JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

STAFF STUDY OF THE EMERGENCY MEDICAL SERVICES SYSTEM IN THE COMMONWEALTH OF PENNSYLVANIA

DECEMBER 2013

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The Joint State Government Commission was created by the act of July 1, 1937[1] (P.L.2460, No.459), as amended, and serves as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.

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[1] Act of July 1, 1937 (P.L.2460, No.459), amended by the Act of March 8, 1943 (P.L.13, No.4), the Act of May 15, 1956 (P.L.1605, No.535), the Act of December 8, 1959 (P.L.1740, No.646), and the Act of November 20, 1969 (P.L.301, No.128).

General Assembly of the Commonwealth of Pennsylvania
JOINT STATE GOVERNMENT COMMISSION
Room 108 Finance Building - 613 North Street
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December 2013

To the Members of the General Assembly of Pennsylvania:

I am pleased to announce the release of the report, Staff Study of the Emergency Medical Services System in the Commonwealth of Pennsylvania, which was authorized by 2012 House Resolution 315. The resolution directed the Commission to study the administrative effectiveness of the Emergency Medical Services (EMS) system. The report includes comprehensive analyses of the operations of Pennsylvania's EMS system and makes recommendations based on input from dozens of first responders, providers, and administrators.

On behalf of the Commission, I extend our thanks to the many individuals who contributed their knowledge, expertise, and wisdom to this study. The EMS system is inherently complicated because it includes the delivery of life-saving medical services along with the administrative and fiscal infrastructure required to provide those services where needed, when needed, on a moment's notice. The assistance of those who work in this system every day, from first responders to executive administrators, was invaluable in producing this report.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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INTRODUCTION

On June 12, 2012, the Pennsylvania House of Representatives adopted House Resolution 315, which directed the Joint State Government Commission (the Commission) and the Legislative Budget and Finance Committee (LBFC) to study the Emergency Medical Services (EMS) system in the Commonwealth, including "the delivery of emergency medical services, training and planning, as well as all-hazard emergency response and disaster response training."

House Resolution 315 directed the Commission to explore the structure of the EMS system to research enhancements to the current delivery model for EMS, state resources, training, restructuring of the EMS regions, and to make recommendations, "for a more streamlined delivery model."[2] While LBFC and the Commission cooperated on this study, review of the policy and financial aspects of the system required separate analyses and therefore separate reports.[3]

The EMS system has experienced many changes since the enactment of the EMS Systems Act of July 3, 1985 (P.L.164, No.45). These changes include a revolution in technology, treatment protocols for providers, new licensing categories, increased training requirements, and implementation of a national standard curriculum for training. The system has also witnessed an increase in the professionalization of EMS, with increasing competition between paid and volunteer ambulance services for manpower, and increased training requirements that make it more difficult to recruit and retain emergency medical technicians (EMTs) and paramedics. The system is strained financially by low reimbursements from Medicare, Medicaid, and private insurers.

The EMS service providers who staff the system in Pennsylvania are dedicated and well-trained, and focused on serving the needs of the individuals within their service areas. They provide high-quality emergency care in an unpredictable environment. Unfortunately, the system faces a number of critical problems, including insufficient funding, a cumbersome organizational structure, overlapping and often inadequate supervision, and complex differences between urban and rural service areas.

The Commission collected extensive feedback through meetings and interviews with providers, the Pennsylvania Department of Health (PADOH), the Bureau of EMS (BEMS), EMS Regional Councils, the Pennsylvania Emergency Health Services Council (PEHSC), and other stakeholders. The organizations suggested how regional councils and the State EMS Advisory Board could be more efficient in terms of spending and operations, and how changes to that structure would affect their services. On some of the issues, knowledgeable observers differed in their opinions of the problems, and offered differing solutions as well. Nonetheless, comments

[2] A complete list of the Commission's seven specific tasks appears in HR315, in Appendix A of this report.
[3] See LBFC, *A Performance Audit of the Emergency Medical System Operating Fund*, September 2013.

from the different organizations were largely consistent in identifying where improvement is needed and how EMS is changing.

Methodology

Primary research consisted of staff interviews with over 130 people who work in Pennsylvania's EMS system in various capacities. These discussions were held both one-on-one and in group settings. In some cases, individuals approached the Commission to provide feedback on their own initiative, so it is important to note that interviewees were not always speaking on their employer's behalf. Otherwise unattributed views represent Commission staff's perception of the consensus of views. Where there was no full consensus, the report presents the views that had substantial support among interviewees. Many of the opinions presented in this report were received with the understanding that they would be kept confidential, and therefore are not attributed.

Commission staff contacted each regional council's executive director and president, along with a mix of EMS providers, (practicing EMTs, paramedics, ambulance service chiefs, transport service administrators, and emergency room physicians), certified training instructors, regional council staff, members of PEHSC, and other stakeholders from across the Commonwealth. Many people in EMS have multiple responsibilities, such as working for providers, serving on regional councils, Homeland Security Task Forces, PEHSC, and county EMS councils. Commission staff attended and observed regional council and PEHSC meetings, conferences, webinars, and training sessions.

While it was not possible to speak with each of the 1,073 licensed ambulance services in the Commonwealth, an effort was made to include each type of EMS service, including:

- Fire-based EMS;
- Municipal-based EMS;
- Hospital-based EMS;
- For-profit EMS;
- Non-profit EMS;
- Advanced Life Support (ALS), Basic Life Support (BLS), and Quick Response Service (QRS);
- Other emergency responders; and
- Transport services.

BEMS was a valuable resource for a variety of data and system information; Commission staff called upon it frequently to provide historical and current information on providers, ambulance services, organization charts, council membership lists, regional maps, demographics and contract information. Regional council staff, boards of directors and officers supplemented this information with by-laws, meeting minutes, annual reports, and work plans. PEHSC staff and state advisory board members provided similar information on the statewide level, including agency audits, conference information, recommendations, and access to meetings.

A literature review of the EMS industry was conducted. Works by many national organizations on the administration, structure, rural perspectives, safety, annual reports, systems assessments, and the future challenges and opportunities of emergency medicine were reviewed. There was, however, a noticeable lack of scholarly writing on the topic from third-party researchers.

In addition to the interviews, the Commission developed a ten-question survey with the assistance of the Ambulance Association of Pennsylvania (AAP). The survey was sent to the AAP's 204 active EMS agencies. The 63 anonymous responses that the AAP received were forwarded directly and exclusively to Commission staff.

A complete listing of the individual interviews, teleconferences, group discussions and regional and state advisory council meetings attended by Commission staff is listed in Appendix F. This list includes the providers where interview subjects were employed at the time of the meetings.

Acknowledgements

The Joint State Government Commission would like to thank the following agencies and individuals for their cooperation and assistance during this study: the Pennsylvania Department of Health; Regional EMS Council members, executive directors, and staff; the Pennsylvania Emergency Health Services Council board and staff; the Pennsylvania Department of Community and Economic Development's Center for Local Government Services staff; the many individuals and agencies from across the Commonwealth who provide EMS services, and were kind enough to provide feedback but are too numerous to name; the executive director and officers of the Ambulance Association of Pennsylvania; and all the other organizations that contributed to this study by sharing their perspectives and identifying their issues of concern. We also thank, specifically, Deputy Secretary of Health Martin Raniowski, former Bureau of EMS Director Joseph Schmider and his staff, including EMS Program Manager Bob Cooney, and The Pennsylvania Emergency Health Services Council's Executive Director, Janette Swade, and President, David Jones, as well as Elizabeths Voras, Project Manager of the LBFC report.

OVERVIEW AND RECOMMENDATIONS

Emergency medical services refers to the treatment of patients who are in immediate need of medical attention and are unable to reach a medical facility without the assistance of trained personnel. It includes all the services that start with dispatching personnel, providing treatment, and through transportation to a hospital. EMS includes the ambulance, its driver, and the medical crew that administers any care required on the scene and en route to the hospital. EMS personnel also assist with the hospital's intake of the patient and advises the facility of the patient's condition by means of a standardized patient care report (PCR), which documents each incident.

Operating this system effectively and efficiently requires management at both the state and local levels. The EMS Act (Act 37) gives PADOH statewide authority over EMS. PADOH designated its Bureau of Emergency Management (BEMS) to certify and license providers and personnel according to 14 medical specialties defined by the act. BEMS, with the assistance of PEHSC, determines the scope of practice of each specialty, including the chain of command and which medical procedures they may perform. EMS regulations prescribe medical protocols, drugs, and medical equipment required or permitted to be used by EMS personnel in response to specified medical emergencies. Under BEMS supervision, staff of the regional councils inspect ambulances and other medical transport vehicles to verify that they meet safety standards. BEMS participates in planning and supervises and regulates key functions such as training and data collection, as well.

The EMS system is a large and complex component of the Commonwealth's public health system. The EMS system has 55,437 certified EMS providers, including 1,073 licensed ambulance services that deploy 4,559 emergency transport vehicles. The providers' medical personnel include 10,146 paramedics (ALS), 38,435 EMTs (BLS) and 4,840 emergency medical responders (QRS). BEMS employs a staff of 16 people, the regional councils collectively employ 120 people, and PEHSC employs six people.[4]

Funding constraints at the federal, state, and local levels have reduced administrative budgets, grant availability, and county and municipal funding to EMS Regional Councils and providers. Certification training is transitioning from state to national standards, bringing new curricula and testing procedures. Scope of practice continues to widen, requiring EMS providers to engage in higher levels of patient care. Implementation of the federal Patient Protection and Affordable Care Act may radically change the structure of healthcare in the United States, including EMS. The regulations under the current EMS Act were adopted on August 23, 2013, and will go into effect by April 10, 2014.

[4] Information presented represents 2012 data provided by PADOH, regional councils, and PEHSC. Staffing data includes all budgeted positions, both full and part time, within Regional Contracts and PADOH. Currently, there are numerous vacancies at all levels.

Administrative Structure

The current tripartite administrative structure consisting of BEMS, the regional councils and the State Advisory Council model has not seen any significant changes since 1985.[5] The board of directors of PEHSC, an umbrella organization of EMS providers, is designated by statute as the State Advisory Board to advise PADOH on issues and problems, and develops the state EMS plan. The State Medical Director under BEMS advises the committees and councils regarding protocols, procedures, and scope of practice.

BEMS contracts with the regional councils to serve as its local extension and point of contact with providers. Regulations are implemented by the regional councils, which handle day-to-day functions such as licensure and certification of ambulance services, providers, and training institutes and instructors. The regional councils are subject to the administrative jurisdiction of PADOH and serve at the department's discretion.[6] Each regional council designates its medical director and various committees to discuss and make recommendations, including the medical advisory and quality improvement committees of each region. All of these components participate in disaster response planning with the Pennsylvania Emergency Management Agency (PEMA), Department of Homeland Security task forces, and other state and local public health authorities.

The average population for Pennsylvania's 15 EMS regions is 847,000. In the 19 other most populous states, the EMS regions range in population from 4,657,000 in California to 79,000 in Wisconsin, which has no EMS regions above the county level.[7] The average population per region in the 20 most populous states is 1,339,000. Increasing the average population of Pennsylvania's EMS regions to that number would reduce the number of EMS regions to nine. Regions played a more significant role when state EMS systems were first established, particularly because the federal funding scheme, largely influenced by The National Highway Traffic Safety Administration (NHTSA), distributed funding along regional lines. Regions lost importance at the beginning of the Reagan administration when the federal government shifted the focus of EMS funding to state governments.

The managerial structure of the EMS system was frequently characterized by stakeholders as convoluted and redundant. There are many layers in the EMS system, from PADOH and BEMS, to the regional councils, PEHSC, individual ambulance services, local governments, and partnerships between public health and emergency management. PADOH has the authority and responsibility to make changes to the councils as needed. Comments from EMS organizations suggest poor communications and ambivalent relations between themselves and PADOH are obstacles to more effective collaboration.

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[5] The statutory law on EMS was consolidated by the Act of August 18, 2009 (P.L.308, No.37) as Chapter 81 of Title 35 of the Pennsylvania Consolidated Statutes. While this act expanded PADOH's authority and the duties of the regional councils, it was accompanied by little structural change. Act 37 could be accurately described as an update of prior law, and specifically, the Act of July 3, 1985 (P.L.164, No.45).

[6] 35 Pa.C.S. § 8109. All citations to sections are to 35 Pa.C.S., unless otherwise indicated.

[7] Arizona, California, Florida, Georgia, Illinois, Indiana, Maryland, Massachusetts, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Tennessee, Texas, Virginia, Washington, and Wisconsin.

The regional EMS structure helps to ensure public access to prehospital care and ambulance transport services by linking local providers with regulatory staff, and by facilitating communication between the state EMS officials, services, and local governments. The regional councils exist to establish the crucial link between the state administration and the front-line providers and their medical staff. The councils help inform and enforce the policy direction from BEMS and keep BEMS informed of how well or poorly the directives are functioning locally.

State Plan

A major component of coordinated EMS activities and objectives is the Pennsylvania EMS System Plan. The plan's purpose is to provide direction to enhance the quality of EMS. Statutorily, it is a responsibility of PADOH to prepare the plan, with the assistance of PEHSC, but in reality the roles are reversed, as PEHSC's State Plan Task Force drafts the plan with feedback from PADOH. The State EMS System Plan is the subject of frequent meetings and reviews, but it appears that it does not have much effect on day-to-day operations of EMS. It is clear that the Commonwealth needs a State EMS System Plan, but in fact, the plan is not useful, with no means to implement those objectives, or accountability to measure outcomes.

Regions and Regional Councils

Regional councils are private organizations or local government affiliates that contract with PADOH to oversee EMS operations within the 15 regions. Each employs an executive director and selects a board of directors to conduct its business. The regional boards vary in membership, ranging in size from ten to 60, and committee structures, meeting requirements, duties, purposes, and organization vary from one regional council to another. Each council, while under contract with PADOH, is in practice a largely independent entity. Ten of the regions cover multiple counties. Philadelphia and the four adjacent counties operate as single county regions, where the councils are composed mostly of government officials or their appointees, and council staff are county employees who work in county facilities. Further detail and critique of the regional council structure is provided in subsequent sections of this report.

Data Collection

Licensed EMS services are required to submit data to the regions and BEMS, as the latter may require, under the provisions of Act 37.[8] Much of these data are compiled by the providers from PCRs as mandated by section 8106. Providers must submit PCRs to BEMS to receive reimbursement for their services. Currently, each regional council is free to choose vendors for PCR data collection. The data the regions submit to PADOH are in a number of different configurations; upon submission, PADOH converts each region's data into a standard format.

