E. Wertz Memorial EMS for Children Award

John Erbayri – Children's Hospital of Philadelphia

Dr. George Moerkirk Memorial Outstanding Contributions to EMS Award

Dr. William Jenkins – Westmoreland Co Hospital

David J. Lindstrom EMS Innovation Award

John Jordan – Somerset Ambulance

EMS Agency of the Year

Penn Township Ambulance

Pennsylvania's 47th Annual EMS Conference

The annual Pennsylvania State EMS Conference has long been recognized as a leading source of continuing education for the emergency medical services community. Always evolving, this event continues to adapt its format in response to evolving circumstances.

Conference 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:

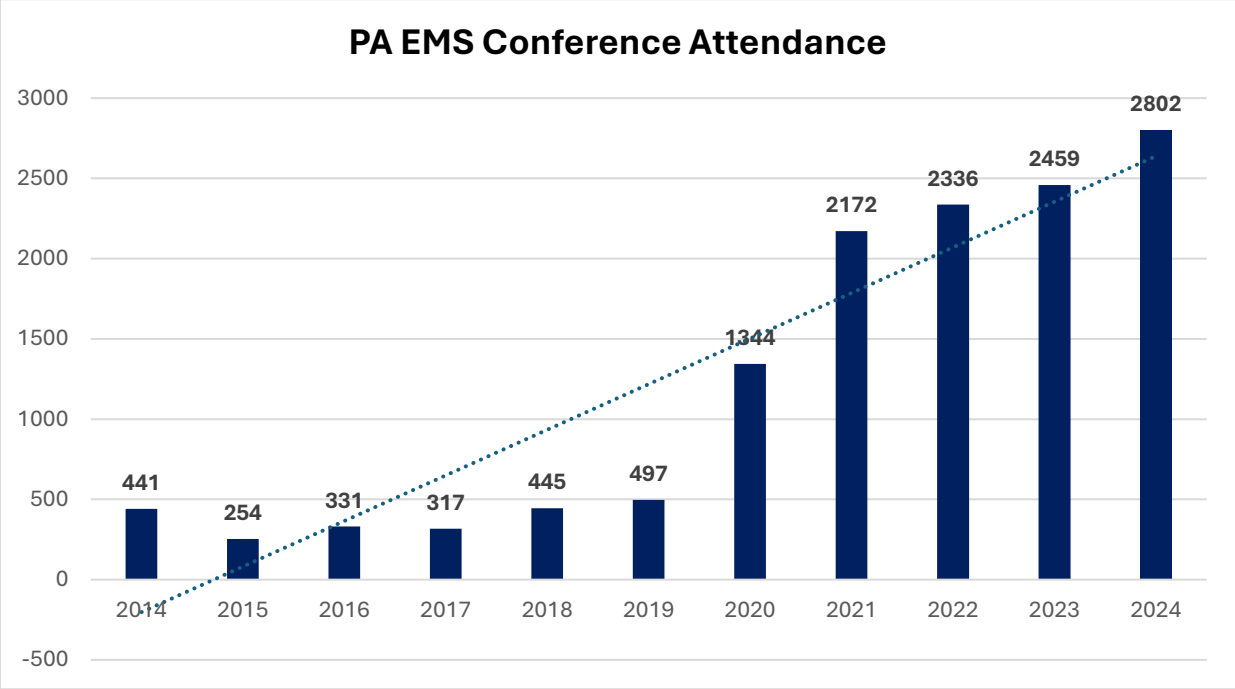
- Numerous nationally recognized presenters originated from across the United States
- A total of 24 educational sessions providing EMS continuing education credits in the following categories
  - Clinical Patient Care – 14.5
  - Other – 11.5
  - EMSVO – 1.0
- Sessions were offered live, via an online streaming platform, over a period of 4 days. This allowed for real-time interaction similar in many ways to what would be offered at a traditional conference.
- All sessions were recorded, allowing them to be offered for an extended period, greatly expanding the reach of the program.
- Use of a state-of-the-art virtual conference software platform allowed for a high-quality user experience, networking opportunities, and a virtual exhibitor hall.
- Lower costs and generous sponsor support allowed the program to be offered at a nominal fee of $10.00 per person.