[8] *See* §§ 8105(b)(3) and 8109(c)(2).

Funding

The biggest obstacle facing the EMS system is inadequate funding. Most of the revenue received by the system comes from third-party insurance payments by Medicare, Medicaid and commercial insurance carriers. Administration and regulatory enforcement is funded through the Emergency Medical Services Operating Fund (EMSOF), a special fund comprised of surcharges on traffic citations, and fines, fees, and penalties collected under section 8153. The small amount of EMSOF funds that is not used to defray administrative costs is distributed as grants to providers. BEMS is the only direct recipient of General Fund money for EMS services.

EVALUATION OF EMS SYSTEM

The EMS system is continually challenged by the variety and breadth of its missions. On the front line, the system consists of local providers employing a mix of paid and volunteer personnel. Providers can be based through local fire services, municipalities, or hospitals. They may be established as volunteer, part-time, for-profit, or non-profit organizations. Providers' obligations include emergency response, health maintenance, and public health education.

A challenge particular to Pennsylvania's EMS system is the need for it to be responsive to widely varying conditions, from densely-populated and technologically-advanced metropolitan centers, to sparsely-populated rural areas with limited resources. To some extent, the problem of greater distance to healthcare facilities and training centers is inherent in the nature of rural life. Providing both metropolitan and rural areas of the Commonwealth with access to high quality EMS requires collaboration among all stakeholders.

Individual services may be called on to respond to large-scale local emergencies. Many voluntarily participate in EMS strike teams, which are organized in each of the current regions. Strike teams are coordinated by PADOH and funded by a combination of federal hospital preparedness and regional planning and coordination grants. BEMS supervises this level of EMS planning for the response to public emergencies, such as major storms, terrorist attacks, and large-scale threats to public health.

While all levels of emergency services should work in cooperation across federal, county, and municipal agencies, Commission staff observed a system with many decentralized parts. Emergency management, public health and hospital systems, law enforcement, Homeland Security task forces, EMS strike teams, and 9-1-1 centers were often compartmentalized in their respective command structures.[9]

[9] Most specific comments and recommendations regarding EMS and Emergency Management could not be formulated due to the lack of cooperation by PEMA. While contact was made and a meeting was held between the Commission and PEMA staffs, PEMA failed to respond to the Commission's further requests for information.

The EMS system is strained by manpower problems. Services struggle with increasing demands for faster response times, lower scratch rates,[10] increased training requirements, and increased scope of practice in some specialties. Like other healthcare providers, they are pressed to modernize technology, strive for higher quality of treatment, and adhere to insurers' fee schedules. While some services and hospital systems are actively addressing these issues through partnerships that strategically address service coverage, it appears that more consolidation or closer cooperation among providers is needed. The Department of Community and Economic Development offers a range of assistance to providers that wish to consolidate their operations.

Provider compliance with items in state contracts is spotty. The state frequently overlooks failures to comply with requirements for quarterly progress reports and evaluations. While Act 37 requires PEHSC to assist PADOH in developing the state EMS plan, in practice PEHSC is given primary responsibility for drafting the plan. BEMS has allowed entities affiliated with the regional councils to be licensed as first responders, thereby permitting a clear conflict of interest because entities may hinder competitors through the exercise of regulatory responsibilities. From various sources, Commission staff received comments that BEMS renews contracts without evaluation by its staff and that compliance with the regional work plans is not reviewed.

Operationally, Pennsylvania's EMS system is comprised of volunteer and paid staff who are dedicated, responsive, and well-trained to deliver high quality care when medical emergencies strike. However, inadequate funding, a convoluted administrative structure, more stringent training requirements, rapidly-evolving technology, advances in medical knowledge, and rising expectations regarding treatment outcomes combine to produce a challenging landscape for everyone involved in the EMS system, from first responders to statewide administrators.

The administrative and regulatory layers of the system have been criticized as convoluted with redundancies, inconsistencies, poor communications, and overlapping responsibilities. At the same time, the system is faced with a barrage of recent changes, including the appointment of a new BEMS director, the promulgation of new regulations under Act 37, the shift from state-based training standards to the National Standards Curricula,[11] the increasing movement from volunteer to paid professional services, and potential realignment of the regional councils. The Commonwealth's EMS system has favored decentralization since its inception, presumably as a response to Pennsylvania's significant variations of geography, socio-economic demography, and longstanding tradition of local control.

However, the fragmentation and complexity of the management structure has led to discrepancies in practice among regions. Oversight at the regional level is assigned to providers themselves, which may create conflicts of interest. There is a noticeable lack of uniformity and consistency across the regions. Reportedly, BEMS has not enforced provisions of regional council contracts, and there is a noticeable lack of accountability within areas of EMS administration. Improvements to oversight and accountability can be implemented by PADOH without amending

[10] This term refers to incidents where an EMS service is unable to assist a patient within its service area and must rely on a backup provider to cover the call

[11] Office of EMS, National Highway Traffic Safety Administration, "Education," http://www.ems.gov/EducationStandards.htm October 3, 2013.

Act 35. It has been suggested that regional councils should consolidate to reduce administrative and regulatory complexity and redundancy.

RECOMMENDATIONS

A combination of targeted grants, consistent leadership and advocacy, improved organization communications, and interagency collaboration will help address the challenges facing EMS. The State EMS Plan and the regional work plans should be drafted to be consistent with one another and to translate their strategic objectives into measureable goals. PADOH also needs a more vigorous and consistent focus of its oversight of the EMS regions. Most important, there needs to be collective effort to overcome challenges to "assure that there are high quality and coordinated emergency medical services readily available to the residents of this Commonwealth."[12]

Administrative Structure

1. The State Advisory Board should be constituted in a manner that is more consistent with other executive advisory boards. It should continue to provide advice and consultation to PADOH as stated in section 8108(b)(2) and (3). The Secretary of Health or a designee should serve as an ex officio member. Four members should be appointed by the General Assembly, with one member appointed by each of the four caucuses. The remaining members should be appointed by the Governor from among lists of nominees of interested organizations, including regional councils, ambulance services, educational institutions, medical professional organizations, hospitals, county and municipal governments, emergency management, fire services, and police.

2. When PADOH submits topics or issues for consideration to the State Advisory Board, the submission should include, where possible, background information, the objective of the proposal, and a deadline for the report and recommendation. To the extent possible, the board's report should include recommendations with supporting data and research, projected costs, proposed funding sources, coordination with the State Plan, impact on education and training, and an implementation plan.

3. PEHSC should be reconstituted as an independent umbrella organization of the Commonwealth's EMS providers. Funding for PEHSC should come from its member organizations. PEHSC may serve a useful purpose as an advocate for EMS to the public and to state government. While the statutory identity between PEHSC's board of directors and the State Advisory Board should be terminated, PEHSC officials and members would be eligible for selection for membership on the board and for grants and contracts from BEMS.

[12] § 8102(2).

4. At the local level, PADOH's regulatory functions of licensure, certification, and inspection should continue to be performed by regional staff pursuant to contracts with PADOH, pursuant to section 8109. It is also appropriate for regional staff to continue to link PADOH with local providers by serving as the department's local point of contact, to identify and advocate for regional initiatives, and to serve as a clearinghouse for information between PADOH and providers.

5. Regional EMS councils should standardize procedures, especially with respect to data submitted to PADOH.

6. The number of EMS regions should be reduced from 15 to a smaller number, and single county regions should be consolidated.

7. To prevent inconsistent missions and conflicts of interest between regulatory and operational responsibilities, regional councils should be prohibited from the management of operational entities that are licensed or certified under Act 37. PADOH could address this problem through a policy directive or changes in the terms of its grants or contracts with the regions.

8. Data should be collected by a statewide, coordinated system, with standard data elements as required by the National EMS Information System (NEMSIS) and supplemented by other elements as required by PADOH. Data collected by providers through PCRs should be submitted directly to PADOH or to a single vendor selected by PADOH. A single collection point would eliminate the need to manipulate multiple data formats.

9. PADOH and BEMS should expand the annual report required by section 8111(d). The report should include detailed information about regional councils, the State Advisory Board, strike teams, ambulance service providers, training, personnel, PCR data, preparedness activities, and EMSOF. The report should also include the status of State Advisory Board recommendations, consolidation efforts among local services, and an assessment of progress under the State EMS Plan.

10. PADOH should work with other Commonwealth and federal agencies to strengthen collaboration on emergency management, preparedness, and support for volunteer ambulance services.

11. PADOH should strive to provide clearer lines of communication with, and direction to, the regional staff and State EMS Advisory Board. Knowledgeable observers commented that PADOH has been inconsistent in providing direction to the regions and State Advisory Board and that it must communicate its expectations, strategic planning, and system goals more consistently and clearly.

Funding

12. EMSOF grants should focus on regional initiatives and collaboration, emergency response coordination, strategic planning, and recruitment and retention. Statewide administrative costs of BEMS should continue to be funded by the General Fund through PADOH and BEMS.

13. The Volunteer Ambulance Service Grant Program should be more balanced between fire and ambulance services.[13] Currently, 88 percent of the $30 million available is earmarked for fire service grants and 12 percent, or $3.6 million, for ambulance service grants. Eligibility should be expanded to include municipal and non-profit ambulance services, including services that utilize full-time paid staff.

14. EMSOF grants should be distributed directly from BEMS to ambulance services in a manner similar to the Volunteer Ambulance Service Grant Program, so that all regions are subject to the same formula and eligibility criteria, with established minimums and maximums for eligible applicants. The role of the regional councils in this process should be advisory rather than administrative.

15. PADOH should strengthen its policies regarding licensure fees. Specifically:
    a. PADOH should collect a fee for the inspection and licensure of all nonemergency transport vehicles referred to in section 8139.
    b. PADOH should collect a fee for the reinspection of all emergency and nonemergency response vehicles. Fees for reinspections should be greater than for initial inspections, and possibly increased further for repeated reinspections.
    c. All monies collected as inspection and reinspection fees should be distributed through the EMSOF account to supplement PADOH's current allocation for EMS support under section 8153(c). In view of the perception among EMS officials that their function is underfunded, these monies should be exempt from the current allocation to Catastrophic Medical and Rehabilitation Fund (CMRF) under section 8153(d).
    d. All civil penalties collected under section 8142(b)(4) should be included in the EMSOF account and excluded from the CMRF.

Operations

16. PADOH should encourage collaboration between EMS and other PADOH regional entities. Efforts to that effect could include the following:
    a. Realignment of the EMS regions with the six State Health Districts;
    b. Sharing of services and consolidation of functions between BEMS, the Bureau of Community Health Systems, and the Office of Public Health Preparedness;
    c. Coordinating the use of hospital preparedness and other federal grants for regional preparedness and response; and
    d. Sharing locations and services, including group purchasing of supplies, insurance, equipment, and use of state vehicles.

[13] § 7823.

17. Oversight of emergency and nonemergency healthcare transportation services and the licensing of wheelchair and stretcher transport vehicles, currently performed by the PUC under Title 66 of the Pennsylvania Consolidated Statutes section 2501(b)(2)(ix), should be consolidated within PADOH.

18. PADOH should designate an emergency operations manager in each EMS region to improve incident command and establish a direct link and chain of command from PADOH's lead emergency preparedness liaison officer, who is under the Bureau of Public Health Preparedness.

19. PADOH should reorganize regional strike teams to designate, in advance, which component providers will be primary responders and which will be alternate responders. This would better coordinate deployment, unify responses with other emergency management teams and improve the command structure, prepare logistics before deployment, and manage reimbursements to providers and health systems.

Planning

20. With the assistance of the State Advisory Board, BEMS should redraft the State Plan. The Plan must be simplified to clarify its operational mandates and reflect a more strategic focus.

21. BEMS should review the plans of the regional councils to make them consistent with the State Plan and to covey specific and measureable goals. The work statement included in the grants to the regions should define BEMS's expectations with regard to adherence to the State Plan.

Training

22. PADOH should further standardize training across the Commonwealth in accordance with the National Standards Curriculum with only limited variations justified by specific local conditions.

23. BEMS should ensure the convenient availability of training institutes and testing centers within regions by working with public safety training centers within community colleges to offer courses at their own campuses or expanded satellite venues through intermediate units, medical facilities, technical schools, career and technology centers, or fire, police, or other emergency service facilities.

24. EMS regions should provide BEMS with annual needs assessments of regional recruitment and retention. This will assist BEMS with distribution of educational materials and help target regional recruitment and retention programs and incentives.

25. BEMS should establish a system of annual self-reporting of continuing education credits by trainees to BEMS.

As the Commonwealth's EMS system has evolved, the legislative intent to "assure that there are high quality and coordinated emergency and urgent medical services readily available to the residents of this Commonwealth to prevent premature death and reduce suffering and disability which arises from severe illness and injury" has remained unchanged.[14] The system has grown from providing basic transport with minimal care into one requiring highly trained providers who can administer prehospital care in well-equipped mobile units. It has been suggested that within a few years, a fully equipped ambulance will approach the level of care provided by hospital emergency departments. As advanced technology and treatment protocols become available, dedicated cooperation among all providers will enable continued EMS improvements.

[14] § 8102(2).