Historical Comparison	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total Attendance	**441**	**254**	**331**	**317**	**445**	**497**	**1344**	**2172**	**2336**	**2459**	**2802**
Multi-Day General Conference	250	98	206	221	206	241	n/a	n/a	n/a	n/a	n/a
Single-Day General Conference	64	81	47	64	60	43	n/a	n/a	n/a	n/a	n/a
Exhibitors	44	37	25	25	51	100	n/a	n/a	n/a	n/a	n/a
Registered Nurse Attendance	33	20	27	27	19	26	68	152	196	n/a	n/a
Preconference Attendance	183	69	50	86	109	87	n/a	n/a	n/a	n/a	n/a

Registration by Certification Level	
Highest Certification	**Total**
Emergency Medical Responder (EMR)	49
Emergency Medical Technician (EMT)	1526
Advanced Emergency Medical Technician (AEMT)	120
Paramedic	919
Prehospital Registered Nurse (PHRN)	135
Prehospital Physician Extender (PHPE)	4
Prehospital EMS Physician (PHP)	23
Not Certified / Not Listed	26

Registration by EMS Region	
EMS Region	**Total**
Bucks County EMS Council	123
Chester County EMS Council	133
Delaware County EMS Council	121
Emergency Health Services Federation (EHSF)	403
Eastern PA EMS Council	593
EMMCO West	104
EMS West	330
EMS of Northeastern PA	162
LTS EMS Council	72
Montgomery County EMS Council	142

Philadelphia Regional EMS	136
Seven Mountain EMS Council	213
Southern Alleghenies EMS Council	134
Not Applicable / Out-of-State	136



Note: Virtual Conference Format Began in 2020

Continuity of Operations

PEHSC maintains, and updates annually, a Continuity of Operations and Emergency Response Plan. The purpose of this continuity of operations plan is to establish how PEHSC will provide 24-hour operations in the event of a local, state, or national disaster and how the Council will provide assistance in local, state, and national planning for disaster response. The purpose of the emergency operations plan is to establish a procedure should PEHSC staff be faced with an emergency while at work. The plan also outlines the procedure PEHSC will use to relocate from its current location, and outlines how PEHSC staff should respond to specific emergencies at the office.

Website and Social Media

PEHSC maintains a website with information about the organization and with clinical and operational information for EMS agencies and EMS providers. Last fiscal year, the website had 27,331 page views from visitors looking for resources and information about the Council and its activities. PEHSC also maintains an EMS for Children website that provides information about the program and provides resources to EMS agencies, EMS providers, and the public about response to pediatric emergencies. Last fiscal year, the website received 7,443 page views from visitors seeking information about pediatric emergency response.

The Council also leverages Facebook and Twitter to communicate with our members and EMS providers and agencies. The PEHSC Facebook account has over 5,000 followers and over 4,000 likes. The Council added a special group to its Facebook account during this fiscal year to assist in identifying workforce solutions through best practices.

Looking Ahead

The financial and staffing crisis continues to negatively impact every EMS agency. With both concerns being fought statewide and nationally, our attention looking ahead has been re-focused on ensuring that EMS is regarded as an essential service by all levels of government, revisiting system wide minimum standards, and additional funding streams for agencies and the system administration.

Acknowledgement

Without the continued support of our council members and individuals who participate on our committees and task forces, PEHSC would face a daunting task to identify and discuss issues to make recommendations to the Pennsylvania Department of Health for EMS system improvement.

This positive attitude enables PEHSC to continue our role in Pennsylvania’s EMS system and meet our mission. The Pennsylvania Emergency Health Services Council would like to thank everyone who has volunteered their time.