ADMINISTRATION AND EVALUATION OF EMERGENCY MEDICAL SERVICES

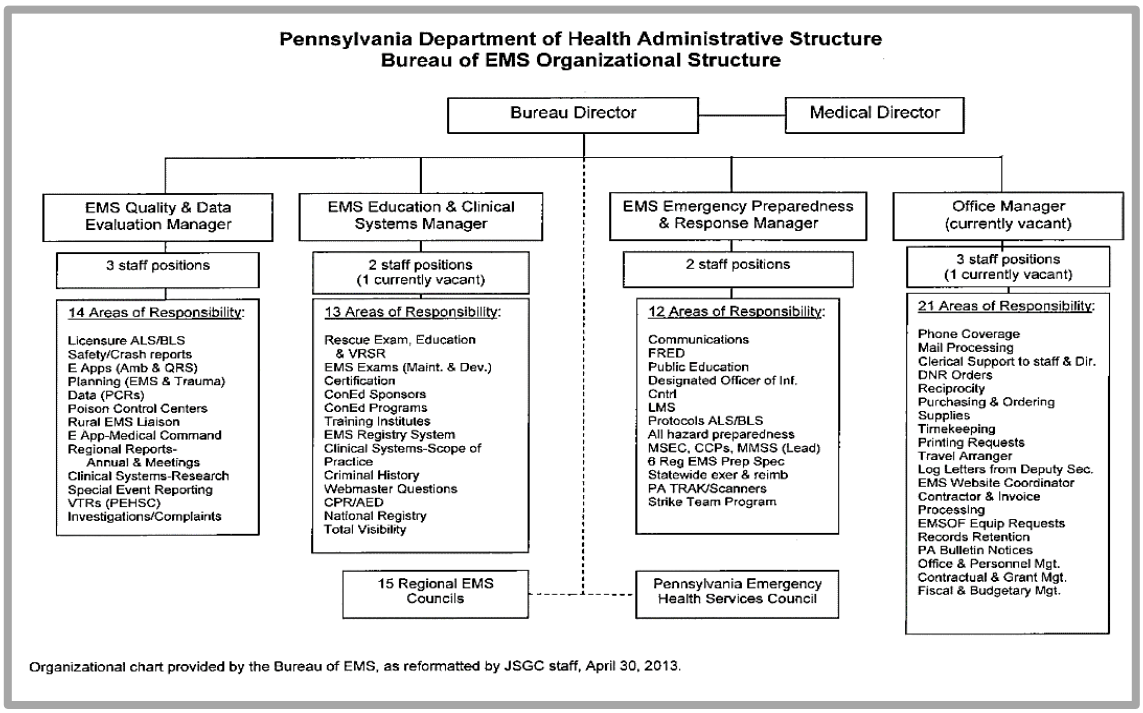
Emergency medical services may be defined as encompassing the full system of emergency medical care and transportation to a healthcare facility that is provided to a patient. The current EMS system was organized across the United States starting in 1966 and has continued to evolve rapidly. Like all contemporary systems of healthcare delivery, EMS is constantly challenged to include new treatments and technological advancements, and to modernize its administration, training, and operations.

The EMS system is comprised of a mix of non-profit, fire-based, municipal-sponsored, hospital-affiliated, and for-profit providers. In addition to standard EMS, many services also provide quick-response, mutual-aid, non-emergency transport, and paramedic intercept services, and employ both volunteers and paid staff. In Pennsylvania, the EMS system is regulated by BEMS, with the assistance of 15 regional EMS councils and the State Advisory Board. In practice, the system encompasses a complex web of public health and emergency management authorities that are charged with providing organizational guidance, administrative oversight, regulatory enforcement, and operational control. The system performs its emergency care function admirably, despite being strained by inconsistent and convoluted layers of administration and oversight and scarce funding.

BEMS's central mission is "to promote effective and efficient operation of Statewide and regional EMS systems," which is to be achieved through 15 statutorily-mandated tasks, including communication, coordination, transportation, data collection, education and training of EMS personnel, and public education. PADOH has the authority and duty to establish, investigate, and enforce regulatory standards for personnel and services, set treatment protocols, determine the authorized scope of practice for each specialty, assist with dispatch protocols, maintain and monitor quality improvement, and prepare and revise the comprehensive Pennsylvania EMS System Plan.

Through its statutory mandate, PADOH licenses EMS agencies, certifies providers, and accredits trainers in 14 different practice categories. The most commonly-licensed agencies provide ALS, BLS, QRS, and air ambulance service. Individuals are certified as paramedics, EMTs, pre-hospital nurses, medical directors, medical command physicians, EMS instructors, and vehicle operators. Regulations for training, required equipment per vehicle, and scope of practice are determined based on the level of care the individual and service are licensed to provide. For example, required staffing for an ALS vehicle includes an EMT and paramedic, whereas BLS can be provided by an EMT alone. An ALS ambulance can be used as a BLS ambulance after minor modifications to the onboard equipment.

The organizational structure of the Pennsylvania EMS system is shown in the following chart.



BEMS is supported in these tasks by regional councils, which are required to assist it in carrying out the provisions of the EMS Act. There are currently 15 regional councils, the number of which is set by PADOH. These councils operate under sole-source contracts with PADOH, formerly of three-year periods, but more recently for one-year periods. The 30-member board of directors of PEHSC serves as the State Advisory Board for EMS under a sole-source contract with PADOH.

The following table lists the 15 regional councils, their locations, and sizes. Note that the number of board members for the councils varies considerably.

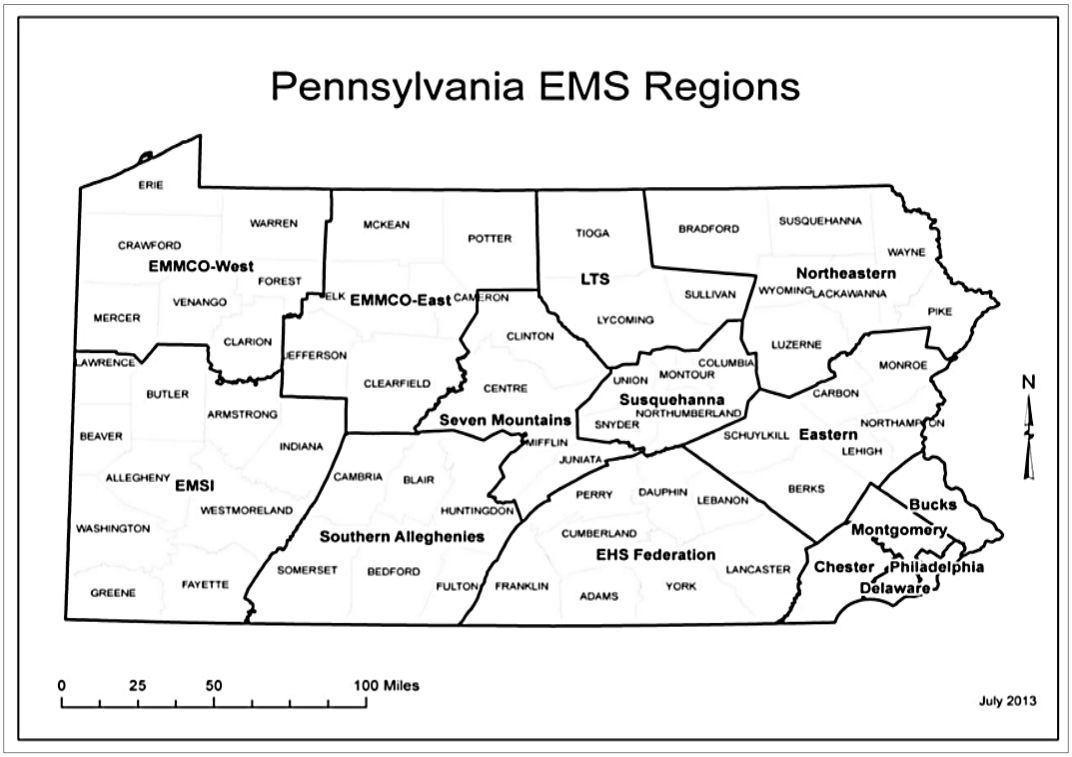
Table 1
Bureau of Emergency Medical Services Regional EMS Councils[15]

Regional Council	Location	Board Members	Staff
Bucks County	Bucks County Emergency Services Center, Ivyland	11	7
Chester County	Chester County Government Services Center, West Chester	18	7
Delaware County	Delaware County Courthouse, Media	37	6

[15] Information presented represents 2012 staffing data provided by PADOH and the regional councils. Currently, there are numerous vacancies at all levels.

Table 1 Bureau of Emergency Medical Services Regional EMS Councils[15]			
Regional Council	**Location**	**Board Members**	**Staff**
Eastern PA EMS	Orefield	34	11
Emergency Health Services Federation	New Cumberland	9	13
EMMCO-East	Kersey	18	4
EMMCO-West	Meadville	25	9
Emergency Medical Services Institute	Pittsburgh	38	12
Lycoming, Tioga, Sullivan EMS Council	Lycoming County Public Safety Center, Montoursville	16	7
Montgomery County	Montgomery County Operations Center	12	7
Northeastern PA EMS	Wilkes-Barre	59	9
Philadelphia	Fire Department EMS Administration Building, Philadelphia	25	7
Seven Mountains	Bellefonte	44	5
Southern Alleghenies	Duncansville	25	12
Susquehanna EHS Council	Northumberland	15	4

The map indicates the area served by each.



State and Regional Plans

Stakeholders commented that the State EMS Plan is the lack of coordination and communication between PADOH, PEHSC, and the regional councils. Further, they say the State Plan lacks broad, strategic directives, and is not explicitly linked to the regional plans. At the same time, the regional plans are comprised of identical terms and are not tailored to the regions' needs and characteristics, nor are the regional plans linked to statewide goals and objectives. Despite being required to do so, many regions do not produce annual reports to PADOH.[16] However, the LTS (Lycoming, Tioga, Sullivan) regional council does produce an annual report that lists strengths, weaknesses, and opportunities, and presents long term goals for improvement. The LTS plan represents a good model for PADOH to implement across all regions.[17]

History of Pennsylvania's Emergency Medical Services

The theoretical basis and the impetus for modern EMS in the United States is the whitepaper entitled "Accidental Death and Disability: The Neglected Disease of Modern Society," prepared by the Committee on Trauma and the Committee on Shock of the National Academy of Sciences, which is part of the National Research Council. Published in 1966, the paper demonstrated that the American healthcare system was ill prepared to address the epidemic of injuries that was the leading cause of death among Americans ages 1 through 37 and made 29 recommendations for improving care. It noted that in most cases, ambulances were inappropriately designed, ill-equipped, and staffed with inadequately-trained personnel. At least half of the nation's ambulance services were being provided by 12,000 morticians. Traffic fatalities in the United States had increased every year since the turn of the century. In 1966, the death toll reached 50,000, a rate of 25 per 100,000; fatalities peaked in 1972 at 54,589. Largely due to improvements in EMS treatment, fatalities due to traffic accidents declined to 32,000 in 2012, a rate of 10 per 100,000.[18]

In the year the whitepaper was published, the Highway Safety Act of 1966 established the federal Department of Transportation (DOT). The legislation authorized DOT to take measures to improve EMS nationwide, including the development of standards for provider training. States were required to develop regional EMS systems, and costs of these systems were funded by NHTSA. Over the next twelve years, DOT allocated more than $142 million in federal funds to EMS system development. The Highway Safety Act of 1966 included funds to create an appropriate training course for emergency care providers, as recommended by the whitepaper. [19]

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[16] Annual reports reviewed by Commission staff included EMSI, Southern Alleghenies, LTS, Eastern, the Federation and EMMCO-West.

[17] LTS EMS Council, "LTS EMS Council Annual Report: July 1, 2011 – June 30, 2012."

[18] National Highway Traffic Safety Administration, "Traffic Safety Facts," December 2012 http://www.nrd.nhtsa.dot.gov/Pubs/811630.pdf; Connecticut Emergency Medical Services Foundation, Inc., "History of Emergency Medical Services," http://www.emsedsem.org/ctemsi/HISTORYpercent20OFpercent20EMERGENCYpercent20MEDICALpercent20SERVICES.pdf.

[19] S*upra* note 13.

In 1971, the Pennsylvania Medical Society (PMS) made recommendations to improve EMS and Pennsylvania began funding emergency healthcare as part of its General Fund budget.[20] PMS identified the following elements needed to prevent death from accidents and trauma: trained manpower, mobile and fixed equipment, medical facilities, communications, coordination, and appropriate funding. The basis of the EMS system was significantly strengthened in 1972, when the U.S. Department of Health, Education, and Welfare allocated $16 million for EMS demonstration programs to develop regional EMS systems in five states.[21] In 1973, community councils on Emergency Health Services were established with four single-county and two regional councils to "study emergency health services, and to develop plans to coordinate a variety of activities into a system of total emergency care, in Pennsylvania."[22]

The federal Emergency Medical Services Systems Act of 1973 established federal grants to fund EMS systems.[23] The grants funded all phases of the program, from planning to training, expansion, improvement, and research. The act required that the grantee districts, which could include several counties, be managed by a single public or private non-profit agency. The act also established 15 components of the EMS system: manpower, training, communications, transportation, facilities, critical care units, public safety agencies, consumer participation, access to care, patient transfer, coordinated patient record keeping, public information and education, review and evaluation, disaster planning, and mutual aid."[24]

Pennsylvania created its administrative structure for EMS at this time. In 1974, PEHSC was created as the statewide non-profit organization to serve in advisory and advocacy roles for EMS. Act 265 of 1976, was enacted as the Commonwealth's first statute on EMS.[25] This legislation established grants for the development of a comprehensive EMS system, specifically to fund contracts with non-profits, local governments, and consortiums for organizing EMS councils; for training, expanding, and improving emergency health services; and for research on EMS systems. Act 265 required 20 percent of the appropriated grant money to be spent for systems serving rural areas. By 1977, PADOH established a Division of Emergency Health Services under the Bureau of Health Delivery System Development. Eleven EMS multi-county regional councils were established, similar to today's current regional structure. The Bradford –Susquehanna region was part of a region shared between New York and Pennsylvania. The Southeastern region was comprised of Philadelphia and its four adjoining counties. A mix of sources provided system funding at that time: 36 percent from various federal sources; 33 percent from Commonwealth appropriations; 15 percent from nongovernmental organizations (NGOs); 15 percent from county and local governments and 1 percent from private endowments. The 1975 EMS Services Plan was drafted to formulate the objectives of this implementation phase.[26]

[20] Commonwealth of Pennsylvania, "Governor's Executive Budget, 1973-1974" Vol. 2, 124.
[21] *Supra* note 17.
[22] Commonwealth of Pennsylvania, "Comprehensive Emergency Medical Services Plan," April 3, 1973, 24, 29-30.
[23] Pub. L. 93-154, repealed by Pub. L. 97-35 on August 13, 1981.
[24] "History of Emergency Medical Services," see *supra* note 17.
[25] Act of November 30, 1976 (P.L.1207, No.265).
[26] Pennsylvania Department of Health, Emergency Health Services, "1977 Annual Report," May 1978.

Act 44 of 1978 reauthorized the EMS program,[27] as Act 265 scheduled for sunset in 1979. It permanently established the EMS grants, increased the funding share for rural areas from 20 percent to 30 percent, and required applicants for grants to include information pertaining to all sources of their income.

The system faced mounting challenges in 1981 when the federal government began to phase out its funding by consolidating EMS funding into block grants to states for preventive health and health services under the 1981 Omnibus Budget Reconciliation Act.[28] The act gave the states more discretion in funding statewide and regional EMS systems. Many of the regional EMS management entities established by federal funding dissolved; however, some continued to operate by changing their focus to provide technical assistance in order to improve EMS quality. Between fiscal year 1981-1982 and fiscal year 1985-1986, total EMS funding in Pennsylvania dropped from $8.4 to $2.9 million. Federal funding dropped from $3 million to $500,000, and local and NGO funding was halved to $1 million. State funding was reduced from $3.4 million to $1.4 million, but its share as a percentage of overall EMS funding rose from 40 percent to 50 percent. Federal funding of regional councils eventually dried up completely, and some other states dissolved them in favor of a statewide or county system, although the councils continued to exist in Pennsylvania. By 1985, the number of regions decreased to nine, as LTS, Susquehanna, and Seven Mountains combined into one region under the SEDA-Council of Governments in Lewisburg.[29]

Act 45 of 1985, entitled the Emergency Medical Services Act,[30] was enacted to establish and maintain "an effective and efficient services system which is accessible on a uniform basis to all Pennsylvania residents and visitors to this Commonwealth."[31] Act 45 established licensing categories for service providers and educational standards for EMS personnel. Furthermore, the act expanded the authority and scope of PADOH oversight, required a statewide EMS plan, and required PADOH to collect and analyze data. Triennial licensing was required, and the Pennsylvania Trauma Systems Foundation was established to accredit trauma centers. The PEHSC board of directors was designated to be the EMS State Advisory Council. Act 45 renewed PADOH authority to contract with regional EMS councils, but brought them under direct state oversight. Additional specific duties of PADOH, the regional councils, and the State Advisory Board were outlined. The concept of regional councils was maintained, with a realigned 16-council system: SEDA-COG was divided into three regions, the Northwest Council was split into East and West, and single-county regions were created in the southeast.[32]

To provide resources for its mandate, Act 45 established a special fund, known as the Emergency Medical Services Operating Fund (EMSOF), to support EMS. PADOH was authorized to distribute monies from the fund for "the initiation, expansion, maintenance and improvement of emergency medical services." The legislation established a $10 surcharge on all moving violations, 75 percent of which was designated for EMSOF and 25 percent for the Catastrophic Medical and

[27] Act of July 13, 1979 (P.L.107, No.44).
[28] Pub. L. 97-35.
[29] Pennsylvania Department of Health, Division of Emergency Medical Services, "1986-1987 Emergency Medical Services Health Plan."
[30] Act of July 3, 1985 (P.L.164, No.45).
[31] *Id*. § 19(b)(1).
[32] *Supra* note 26

Rehabilitation Fund.[33] Of the money earmarked for EMSOF, 75 percent was allocated to EMS systems, with 10 percent of that amount designated for "systems serving rural areas."[34]

In 1988, the Division of Emergency Health Services was renamed the Division of Emergency Medical Services, and Act 45 was amended for the first of two times. The 1988 amendment added a $25 fee for Accelerated Rehabilitative Distribution to further fund EMSOF, required the Auditor General to annually audit EMSOF, and required regional councils to obtain input from local EMS providers and include them in council membership. The purpose of EMSOF was expanded to include distributions to eligible EMS providers and regional EMS councils.[35] Amendments enacted in 1994 added certifications for first responders and prehospital nurses, increased disciplinary measures for EMTs and paramedics, and provided for EMSOF funding to the State EMS Advisory Council.[36]

Under PADOH's organization, statewide EMS administration was assigned to a subordinate division of the Bureau of Health Planning until 1998, when it became a separate office under the Deputy for Health Planning and Assessment. BEMS was established in 2006.

Currently, nearly 100 percent of regional councils' and the State Advisory Council's funds are provided by EMSOF, with smaller contributions coming from county governments and specific federal and state grants for preparedness, training and EMS for Children.

The act of August 18, 2009 (P.L.308, No.37) superseded Act 45. Act 37 codified the provisions relating to EMS into Chapter 81 of Title 35 of the Pennsylvania Consolidated Statutes. The purpose of the legislation was to continue the improvement of this "essential public service and healthcare safety net for many Commonwealth residents."[37] While legislation in the 1970s and 1980s had established EMS, the new law focused on "development, maintenance and improvement."[38] Act 37 expanded PADOH's powers and duties, permitting it to make major policy decisions related to EMS, and assigned the department responsibility for EMS performance. The Act amended revisions to the statewide comprehensive plan, standardization of data collection and reporting, and the use of data and plan objectives for contracting and grant purposes. Nine professional practice categories were added, including their respective requirements relating to certification, licensing, training, continuing education, scope of practice, required staffing levels, and disciplinary provisions. The powers and duties of the State Advisory Council (renamed the State Advisory Board) and the regional EMS councils remained essentially unchanged.

[33] *Supra* note 29, at § 14.
[34] *Id.* at § 17.
[35] Act of October 21, 1988 (P.L. 164, No. 45).
[36] Act of October 5, 1994 (P.L.557, No.82).
[37] § 8102(1).
[38] § 8153(c)(3).

On August 22, 2013, final regulations under Act 37 were approved under the Independent Regulatory Review Act and all regulations will be in effect by April 10, 2014.[39] Key substantive provisions of Act 37 were suspended by the terms of the legislation pending approval of the regulations, and they will also go into effect when the regulations do.[40]

Previous Evaluations of the Pennsylvania EMS System

The first departmental evaluation of Pennsylvania's EMS system was published in 1994.[41] Its purpose was to assess the role and function of regional EMS councils and evaluate their relationship with the providers. A survey had been conducted through interviews between PADOH staff, EMS Regional Council staff, and group discussions with providers to measure the system's performance of 25 program responsibilities under Act 45. Of the 16 regional councils, only LTS was rated as Excellent, while Federation, Seven Mountains, Bucks County, Chester County, and Susquehanna regions rated as Very Good to Good. Most others were rated Fair to Good, Inconsistent, or Improving. Two regions, Northeastern and Delaware County, rated as Poor. The most common complaint about PADOH was its lack of effective medical direction.[42]

The report also evaluated the regional councils' compliance with reporting requirements. LTS was rated as Excellent and the same group of five was rated as Good. The remaining were labeled as Inconsistent, Fair, or Poor. Provider relationships and flow of information were identified as organizational strengths, while weaknesses included inadequate public education and poor policy direction from PADOH. Other noted weaknesses of PADOH were identified as inconsistent enforcement, role conflicts, and relationship tensions.[43]

The report recommended improving efficiency by centralizing some functions and streamlining others; redefining the role of PEHSC; improving communications between PADOH, regions, providers, and the public; enhancing the regional councils' involvement in policy development; and for PADOH to act consistently and decisively when correcting ineffective or inefficient regional council performance.[44]

In 1998 LBFC conducted a performance audit of EMSOF. The audit report proposed 24 recommendations to address concerns across the EMS system. These concerns included a lack of quality assurance procedures, including periodic reviews or evaluations of regional councils; the need for an improved process of awarding and evaluating regional contracts with PADOH; failure of the Office of EMS to act as a true lead agency; need for an improved formula and process to allocate EMSOF funds; a need to improve EMS system funding and expand EMSOF revenue; poor statewide EMS system planning; lack of a clearly defined role for the State EMS Advisory Council; and perceived competition between PADOH and the advisory council for leadership of EMS. Many of these administrative and operational problems had been previously noted in a 1991

[39] The regulations promulgated on that date are at 43 Pa.Bul. 6093 (October 12, 2013). The regulations are codified at 28 Pa. Code §§ 1021-1033.7. *See also* http://www.irrc.state.pa.us/regulation_details.aspx?IRRCNo=2917.
[40] Act of August 18, 2009 (P.L.308, No.37), §§ 7 and 9.
[41] CenPenn Systems, "Emergency Medical Services in Pennsylvania: System Administration in Pennsylvania," A Project Sponsored by the Division of Emergency Medical Services, Pennsylvania Department of Health, March 1994.
[42] *Id*., at 49, 50-51.
[43] *Id*., at 51, 53, 54, 59, 115.
[44] *Id*., at 121-129.

LBFC audit, and had not been resolved by 1998.[45] LBFC's latest performance audit was authorized by HR315, the resolution mandating this report.[46]

In 1990 and 2001, PADOH partnered with the NHTSA on technical assessments of Pennsylvania's EMS system and programs. The 2001 assessment called for improved data collection and use; a statewide comprehensive EMS plan; implementation and monitoring of the plan; and development of more specific benchmarks for EMS system performance and evaluations.[47] Each of these evaluations documents recurrent problems. Conclusions drawn from the evaluations recommended improved consistency between regions, improved system funding, tighter oversight by PADOH, and improved communications between PADOH and the regions, the providers, and the public.

In 2010, the Center for Rural Pennsylvania surveyed county emergency management agency coordinators, 9-1-1 coordinators, State Police area commands, DEP regional directors, and regional EMS council directors. Of those surveyed, 77 percent felt they did not receive adequate funding. Most respondents answered that there were sufficient opportunities to obtain both federal and state grants, but available funds were decreasing. Furthermore, they noted that rural counties in particular were adversely affected by staff and budget reductions. The report compared the spending for public emergency management by Pennsylvania and neighboring states. In 2007, Pennsylvania spent $2.56 per capita compared to Maryland's $5.48 and Ohio's $14.89.[48] Decreases in funding and the number of volunteers were shown to be the problems affecting emergency services in general and other emergency services as well.

The *2011 National EMS Assessment* was released in 2011 by the Federal Interagency Committee on Emergency Medical Services (FICEMS) and funded by the NHTSA. The document covers 11 major categories, 50 subcategories, and 200 topics, and provides detailed analyses and rankings on specific topics. Pennsylvania compares favorably to other states in some criteria. For example, the Commonwealth is typical with regard to the establishment of its EMS office, as 45 percent of other states share its organization structure. Pennsylvania is on par with other states in the frequency of EMS education, in setting training standards, and in credentialing. The Commonwealth is, however, in the lower half of states in its level of state regulatory enforcement. Pennsylvania also lags others in data collection, funding, training grants, and participation of providers in planning and development.[49] Among concerns noted in the FICEMS report was the common overlap of regulators and advocates, a situation of particular significance in Pennsylvania.

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[45] LBFC, "A Performance Audit of the Emergency Medical Services Operating Fund," February 1998, S-16-S-34.
[46] *Id*., at 47.
[47] National Highway Traffic Safety Administration, "Commonwealth of Pennsylvania, A Reassessment of Emergency Medical Services," February 13-15, 2001, 30-32.
[48] Thomas R. Mueller and Jamie D. Mitchem, "Survey of Emergency Management and Preparedness Agencies in Pennsylvania's Rural Counties," The Center for Rural Pennsylvania, July 2010.
[49] Federal Interagency Committee on Emergency Medical Services, "2011 National EMS Assessment," U.S. Department of Transportation, National Highway Traffic Safety Administration, 2012, *available at* http://www.ems.gov.

In an interview with Commission staff, Dia Gainor, director of the National Association of State EMS Officials (NASEMSO) and panelist for the FICEMS report, recognized Pennsylvania as having one of the most comprehensive EMS acts in the nation, and commended the Commonwealth's "strong system approach." [50] Ms. Gainor added that Pennsylvania has strong community-level decision making and service delivery that can, if properly utilized, facilitate standardization and accountability. The Commonwealth is not unique among states in having large volunteer contingents, but volunteers "create persistent headaches in training and scope of practice issues." Speaking more broadly, Ms. Gainor commented that many shortcomings persist from poorly managed strategic planning and resource allocations, despite now consistent funding streams in most states, and that the National EMS Standards have been adopted in 49 states.

Evaluations of Other State Systems

Virginia's Department of Health commissioned a report of its EMS system in 2007.[51] The study of Virginia's regional council system noted the following deficiencies:

- lack of standardization;
- inconsistent program and service offerings;
- boundaries of councils not aligned with the service areas of other public safety agencies;
- lack of visibility of the office of EMS within state government;
- inability of EMS to cooperate with other public safety departments;
- development of self-serving "kingdoms" that serve the needs of only local EMS constituents; and
- lack of coordination between regions on critical EMS preparedness planning.

Public Health officials in the Commonwealth have made similar criticisms of Pennsylvania's EMS system.

EMS Funding In Other States

EMS officials in the 20 most populous States were contacted for information about funding within their states.

The list of funding provisions and examination of the pertinent statutes is based on questions asked of EMS officials. Not all states responded. Included in the list are state and local fiscal supports for EMS systems. Payments for services and private support are not shown, except where specifically mentioned by the respondents.

States use a wide variety of sources to fund their EMS operations. Of the states reviewed here, four (Massachusetts, Michigan, Texas, and Wisconsin) appropriate support from their

[50] Dia Gainor, Executive Director, National Association of State EMS Officials, teleconference with Commission staff on February 12, 2103.
[51] AMSI, Inc., "Final Report, Regional Emergency Medical Services Council Study," presented to the Commonwealth of Virginia, Department of Health, Office of EMS, August 2007, 85-87.

general funds. Ten states utilize special funds (like Pennsylvania's EMSOF) to support their systems. The sources of special funds are: traffic fines (Arizona, Florida, Georgia, New Jersey, Ohio, and Pennsylvania); vehicle registration fees (Georgia, Maryland and Ohio); licensure and certification fees (Michigan, Ohio and Texas); other fines (Ohio); bail forfeitures (Ohio); and assessments on third-party health service payers and health service providers (New York). Tennessee and Washington rely entirely on local funding, and North Carolina's system is funded primarily through a private endowment.

Arizona	The Arizona Bureau of EMS and Trauma Systems receives no General Fund appropriation. It is funded almost exclusively from a 13% surcharge on motor vehicle fines, 48.9% of which is deposited in the EMS Operating Fund. The Arizona Legislature appropriates funding for the Bureau from the EMS Operating Fund. Eight percent of the EMS component of the Bureau's funding is set aside to be distributed to the four EMS regions for EMS-related personnel expenses, education, training, and equipment for cities and towns with a population under 90,000.[52]
Florida	Florida's EMS system does not receive funding from the General Fund. Financial support comes through the Emergency Medical Services Trust Fund (EMSTF). The primary sources for the EMSTF include licensure and regulatory fees from EMS providers and various traffic fines for violations such as reckless driving, driving under the influence, and failure to wear a seatbelt.[53] Chapter 401 of the Florida Statutes outlines the responsibility of the state's Department of Health in administering the Florida Emergency Medical Services Grant Act, which includes the distribution of money between state and county governments. Under section 401.111, the Department of Health makes grants to local governmental agencies, EMS organizations, and youth athletic organizations. Funds deposited in the EMSTF under sections 316.061, 316.192, 318.21, and 938.07 are used to improve and expand prehospital EMS in the state as provided in section 401.113. The distribution of the EMSTF monies is as follows: • 45% is divided among the counties according to the proportion of the combined amount deposited in the trust fund from the county. Each board of county commissioners distributes these funds to EMS organizations and youth athletic organizations. • 40% is used by the Department of Health for matching grants to local agencies, municipalities, EMS organizations, and youth athletic organizations for EMS, research, evaluation, community education, injury-prevention programs, and first aid training. At least 90% of these moneys are available on a cash matching basis. These grants are contingent on the recipients providing 25% of the approved grant amount. Up to 10% of these funds must be made available to rural EMS. These grants are contingent on the recipients providing 10% of the approved grant amount.

[52] Rep. Paul Boyer, Arizona House of Representatives, June 4 and 8, 2013; Ariz. Rev. Stat., §§ 12-115.02, 36-2218, and 36-2219.01(B)(2).
[53] Fla. Stat. §§ 20.435, 401.345.

Florida cont.	• The remaining 15% is used by the Department of Health for capital equipment outlay, personnel, community education, evaluation, and other costs associated with administering the EMS program. Any funds not used for this purpose are used for rural grants. These funds are disbursed based on the need for EMS services, the requirements of the population to be served, and the objectives of the state EMS plan.
Georgia	Georgia's EMS system does not receive a direct appropriation. The providers that transport Medicaid patients receive reimbursement from the state Medicaid program. Their annual allocation is approximately $8.7 million in state funds. All EMS providers are eligible for trauma-related uncompensated care reimbursements and EMS vehicle replacement grants from the Georgia Trauma Commission (GTC). The GTC is funded by "super speeder" fines and driver's license reinstatement fees. No information was provided on local EMS.[54]
Maryland	State budgetary support for Maryland's EMS system is provided through a special fund, the Maryland Emergency Medical System Operational Fund (MEMSOF), rather than from general funds. MEMSOF is funded by a surcharge on vehicle registration fees. The surcharge was recently increased by $3.50 in an effort to prevent the fund from being insolvent.[55]
Massachusetts	The Massachusetts Department of Public Health's Office of Emergency Medical Services (OEMS) provided $893,189, and the five regional EMS councils, as a group, provided $931,959. No amounts were appropriated through special funds. The Regional EMS Councils function in place of county EMS administrators in Massachusetts. The regional councils are not government entities, but rather, private non-profits that contract with OEMS and have a statutory role to assist OEMS in coordination on the local level. The regions themselves do not operate EMS services and have no direct regulatory authority. Many cities and towns provide EMS service through their fire departments, police departments, or EMS departments. These providers receive local aid funding from the state, but nothing specifically earmarked for EMS.[56]

[54] E-mail to Commission staff from Margie Coggins Miller, Senior Budget and Policy Analyst, Budget and Research Office, Georgia House of Representatives, April 23, 2013.
[55] E-mail to Commission staff from Patricia D. Gainer, Deputy Director, Maryland Institute of EMS Services (MIEMSS), April 24, 2013.
[56] E-mail to Commission staff from Ridgely Ficks, Office of EMS, Massachusetts Department of Public Health, April 22, 2013.

Michigan	EMS services receive $385,300 from the Michigan General Fund. Additional funding comes from the Crime Victim's Rights Fund.[57] EMS and trauma systems receive the portion not used for crime victim services. EMS licensure fees[58] make up the balance of support.[59]
New Jersey	The New Jersey EMS system does not receive money from the state's general fund. The Emergency Medical Technician Training Fund (EMTTF) was established by the EMTTF Act (P.L.1992, c.143) on November 19, 1992. The EMTTF does not fund state or local EMS agencies, but rather reimburses agencies that provide initial or continuing EMT education to members of eligible volunteer EMS agencies.[60] Eligible agencies are defined by New Jersey Administrative Code section 24:5F-20 as "an ambulance, first aid and rescue squad that provides emergency medical services without receiving payment for those services." New Jersey Statute section 26:2K-56 establishes the EMTTF as a non-lapsing, revolving account administered by the Commissioner of Health and funded by $0.50 surcharge on each fine, penalty, or forfeiture imposed and collected for any motor vehicle or traffic violation in the state.
New York	New York's EMS system is not funded from the General Fund, it is funded through a special fund for hospital care reimbursement and other healthcare initiatives under the Health Care Reform Act. The fund is financed by surcharges and assessments on third-party payers and providers of healthcare services. Of the amounts allocated for EMS, at least half is allocated for training costs and the remainder for administration of the state EMS bureau, the state and regional EMS councils, and EMS-related contractors.[61] State funding is allocated to the county and municipal levels for training only, not for direct response or provision of prehospital patient care.[62]
North Carolina	In North Carolina, the only state funding is $50,000 per fiscal year for the State Medical Director. No other funds are allocated from the State General Fund for the provision of EMS. The Duke Endowment, a private charitable organization, has allocated funds to aid local EMS agencies with the purchase of specific medical equipment, such as waveform capnography devices. These funds are managed and distributed through the Office of EMS of the state Department of Health and Human Services and are provided to the licensed EMS agencies statewide. The only other funding comes from federal grants, such as the EMS for Children grant and the ASPR Hospital Preparedness grant. There are no EMS appropriations, licensure fees, or fines.

[57] Mich. Comp. Laws §§ 780.904, 780.905.
[58] Mich. Comp. Laws §§ 133.20901-333.20979.
[59] E-mail to Commission staff from Sue Malkin, Budget Division Director, Michigan Department of Community Health, April 25, 2013.
[60] Email to Commission staff from Candace Gardner, Office of EMS, New Jersey Department of Health, April 25, 2013.
[61] See N.Y. State Fin. Law, § 97-q.
[62] Letter to Commission staff from Lee Burns, Director, Bureau of EMS, New York State Department of Health, April 24, 2013.

North Carolina cont.	The federal ASPR grant is managed by the office of EMS, and funds are divided between the eight regional advisory committees (RACs) of the state trauma centers. By rule, each EMS agency and hospital must affiliate with one of the eight RACs, based upon patient referrals. The funds are then distributed by the RAC to their EMS agencies based upon fundable projects provided through ASPR grant guidance.[63]
Ohio	No general revenue is associated with EMS through the Department of Public Safety. However, local governments receive general revenue funding through the Local Government Fund. At the state level, the Division of EMS and the State Board of EMS receive funding through the Trauma and EMS Fund.[64] The revenue sources for the fund are seat belt violation fines,[65] fines and bail forfeitures,[66] reinstatement fees for OVI suspensions,[67] vehicle registration and title fees,[68] EMS recertification fees,[69] and EMS Fund disciplinary fees.[70] County and local governments may also have dedicated revenue to fund EMS separate from general revenue available to each government. Of the revenue in the Trauma and EMS Fund in fiscal year 2013, $2,711,069 was appropriated for operations of the Division of EMS, and $4,229,819 was appropriated for grants from the Division of EMS to county and local governments.[71]
Tennessee	Tennessee's EMS system receives no money from the General Fund or any special funds. EMS services are funded through charges for services. Some providers receive funding from county governments to provide services in their service area.[72]
Texas	As of fiscal year 2012-13, the Department of State Health Services utilizes three different funding sources from two strategies (Health Care Professionals, and EMS and Trauma Care Systems) to administer its EMS regulatory responsibilities across the state. Under the Health Care Professionals Strategy, the department utilized about $612,000 from general revenue appropriated to administer activities within the strategy, and about $1,900,000 from the Bureau of Emergency Management Account, a dedicated fee account for EMS. Under the EMS and Trauma Care System Strategy, the department utilized about $110,000 from the Permanent Fund for EMS and Trauma Care, a dedicated account for EMS and Trauma Care Systems.

[63] E-mail to Commission staff from Donnie E. Sides, Operation Manager, Office of EMS, North Carolina Department of Health and Human Services, April 24, 2013.
[64] Ohio Rev. Code Ann. § 4513.263.
[65] *Id.* at § 4513.263.
[66] *Id.* at § 5503.04.
[67] *Id.* at § 4511.191(F)(2)(g).
[68] *Id* at §§ 4501.34(B), 4503.26(B), 4505.14(B), 4506.08(D), & 4509.05(C).
[69] *Id.* at § 4765.11(A)(3).
[70] *Id.* at § 4765.55(B)(5).
[71] E-mail to Commission staff from John E. Sands, Chief of EMS Operations, Ohio Division of EMS, May 1, 2013.
[72] E-mail to Commission staff from Donna G. Tidwell, EMS Director, Tennessee Department of Health, April 29, 2013.

Texas cont.	These funds come from fees and civil and administrative penalties related to licensing of EMS providers and trauma facilities, and their personnel, instructors, examiners, and coordinators.[73]
Washington	The state sets the standards and regulates EMS providers, and regulates and licenses all ambulance and aid services and vehicles. Operations are funded by local governments. Counties may levy a property tax upon approval of a referendum. In order for a city or town to establish an "EMS utility," the municipality must find that existing services are inadequate, and fees and charges for the service must be determined in accordance with a "cost of services" study. EMS levies may be established for an initial period of either six or ten years by vote of a three-fifths popular majority, and may be continued by a majority vote.[74]
Wisconsin	EMS receives $620,314 from the General Fund for EMS Office Operations, and ambulance service providers receive $1,920,000 for service improvements. The funds received by the ambulance service providers from the state "must supplement existing budgeted monies of or provided to an ambulance service provider and may not be used to replace, decrease or release for alternative purposes the existing budgeted monies of or provided to the ambulance service provider."[75] No money for EMS is received from special funds.[76]

Federal Funding

Federal funding for EMS represents a small but nonetheless significant portion of the total EMS funding for many states. The most common funding received is through the Federal EMS for Children Partnership Grant and the Preventative Health Block Grant. EMS grants to individual services are rare. The bulk of federal grant money is dedicated to fire services or fire-based EMS. Most other funding, provided through FEMA, the Department of Homeland Security, or the Department of Health and Human Services, is designated for emergency and public health preparedness efforts. Those sources support infrastructure at the state level, with funds provided directly to state agencies, and do not directly fund EMS services. Pennsylvania's Homeland Security Task Forces and Office of Public Health Preparedness are the pass-through agencies for federal resources to support infrastructure at the state level and do not directly fund county or municipal EMS programs. Unfortunately, the Commonwealth anticipates a $1.6 million cut in funding for public health preparedness programs.[77]

[73] E-mail to Commission staff from Greg Wilburn, Division for Regulatory Services, Texas Department of State Health Services, May 6, 2013; Texas Health & Safety Code §§ 773.050, 773.054 - 773.057, 773.0572, 773.059-773.060, 773.0611, 773.063, 773.065, 773.071, 773.116, 773.147, 12.0111 and 12.0112.
[74] Municipal Research and Services Center of Washington, "Emergency Medical Services" http://www.mrsc.org/subjects/pubsafe/emergency/ems.aspx#state (May 2012).
[75] Wis. Stat. § 256.12(4).
[76] E-mail to Commission staff from Helen M. Pullen, EMS Section, Wisconsin Department of Public Health, May 7, 2013.
[77] Office of the Governor, "Governor Corbett Issues Statement on Federal Funding Cuts," June 21, 2013.

TRAINING AND CERTIFICATION

In January 2013, Pennsylvania began training and certifying paramedics and EMTs according to the National EMS Education Standards (NEMSES).[78] The NEMSES were developed based on the NHTSA's 1996 report, *EMS Agenda for the Future*, and a follow-up report in 2000, *EMS Education Agenda for the Future: A Systems Approach*. Although education standards are established for the programs, the format "will allow diverse implementation methods to meet local needs and evolving educational practices." Furthermore, "instructors and educators will have the freedom to develop their own curricula or use any of the wide variety of…lesson plans…available at each licensure level." The goals of the NEMSES are "program efficiency, consistency of instructional quality and student competence." Prior to January, first responders were tested according to state EMS standards and issued a state license to practice that was not transferable to states that participated in NEMSES.

The National Registry of Emergency Medical Technicians (NREMT) program accredits institutions rather than instructors, and Pennsylvania incorporated the NREMT practical and written (now, computer based) exam into its paramedic certification process.[79] Paramedic students who pass both parts of the NREMT-P examination become nationally certified and qualified to work as paramedics in Pennsylvania. Once admitted to practice, paramedics are not required to maintain their national certification status to keep their Pennsylvania certifications and only need to complete continuing education classes required by the Commonwealth. Use of the NREMT standards for EMTs, advanced EMTs, and paramedics was implemented by PADOH at its discretion under Act 37, and was intended to align with standards accepted by all other states except Illinois, New York, and Wyoming.[80]

PADOH's decision to adopt national standards was controversial. Some providers and services felt it was long overdue, claiming that the Commonwealth would benefit from a more professional EMS system, while others felt it was not necessary, would create barriers to entry, and ultimately weaken the system. The new testing requirements will increase course hours and probably increase the cost of testing. New institutional accreditation requirements and new testing centers will likely increase the distance students must travel to training facilities. Currently, Pennsylvania has training programs at 188 sites,[81] including 36 ALS and 36 BLS training institutes that provide certification. The institutes are located at all 14 of the community colleges, each of the EMS Regional Council offices, and BEMS.[82]

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[78] NHTSA, "National Emergency Medical Services Education Standards," January 2009, 1.
[79] "Pennsylvania Paramedic and EMT Certification, Licensing and Exam Breakdown," http://www.emt-national-training.com/pennsylvania-emt.php.
[80] National Registry of EMTs, "State Reciprocity," https://www.nremt.org/nremt/about/stateReciprocityMap.asp.
[81] Data provided by BEMS.
[82] PADOH, "Emergency Medical Services, Human Resources and Education," http://www.portal.state.pa.us/portal/portal/server.pt/community/emergency_medical_services/14138.

There are concerns about access to the new training system, but they do not seem urgent. Both EMTs and paramedics are currently on the Department of Labor and Industry's high-priority occupation list in all parts of the state.[83] In an example of inconsistencies among the regions, each is allowed to adjust its curricula under established guidelines to prepare students for certification exams. BEMS should further standardization of the core curriculum and limit deviations therefrom. Along with further standardization of core curriculum, BEMs should limit deviations in curricula that are presently permitted.

Regional councils are responsible for coordinating and conducting continuing education for providers within their respective regions. They ensure the availability of resources, and by all accounts, continuing education is readily accessible. Regions also maintain records of each trainee's continuing education credits. A system in which providers self-report training credits should be considered in order to streamline the administration of continuing education programs. By centralizing recordkeeping, providers could submit their data electronically to the department for licensure purposes.[84]

Of course, the problem of access to certification training is greatest in rural areas because of greater distance. Volunteer services clearly suffer the most from barriers of time, distance, and cost, which discourage citizens from volunteering, especially because reimbursement is limited by scant resources. Classroom and distance learning technology are tremendously beneficial for widespread rural providers, but are of limited benefit for practical training. Distance learning can assist with the theoretical aspect of training (e.g., anatomy and description of diseases and medical conditions) but is much less useful for imparting the skills that require hands-on training. The rural providers interviewed for this report were the least likely to work collaboratively and make use of technological advances in training.

These programs also benefit EMS professionals providing the paramedicine because they can schedule visits to these patients during down time, and can provide additional revenue for the EMS agency. Patients, insurers, and hospital systems are bearing the burden for expensive care and treatment, but by providing this form of home care (or outreach), the EMS system could be enhanced and strengthened financially. Pilot projects are currently being explored in many parts of Pennsylvania. One example is helping to ensure a smooth transition from the hospital to home, with several visits to help coordinate prescriptions, set up appointments, and monitor progress in order to help reduce hospital readmissions. Protocols, scope of practice, mutual decision making, referrals, and follow-up visits are all part of those discussions among stakeholders and health professionals.[85]

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[83] Pennsylvania Department of Labor and Industry, Pennsylvania Workforce Development List, "2010 Regional High Priority Occupations," http://www.portal.state.pa.us/portal/server.pt?open=514&objID=575079&mode=2.

[84] Southern Alleghenies Council, "Continuing Education Courses," September 21, 2012; Seven Mountains EMS Council, "EMS Education Coordinator Activities, October 1, 2012 thru December 31, 2012."

[85] Interview with Dan Swayze, Vice President of the Center for Emergency Medicine of Western PA, December 19, 2012; University of Pittsburgh, "Novel Community Paramedic Program Announced by Pitt's Congress of Neighboring Communities (CONNECT)," March 18, 2013 http://www.gspia.pitt.edu/AboutGSPIA/DigitalMediaCenter/News/ViewArticle/tabid/134/ArticleId/1717/Novel-Community-Paramedic-Program-Announced-by-Pitt-s-Congress-of-Neighboring-Communities-CONNECT.aspx; Peak of Health, "Easing the Hospital to Home Transition," Fall 2013, pg. 6.

PEHSC AND THE STATE ADVISORY BOARD

Legal Status

The EMS System Act (EMS Act)[86] identifies the PEHSC Board of Directors as the State EMS Advisory Board,[87] which advises PADOH regarding emergency medical services.[88] The State EMS Advisory Board's duties are provided as follows:

1. Elect officers.

2. Advise the department concerning manpower and training, communications, EMS agencies, content of regulations, standards and policies promulgated by PADOH under this chapter and other subjects deemed appropriate by the department.

3. Serve as the forum for discussion on the content of the Statewide EMS system plan, or any proposed revisions thereto, and advise the department as to the content of the plan.[89]

The Board is purely advisory to PADOH and has no power to mandate action.

The Board is subject to the Open Meetings Law. The voting members of the Board serve three-year terms and may sit for not more than two consecutive terms. A simple majority of the voting members constitutes a quorum.[90]

PEHSC was organized in 1974 to serve as a statewide advisory board to PADOH on issues related to EMS. The EMS Act formally recognized the board of directors of PEHSC as the official EMS advisory body to PADOH,[91] which contracts with PEHSC to serve in that capacity.

[86] *Supra* note 29.
[87] § 8103.
[88] § 8108.
[89] § 8108.
[90] § 8108(c), (d), and (e).
[91] LBFC, *Performance Audit of the Emergency Medical Services Operating Fund*, February 1998, 98.

The statutory relationship between the Board and PEHSC is defined as follows:

> The board shall be composed of volunteer, professional and paraprofessional organizations involved in EMS. The board shall be geographically representative of the provider organizations that represent EMS providers, firefighters, regional EMS councils, physicians, hospital administrators and other healthcare providers concerned with EMS. The board may be composed of up to 30 organizations. Each organization that is a member of the Pennsylvania Emergency Health Services Council and is elected to serve as a member on the board shall have one vote on the board.[92]

PEHSC is a non-profit corporation that qualifies as a charitable organization under section 501(c)(3) of the Internal Revenue Code. Membership is comprised of 90 organizations representing all facets of EMS in Pennsylvania. Each year, each organization appoints one representative and one alternate to serve on PEHSC, and PEHSC elects a Board of Directors, comprised of representatives of at least 30 of its member organizations.[93] Its executive director and staff of five full-time employees oversee PEHSC's operations. The Board is comprised mainly of veteran participants in the EMS system, many of whom have held in various roles within the system. In general terms, PEHSC should be a liaison between providers and PADOH.

A potential difficulty with the current structure is suggested by *Hetherington v. McHale*,[94] where the Pennsylvania Supreme Court held that a private organization may not be given the power to appoint members to a public body that has the power to allocate public funds. Such an appointment power was held an improper delegation of legislative authority to private organizations. Because the State EMS Advisory Board has only advisory duties and does not directly distribute monies or exercise any governmental function, its composition does not conflict with *Hetherington*. However, the delegation to a particular private organization (albeit an umbrella organization) of the exclusive power to select perpetually the membership of a governmental agency raises similar concerns. Similar concerns raised, however, when exclusive power to perpetually select the membership of a governmental agency. In this case, the State EMS Advisory Board is delegated to a particular private organization, PEHSC.

State Board Exercise of Advisory Power

The State EMS Advisory Board, in carrying its duties, develops, considers, and proposes recommendations under three categories: research, new drug/device/technique, and pilot projects under established protocols.[95] Its formal recommendations to PADOH represent the core of its mission. In fiscal year 2010-2011, the Board forwarded the following "votes to recommend" (VTR)[96] to PADOH:[97]

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[92] § 8108(a).
[93] EMSOF Audit, 98.
[94] 329 A.2d 450 (Pa. 1974).
[95] The respective protocols are set forth at PA EMS Research Process at http://www.pehsc.org/documents.htm (visited July 9, 2013).
[96] The Board refers to a recommendation as a "VTR," for "vote to recommend."
[97] PEHSC, Fiscal Year 2010-2011 Annual Corporate Report to the PEHSC Board of Directors, 11-12.

VTR 1210-1: Pediatric Transfer Guidelines. PADOH should include pediatric transfer guidelines in the next publication of the statewide basic life support guidelines. PADOH approved this VTR with modifications.

VTR 1210-2: Transfer of Care Pilot Form. PADOH should revise the content of the pilot project transfer of care form. PADOH accepted this VTR and promised to take the recommendation under advisement in the development of the form.

VTR 1210-3: PA EMS Field Provider Data Element Manual. PADOH should adopt the revisions to the manual and distribute it to providers by posting it on the BEMS website. PADOH accepted this VTR, but will delay publishing the manual pending further clarification and review by regional councils and PCR vendors.

VTR 0311-02: PCR Narratives and Protected Health Information. PADOH should instruct approved software vendors not to submit data elements that might include protected health information under HIPAA from information collected by BEMS and the regional councils. DOH approved this VTR and informed the PCR vendor's identifying data fields that will be forwarded to BEMS.

VTR 0611-02. EMSC Voluntary Recognition Program. PADOH should adopt the EMS for Children (EMSC) voluntary recognition process for ambulance services. PADOH accepted this VTR with the understanding that the EMSC program coordinator will work with BEMS and regional licensing coordinators to implement the program.
The Board forwarded the following recommendations to PADOH in fiscal year 2011-12:[98]

VTR 1211-01. Changes to the Required Equipment List—Pulse-Oximetry Devices. PADOH should include units that can assess both adult and pediatric patients by July 1, 2013, for all ambulance types. PADOH accepted this VTR, except it will not require the devices for QRS units.

VTR 1211-02. Child Abuse Checks for EMS Providers. PADOH should expand its criminal history monitoring to include screening for convictions for crimes against children through PA Child Line, to be performed as part of licensure documentation and screening of students enrolled in certification programs. PADOH agreed to provide information on accessing Child Line to EMS agencies and educational facilities and to monitor the progress of 2011 HB 2038, which would have required background checks for new EMS providers.[99]

VTR 1211-03. Voluntary Rescue Service Recognition Marketing Program. PADOH should develop a short- and long-term marketing plan to increase participation in the Voluntary Rescue Service Recognition Program. PADOH responded that BEMS has been working with the Fire Commissioner to implement this program. Fiscal constraints have limited the program, but PADOH will consider adopting this VTR in the future.

[98] PEHSC, Fiscal Year 2011-2012 Annual Corporate Report to the PEHSC Board of Directors, 11-15.
[99] The House did not act on 2011 House Bill 2038, Pr.'s No. 3063, and the bill expired at the 2011-2012 legislative session.

VTR 0312-01. Changes to Required Equipment List—12 Lead EKG. DOH should add this device to the list and include data transmission by ground and air ALS vehicles in FISCAL YEAR 2012-13. BEMS accepted this VTR.
VTR 0312-02. Reception of 12 Lead EKG Data by Medical Command Facilities. PADOH should require all such facilities to have the capability to receive wireless 12 lead EKG data in FISCAL YEAR 2012-13. BEMS accepted this VTR.
VTR 0312-03. Changes to List of Approved Drugs for ALS Ambulance Services: Control of IV Infused Medications. PADOH should add a requirement applicable to ALS ambulance services for an IV infusion pump or mechanical flow control to control the rate of continuously infusing IV medications and require each ALS unit to carry at least one such pump or flow control. PADOH accepted this VTR.
VTR 0312-04. Changes to the List of Approved Drugs for ALS Ambulance Services: Removal of Heparin Flush. PADOH accepted this VTR.
VTR 0312-05. Changes to Statewide ALS Protocol 7007-Seizures. PADOH should include an option for intramuscular administration of midazolam to control seizures. BEMS accepted this VTR and will consider this treatment when protocols are updated.
VTR 0312-06. Change to BLS Level Provider Scope of Practice: Addition of Mechanical CPR Devices. PADOH should permit the use of such devices by all certified providers. PADOH took this VTR under advisement and promised to notify PEHSC of its decision.
VTR 0312-07. EMS Transfer of Care Form. The VTR proposed a revised form to document the transfer of care of a patient from EMS to a receiving facility. PADOH thanked the Board for its revision of the form and promised to circulate the form broadly for comment in anticipation of promulgating a form by regulation.
VTR 0612-01. Critical Care Paramedic Project. PADOH should adopt the standards of care and expanded scope of practice as stated in PEHSC's report "Establishing the Critical Care Paramedic in Pennsylvania." PADOH accepted this VTR as a starting point that will follow the adoption of regulations under the Act.
VTR 0612-02. Vehicle Extrication Awareness Education. PADOH should accept the "Vehicle Extrication Awareness Education" instructional guidance for inclusion in the EMS certification programs. PADOH accepted this VTR and the document.
VTR 0612-03. Essential Transfer of Care Elements. PADOH should publish a notice in the Pennsylvania Bulletin of the required and recommended patient information needed for immediate transmission for patient care as formulated by the Board. BEMS promised to publish a list of required elements following the promulgation of regulations under the Act. BEMS promised to obtain feedback on the current form before publishing a final list of transfer of care elements.

State EMS Plan

Act 37 states that PEHSC is to advise PADOH regarding the contents of Pennsylvania's triennial State EMS Plan and to serve as a forum for discussion of that plan.[100] In practice, PEHSC has been primarily responsible for drafting the plan. PEHSC models its plan closely after the federal plan, as developed by the National Association of EMS Officials (NASEMSO) and NHTSA.[101] The current plan identifies 67 indicators and grades the progress of the system toward reaching the plan's objectives on a scale from 0 to 5 as follows:

0 – Unknown
1 – There is little or no known effort in this area
2 – There is a system in place but not recognized or functioning
3 – There is a system in place and it is recognized
4 – There is a system in place and it is recognized and functioning
5 – Reflects the most mature and complete status for that element of the system

PEHSC has further identified the following indicators as priority items for plan years 2010-2013 (number in parentheses is the rating at the start of the plan):

- Use of goals that are time-specific, quantifiable and measurable (3)
- Budgets are developed for DOH/BEMS and other subsystem infrastructure (2)
- Established method for collecting EMS financial data (1)
- EMS system, DOH/BEMS funding (4)
- Performance Standard established for turnover rate of prehospital providers (1)
- DOH/BEMS brings together stakeholders to improve specialty care subsystems (4)
- Coordinated communication system with multidirectional communication (2)
- Develop and adopt community outreach self-determination program (1)
- Expert review of the system performance data by state advisory board (2
- Generation of EMSIS (EMS System Information System) reports by the EMS system (2)
- Prehospital, statewide, mandatory performance improvement system (3)
- Enforce participation in EMSIS and statewide performance improvement (1)
- Statewide MCI (mass casualty incident) assessment (2)
- Statewide EMS MCI plans are clearly defined and integrated (2)

[100] § 8108 (b)(3); PEHSC, State EMS Plan Task Force, Pennsylvania's Emergency Medical Services System Plan (June 2010), http://www.portal.state.pa.us/portal/server.pt/community/emergency_medical_services/14138/statewide_ems_development_plan/556953.

[101] PEHSC, State Plan Task Force, Pennsylvania's Emergency Medical Services System Plan 2010, Year 1-3 Priorities (Reformatted), 3.

Based on comments received by Commission staff, the plan appears to have little connection to daily operations of the EMS system. PADOH largely leaves the development of the plan to PEHSC, subject to the former's input, which is the reverse of the responsibility mandated by the EMS Act.[102] There was no indication that BEMS uses the state plan to evaluate the performance of regional management or providers. The plan's 67 goals, and even the 14 short-term goals, may be too numerous to make it effective. Some of the goals have been criticized as "plans to make plans," and the direct connection between this extensive planning and patient care is not always clear to some regional staff.

Relationship Amongst PEHSC and PADOH

BEMS and PEHSC both agree that their crucial relationship has not been optimally collaborative and productive. PEHSC's position as an independent contractor of the department it advises puts it in a difficult position. PEHSC, is unique as an advisory board. Of the Commonwealth's 170 advisory boards, commissions, and committees, none other than PEHSC operates under a procurement contract with the department it advises. PEHSC funding is also tied to EMSOF, as the State Advisory Board is designated an authorized recipient of EMSOF funding.[103] Unlike the regional councils, which are recipients of grant funding, PEHSC must comply with the state's procurement contract process as it applies to private providers in its relations with PADOH, including policies mandating retroactive reimbursement for documented services.

During the period of this study, there was considerable disagreement between PADOH and PEHSC regarding their legal relationship. At the start of calendar year 2013, PADOH advised PEHSC that its funding of the latter for fiscal year 2013-14 would be shifted from a grant to a contract basis. A contract is understood to give the funding entity closer control. PADOH took the position that a contract is required under the Procurement Code.[104] Section 8108(g) permits PADOH to elect between a grant and a contract, and as both the more specific and the later-enacted statute, section 8108(g) should control over the Procurement Code in case of conflict between them.[105] Thus, PADOH was not required to enter into a procurement contract with PEHSC, but it was within its rights to choose to do so. Furthermore, in fiscal year 2013-14 PADOH required PEHSC to submit requests for reimbursements after work was completed, whereas before PEHSC was paid in advance in twelve equal monthly installments.

PEHSC responded by requesting that the agreement format for fiscal year 2012-13 be continued for fiscal year 2013-14, and that the two parties continue discussions to work out a mutually-satisfactory arrangement.[106] PADOH replied by iterating its position on monthly reimbursement, but acceded to twice-monthly reimbursement for the first three months of the contract "to help ease any potential cash flow issues which PEHSC might encounter during the

[102] § 8108(b)(3).
[103] § 8153(c)(2).
[104] Letter from Joseph W. Schmider, Director of BEMS, to David Jones, President of PEHSC, January 7, 2013. The Procurement Code is Title 62 of the Pennsylvania Consolidated Statutes.
[105] *See* 1 Pa.C.S. § 1933.
[106] Letter from Suellen M. Wolfe, counsel to the Board, to Alison Taylor, Chief Counsel of PADOH, February 12, 2013.

initial months of the new agreement."[107] Presumably, PADOH reimbursements thereafter would be upon requests for reimbursement. The change in the contract has required PEHSC to take out bank loans to continue operating until PADOH approves the funding for its work. Approval of the contract between PADOH and PEHSC was delayed beyond the beginning of fiscal year 2013-14, resulting in a 15-day furlough of PEHSC staff.[108] This report will not comment on the merits of the respective positions of the parties to this kerfuffle, as they are beyond the competence of Commission staff, except that it appears that the change in procurement policy or its implementation between PADOH and the Board evidenced a lack of cooperation and trust between the parties.

Evaluation of PEHSC's Performance

PEHSC's recommendations on such matters as protocols, scope of practice, and required medical equipment are vetted over many months, although PEHSC does not issue detailed reports in support of its recommendations. When PEHSC forwards these recommendations to PADOH, the latter acknowledges receipt, but often refrains from communicating a substantive response. Commission staff believe that the advisor-department relationship would be more cooperative if the more conventional advisory committee structure were adopted for EMS. PEHSC could thereafter continue to exist as a wholly independent research and advocacy organization.

Commission staff collected the opinions of regional and line staff regarding PEHSC's effectiveness and the quality and value of its work. There was a decided split of opinion, with some observers opining that PEHSC was valuable and others saying it was ineffective. One observer complained that PEHSC approved upgrades to medical standards without regard to the ability of local providers to fund them. Others saw PEHSC as uniquely valuable in its ability to bring together representatives from the various components of a sprawling system to agree on ways to improve the EMS system. The reports that accompany the VTRs are usually short and lacking in detailed discussion. PEHSC's recommendations are supported mainly by the collective views of its membership, especially the rotating membership of its Board. Some observers commented that PEHSC is best suited for studying long-term issues such as implementing community paramedicine, keeping the system abreast of evolving medical technology, and configuring EMS services to respond to the Affordable Care Act.

Recommendations

The State Advisory Board should be restructured to separate it from PEHSC and PADOH. It should be tasked with providing advice and consultation to DOH on matters pertaining to EMS as defined in section 8108(b)(2) and (3). The Board should be permitted to contract with PEHSC for research and advisory services, but PEHSC should be a separate, independent organization from the Advisory Board, funded solely by its member organizations.

[107] Letter from Keith B. Fickel, Senior Counsel of PADOH, to Suellen W. Wolfe, counsel for PEHSC, March 13, 2013.
[108] Message from David Jones to PEHSC staff, June 27, 2013.

Together, PEHSC and the State EMS Advisory Board currently are an anomaly in the structure of Pennsylvania state government. The State Advisory Board should have primary responsibility for assisting BEMS in developing policy for the Commonwealth's EMS system and developing the State Plan. PEHSC may continue to be useful in providing input where the views of a broad array of EMS personnel or an intensive research effort is needed. At the same time, PEHSC may serve as an advocate for the EMS system before the General Assembly and the public, since its funding would not be under PADOH's control.

Appointments to the Advisory Board should be made consistent with other advisory boards of public health agencies. Such boards typically include appointment by the Governor and the leadership of both chambers and both parties of the General Assembly. The remaining members may be chosen by the Secretary of Health from among nominees submitted by interested organizations, including PEHSC, regional EMS councils, ambulance services, educational institutions, hospitals with varying levels of emergency care, county and municipal governments, public emergency management, fire services, and police.

Some representation from each EMS region should be guaranteed. PADOH representation should be limited to the Secretary of Health (or his or her designee). No other staff from PADOH, (whether based in a region or in Harrisburg) should serve on the Advisory Board. Board members should serve without compensation, except for reimbursement for reasonable expenses actually incurred, and the service of Board members should be subject to term limits.

PADOH's process for submitting topics for consideration to the State EMS Advisory Board should be regularized and include a timeline for consideration and reporting the objectives of proposed initiatives and sufficient background information to help focus discussion and enhance feedback. The board's recommendation process should be revised to encourage argument based on supporting data and research, determination of projected costs and funding sources, coordination with the State Plan, consideration of the recommendation's effect on education and training, and an implementation plan. Careful attention to the interaction process between PADOH and the State EMS Advisory Board may help to create a cooperative relationship that permits a candid exchange of views.

While the loss of PEHSC's official statutory recognition as the organization that supplies the State EMS Advisory Board may be viewed as a loss of status, it does open up some promising opportunities. Staff heard many complaints that EMS lacks an effective advocate before the public and especially before the General Assembly. For its part, PEHSC complained that it could not perform, simultaneously, the role of advisor and advocate and that it felt inhibited from giving frank advice because of its complete dependence on PADOH for its funding. As the major umbrella organization for all organizations involved in EMS, PEHSC can serve as its advocate. Furthermore, unless forbidden by its contract with PADOH, PEHSC can pursue secondary income to fund its activities.

The ground rules outlined here are similar to those used for a wide variety of advisory bodies in healthcare and other contexts. Tables 2 presents examples of other health advisory boards appointed for PADOH.

Table 2
Pennsylvania Public Health Advisory Boards

Board (Members)	Citation	Appointment
Pennsylvania Emergency Health Services Council Board (PEHSC Board)/State EMS Advisory Board (30)	35 Pa.C.S. § 8108	Up to 30 EMS-related organizations
Advisory Health Board (13)	Administrative Code § 448(f); 71 P.S. § 158(f)	No provision (selected by Secretary of Health?)
Cancer Control, Prevention and Research Advisory Board (11)	Pennsylvania Cancer Control, Prevention and Research Act (December 18, 1980 (P.L.1241, No.224)), § 3; 35 P.S. § 5633	Secretary of Health and 10 members appointed by Governor and confirmed by the Senate
Pennsylvania Drug, Device and Cosmetic Board (11)	The Controlled Substance, Drug, Device, and Cosmetic Act (April 14, 1972 (P.L.233, No.64)), § 131; 35 P.S. § 780-131	Secretary of Health and 10 members appointed by Governor and confirmed by the Senate
Governor's Advisory Council on Physical Fitness and Sports (15)	Executive Order, September 24, 1997	Appointed by the Governor
Health Policy Board (15)	Health Care Facilities Act (July 19, 1979 (P.L.130, No.48)), § 401.1; 35 P.S. § 448.401a	Secretary of Health and 14 members appointed by Governor and confirmed by the Senate
Health Research Advisory Committee (9)	Tobacco Settlement Act (June 26, 2001 (P.L.755, No.77)), § 903(b); 35 P.S. § 5701.903(b)	Secretary of Health, four members appointed by the Governor, four members appointed by the General Assembly
Hearing Aid Advisory Council (8)	Hearing Aid Sales Registration Law (November 24, 1976 (P.L.1182, No.262)), § 201; 35 P.S. § 6700-201	Appointed by the Governor
Organ Donation Advisory Committee (15)	20 Pa.C.S. § 8622©	Appointed by the Governor
Renal Disease Advisory Committee (11)	Act of June 23 (P.L.419, No.140), § 4; 35 P.S. § 6204	Members appointed by Governor and confirmed by the Senate
Tobacco Use Prevention and Cessation Advisory Committee (8)	Tobacco Settlement Act (June 26, 2001 (P.L.755, No.77)), § 705; 35 P.S. § 5701.705	Secretary of Health, four members appointed by the secretary, four members appointed by the General Assembly

Table 3 shows the organizational provisions of states' EMS advisory boards. Pennsylvania's board is the only one whose members also serve as the board of directors of a non-profit industry association that elects its board from its membership. An executive-level state government official appoints all other states' EMS advisory board members.

Table 3
Pennsylvania and Other States' EMS Advisory Boards

State	Board/Council (Members)	Citation	Appointment	Term
Pennsylvania	Pennsylvania Emergency Health Services Council Board (PEHSC Board)/ State Advisory Board (30)	35 Pa.C.S. § 8108	PEHSC	3 years
Pennsylvania	Regional EMS Councils (15 councils, 9-60 members)	35 Pa.C.S. § 8109	Council members	--
Arizona	EMS Council (22)	Ariz. Rev. Stat. § 36-2203	Director of the DPS and Highway Safety Coordinator; 20 members appointed by Governor.	3 years
Arizona	Medical Direction Commission (12)	Ariz. Rev. Stat. § 36-2203.01	Medical Director of EMS and Trauma System in the DOH	3 years
Arizona	Protocols, Medications, and Devices (PMD) Sub-Committee (12)	Ariz. Rev. Stat. § 36-2203.01	Appointed by EMS Council	--
California	Commission on EMS (18)	Cal. Health & Safety Code § 1799.50	3 members appointed by Senate Rules Committee, 3 members appointed by Speaker of the assembly, 12 members appointed by Governor	3 years, two term limit
Florida	EMS Advisory Council (15)	Fla. Stat. § 401.245	Appointed by the State Surgeon General, except state agency representatives appointed by the respective agency head.	4 years
Florida	Emergency Medical Review Committee (12)	Fla. Stat. § 401.425	Appointed by State Surgeon General	4 years
Georgia	State EMS Advisory Council	Ga. Code § 511-9-2	Appointed by Commissioner of DOH	--
Georgia	EMS Medical Directors Advisory Council	Ga. Code § 511-9-2	Appointed by Commissioner of DOH	--
Georgia	Regional EMS Council	Ga. Code § 290-5-30.3(3)	Appointed by DOH	--

Table 3
Pennsylvania and Other States' EMS Advisory Boards

State	Board/Council (Members)	Citation	Appointment	Term
Illinois	EMS Advisory Council (26)	210 ILCS 50/3.200	11 members, 1 from each EMS region appointed by each region's advisory committee, 15 appointments by Governor	3 years
Indiana	EMS Commission (13)	Ind. Code § 16-31-2-2	Appointed by Governor	4 years
Maryland	EMS Board (11)	Md. Code Pub. Safety § 13-516	11 members appointed by Governor, 2 serve ex officio	4 years
Maryland	Emergency Management Advisory Council (31)	Md. Code Pub. Safety § 14-105	Members appointed by EMS Board with Governor's approval	--
Massachusetts	EMS System Advisory Board	Mass. Gen. Laws ch. 111C, § 13	Membership prescribed by statute	3 years
Massachusetts	Regional EMS Councils (10-35)	Mass. Gen. Laws ch. 111C, § 4	Regions designated by commissioner of public health	--
Michigan	State EMS Coordination Committee	Mich. Comp. Laws§ 33.20915	Membership prescribed by statute	3 years
Missouri	State EMS Advisory Council (16)	Mo. Rev. Stat. § 190.101.1	Appointed by Governor with advice and consent of Senate	4 years
Missouri	Regional EMS Advisory Committees	Mo. Rev. Stat. § 190.102.1	Six regional committees appointed by Director of Department of Health and Senior Services	4 years
New York	State EMS Council (31)	N.Y. Pub. Health Law § 30-3002	Appointed by commissioner of DOH	2 years
New York	State Emergency Medical Advisory Committee (31)	N.Y. Pub. Health Law § 30-3002-A	Appointed by Commissioner of DOH	2 years
New York	Regional EMS Council (18 councils, 15-30 members each)	N.Y. Pub. Health Law § 30-3003	Councils designated and members appointed by Commissioner of DOH.	4 years
New York	Regional Emergency Medical Advisory Committees	N.Y. Pub. Health Law § 30-3004-A		--
North Carolina	State EMS Advisory Council (25)	N.C. Gen. Stat. § 143-510	21 members appointed by Secretary of Department of Health and Human Services, 4 members appointed by General Assembly.	1-4 year terms
North Carolina	North Carolina Medical Care Commission (17)		Appointed by Governor	--

Table 3
Pennsylvania and Other States' EMS Advisory Boards

State	Board/Council (Members)	Citation	Appointment	Term
Ohio	EMS Board (18)	Ohio Rev. Stat. § 4765.02	Appointed by Governor, except 1 member appointed by director of public safety	3 years
Tennessee	EMS Board (13)	Tenn. Code § 68-140-303	Appointed by Governor	4 years
Texas	Governors EMS and Trauma Advisory Council (15)	Tex. Health & Safety Code § 773.012	Appointed by Governor	6 years
Virginia	Virginia State Board of Health (15)	Va. Code § 32.1-5	Appointed by Governor	4 years
Virginia	Regional Emergency Medical Services Advisory Board	Va. Code § 2.2-2100		--
Washington	Emergency Medical Services and Trauma Care Steering Committee	Wash. Rev. Code § 70.168.020	Appointed by Secretary of Health	--
Washington	Regional and local emergency medical services and trauma care councils	Wash. Rev. Code §§ 70.168.100 and 70.168.120	Established by the department of health by regulation	--
Wisconsin	EMS Advisory Board (15)	Wis. Stat. § 146.58	Appointed by Governor	--

REGIONAL COUNCILS

Pennsylvania state government agencies often work through regional offices that perform necessary functions at regional and local levels. The regional offices also serve as conduits, filtering information about local areas to their headquarters. Strained budgets and growing demands for services have increased the importance of regional offices. In addition to maintaining day-to-day workload balance, communications, and enforcement of state laws and regulations, policy makers consider strategic elements such as shifting demographic and transportation patterns. Boundaries between regional offices are revised and altered to optimize resources so as to ensure adequate services for the health, safety, and well-being of the public. Close monitoring of the organizational infrastructure that connects Harrisburg to local services should be routine. However, the Commission's inquires revealed that supervision of the regional structure of EMS is disturbingly lax.

Regional Councils Structure

PADOH, through BEMS, oversees a network of 15 regional councils that are contracted by PADOH to serve as its regional entities. Each regional council employs an executive director and conducts its business through a board of directors drawn from its constituent EMS providers. The regional boards range in size from ten to 60 members. Philadelphia and the four adjacent counties each operate as single-county regions; their councils are composed mostly of government officials or their appointees, and council staff are county employees who work in county facilities. Elsewhere, the regional councils are private organizations. BEMS supports the activities of the regions through EMSOF grants, and the councils distribute EMSOF grants to their constituent providers. Each council, while under contract with PADOH,is largely independent in practice. PADOH drafts a "work statement" for each region that describes the council's contractual responsibilities. However, their committee structures, meeting requirements, and organization vary from one council to another.

PADOH has done business with the same councils since 1985, never having solicited RFPs for bids. It has been suggested that these long-standing relationships have produced a divided loyalty among the regional staff as they carry out licensing and regulatory enforcement on behalf of PADOH, but are employed by the councils and providers they are responsible for monitoring.

Inconsistencies in operations are common because the regions are separate entities rather than integrated parts of the same organization. Regions have been described as "fiefdoms." Councils are governed by their own by-laws, the number of board membership varies widely, and contracts between PADOH and the boards allow for a fluid and often confusing mix of responsibilities. The regional councils are unsure of their roles as advocates and regulators, their distribution of EMSOF grants to ambulance services, and the criteria for the development of preparedness initiatives. Training, specific educational enhancements, and employee compensation and benefits packages are inconsistent from council to council.

An example of the resulting inefficiency involves the continuing education database maintained by PADOH. The regional councils control data collection on continuing education credits for first responders, whereas direct reporting by first responders of their own credits would seem far more efficient. Further demonstrating disparate organizational missions, four different regions hold EMS conferences in addition to the annual statewide conference.

Centralization

Observers express a variety of viewpoints regarding the regional council structure, and growing agreement that the number of regions needs to be reduced. In determining the changes that are likely to improve administration of Act 37, the threshold issue is whether to retain the responsibility of the regional councils to enforce the Act or to centralize enforcement responsibility (e.g., licensure, certifications, vehicle and equipment inspections, and disciplinary actions) in BEMS, in which case regional councils' enforcement staff would be replaced by BEMS employees located in satellite offices. Doing this effectively would require an increase in the number of BEMS employees, but it is likely fewer public employees would be needed overall. A reduced number of regional councils might still be useful to help enable providers to discuss common problems, coordinate activities, bring problems to BEMS's attention, and the like. There would be fewer territorial differences because the regulatory staff would be strictly subordinate to management of PADOH through BEMS. However, the breakup of the single-county regions in the southeast will likely result in the reduction or withdrawal of county government support for EMS in the affected counties.

Another proposed reform is to retain the present decentralized structure with fewer regions and tighter management control. This appears to be the less expensive alternative for the Commonwealth because there will be no need to increase BEMS staff, but at the same time there may be a need to retain more local staff. Because of the perceived problems mentioned above, Commission staff believes it would be desirable for BEMS to require stricter adherence to performance requirements, strengthen evaluations, and standardize operations.

There appears to be little benefit to matching the EMS regions with the PEMA Task Force territories. Only the EMS Federation regional council and PEMA's and South Central Task Force have matching regions. Both the PEMA Task Force regions and EMS regions are currently being evaluated for change, separately. The EMS Regions were in existence for a decade before the task forces were formed in the late 1990s. The regional planning coordinators are also assigned the tasks of maintaining a Regional Disaster Plan, an inventory of EMS resources, and to attend at least 90 percent of the local Regional Counter-Terrorism Task Force meetings.

Regional Boundaries

When the EMS systems were first established throughout the United States in 1973 under the leadership of NHTSA, federal funding was divided along regional lines. The regions were larger than counties but smaller than states, and one EMS region straddled the New York-Pennsylvania border. Regions lost importance at the beginning of the Reagan administration when the federal government began funding EMS programs through state governments. While other states deemphasized regions, Pennsylvania retained them as important administrative entities.[109]

In the 19 other most populous states, the populations of the EMS regions range from 4,657,000 in California to 79,000 in Wisconsin, where there are no EMS regions above the county level. The average population per region in all 20 states is 1,339,000. Increasing the average population of Pennsylvania's EMS regions from the current 847,000 to 1,339,000 would reduce the number of EMS regions to nine. There was a consensus among observers that the number of regions should be reduced. As currently defined, the regions include both large and small populations, areas, and numbers of providers and services. PADOH recently reduced the number of regions by one when it combined Bradford-Susquehanna with Northeastern.

Supervision

Although the PADOH work statement drafted for each region is identical, there appears to be no clear link between the work statement and the State EMS Plan. The work statement includes reporting requirements and an evaluation component, but since 2011, PADOH has neither monitored reporting nor conducted evaluations. In the absence of necessary information, PADOH's ability to evaluate progress toward the goals and objectives of the state and regional plans is diluted considerably.

Some observers have commented that the autonomy of regional councils encourages self-serving advocacy to BEMS. A recurrent and troubling criticism focused on regional council members' interest in particular EMS providers. Some regions manage licensed ALS and QRS services, making them operational entities and distracting them from their mission as administrators. This also has the potential for region councils to compete for calls with the providers they license and regulate. Act 37 does not prohibit regional councils from licensing their own operational entities, but this is clearly inappropriate. The grant or contract between PADOH and each regional council should prohibit the management of the organization that oversees the region from participating in the management of an EMS provider.

Inconsistent Administration

Criticism of a regionally-segmented administration often falls into one of two patterns. One is that everyone administers in the same "cookie cutter" fashion, and that little attempt is made to adapt to local conditions. The second observes that every region is different and leads to a complaint that there is a "crazy quilt" of varying practices that creates difficulties for supervisors or third parties who have to deal with the overall system. Most of the criticisms of the EMS system received by Commission staff fell into the second category.

[109] *Supra* note 50.

There are wide differences in spending, salaries, and benefits packages between regions. Commission staff received complaints that some regions receive more favorable treatment from BEMS than others and that supplemental funding and special projects appear to be awarded in an arbitrary or biased manner. Some regional and local staff believe that the distribution of EMSOF grants is tainted by favoritism and that some regions consistently and unfairly receive more of this funding than others. BEMS admitted to laxity about reporting requirements and their oversight of the regions, and measures of accountability appear limited at best.

Dissimilarities in services exist among the regions. The Emergency Medical Services Institute (EMSI), the regional council for the southwest part of Pennsylvania, is certified as the region's only ALS provider. Five regions, including EMSI, Eastern, EMMCO East, Seven Mountains, and Southern Alleghenies are also licensed QRS providers. There were a number of criticisms that the regional councils fail to cooperate, even when working together could boost efficiency and effectiveness. There are some commendable exceptions. For instance, Susquehanna and Seven Mountains share personnel for education and training functions.

The distribution of information from councils to providers is inconsistent. While information could most easily be communicated via websites, the usefulness and amount of usage of the regions' sites vary significantly. Some regions take advantage of the efficiencies of websites, while others have yet to embrace the opportunities presented by that medium.

The absence of statewide goals in the State EMS Plan makes regional and state quality improvement and assurance difficult to assess. Data collection is standardized, but the submission of the data from regions to the state is cumbersome, and results of data analyses are not available to be used for evaluation of the regions. Some regions help providers with stress management for first responders, assist with narcotics abuse prevention for staff, and provide assistance for ambulance safety programs. Despite the value added by these supports, the participation of regional councils in them varies, and they are not available statewide.[110]

LTS has consistently funneled significant EMSOF money to the providers in its region. Others, such as Seven Mountains, use EMSOF to provide CO_2 monitors, 12-lead batteries, and other resources.[111] Regions also vary in their licensure inspections for ambulances, and intermittent spot inspections. Susquehanna and Seven Mountains hosted a joint conference, EMMCO-West, EMSI, and Eastern host their own conferences.[112] Many of these conferences raise secondary income for the regions, which is often held in separate accounts that are not subject to state reporting or auditing.

Indeed, the core purpose of a state regional office is to deliver state services as effectively as possible. In the case of EMS, each regional council must adapt to the particular conditions of its region. Notwithstanding the significance of that priority, Commission staff conclude that the variations among the regions are too great for efficient administration, and that PADOH should at least seek to standardize and communicate its expectations, and then evaluate the regional councils' responsiveness.

[110] Information from interviews, annual reports, and other documents provided by regional councils.
[111] Interview with Federation.
[112] Information on conferences provided by regional councils.

Secondary Income

Commission staff also received complaints and questions regarding income from regional councils' side projects, especially with regard to secondary income, which for purposes of this discussion can be defined as monies received by regions or providers other than funds from the General Fund or EMSOF, and payments from insurance carriers or patients for services rendered. Secondary income may include charges for conventions and income from outside business ventures of full-time regional officials. The term is not intended to imply that such income is illegal, but it does imply that disclosure requirements may apply and that BEMS may be obligated to make inquiry regarding such income.

PADOH did not collect data on the income regions collect from sources other than EMSOF until an inquiry during the course of this study revealed that PADOH stopped collecting those data several years ago.[113] Audit requirements were also unfulfilled until recently. In 2011, PADOH stopped collecting quarterly progress reports and written evaluations, again despite contract requirements.[114]

BEMS instituted a requirement that councils report secondary income only after LBFC and Commission staff raised questions about the absence of such monitoring during this study.[115] Monitoring this and other important information will help PADOH demonstrate stronger leadership in accountability, adherence to policies and procedures, elimination of conflicts of interest, and prevention of inappropriate activities.

[113] Such income is referred to as "secondary income."
[114] Regional Contracts - Memo PADOH 2/21/2013
[115] BEMS, "Proposed Internal Policy Changes for FISCAL YEAR 13/14," February 21, 2013.

CONSOLIDATION OF EMERGENCY SERVICES

At last count, Pennsylvania's municipal entities include 67 counties, 56 cities, 961 boroughs, one incorporated town, 1,549 townships, 500 school districts, and 20,015 municipal authorities.[116] The Commonwealth has encouraged consolidation of public safety and local government services into larger units that sometimes encompass several counties. This encouragement has taken the form of resources, grants, and staff to engage local stakeholders, assist with planning, and help implement the merger of service units. The Department of Community and Economic Development's (DCED) Center for Local Government Services provides "assistance to foster improved relations between municipal officials and the fire and emergency services community, management and leadership resources, and technical assistance for new Cooperative Partnerships including merging, consolidating, and regionalizing emergency services."[117] Consolidation of police, fire, and EMS has been a key issue to the future of emergency services throughout the Commonwealth. In most cases, these changes are brought on by financial necessity.

According to DCED, 83 percent of Pennsylvania's 1,000 police forces have fewer than 10 officers. "Pennsylvania has more police stations than any other state in the union, with many of them too small to provide a full range of police services."[118] "The benefits of regionalization... are cost savings, consistency in police services and better overall coverage."[119] Some municipalities work together and use grants for hiring, training, investigations, emergency preparedness and response, special police services, and equipment. Cooperation is more common than consolidation. In 2009, an initiative in York County invited 24 area municipalities to jointly pursue a study of police regionalization. Only nine of these municipalities accepted the invitation.[120] At the same time, some municipalities like Northern Lancaster County, Charleroi, and Buffalo Valley have been regionalized with great success.[121]

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[116] Richard Gazarik, "Pa. communities often turn to merger or consolidation to ease financial strains," *TribLIVE*, February 11, 2013, http://triblive.com/news/adminpage/3226733-74/township-merger-borough#axzz2YOiClwhO; J.D. Prose, "Fallstone voters reject merger with Patterson Twp.," *Beaver Times*, May 24, 2013, http://www.timesonline.com/news/local_news/fallston-voters-reject-merger-with-patterson-twp/article_808516f7-4111-5844-8005-1f82aaa08735.html.

[117] DCED, http://www.newpa.com/local-government/fire-emergency-services.

[118] Pennsylvania Department of Community and Economic Development, http://www.newpa.com/local-government/police; Richard D. Miller, Esq., "Regionalizing Police Services," http://www.cdblaw.com/CMSADMIN/document/files/Regionalizingpercent20Policepercent20Services.pdf.

[119] Mike, Reuther, "Boros get an earful about police regionalization," *The Sun Gazette*, February 18, 2010 http://www.sungazette.com/page/content.detail/id/539538.html.

[120] Cliff Lews, "The push for regional police in York," *NewsLanc.com*, November 5, 2009 http://newslanc.com/2009/11/05/the-push-for-regional-police-in-york/.

[121] "Pennsylvania DCED Secretary Recognizes Police Department in Union County for Regionalization Efforts," PR Newswire, July 11, 2012 http://www.prnewswire.com/news-releases/pennsylvania-dced-secretary-recognizes-police-department-in-union-county-for-regionalization-efforts-162101765.html; Ron Stern, "Cooperative Enforcement," Pennsylvania Borough News, September 2012, 38.

Some municipalities that do not have a police force rely on the Pennsylvania State Police as their sole local law enforcement agency. Police services are provided by 51 percent of all municipalities, either through municipal, contracted, or regional services. All other municipalities are served by the Pennsylvania State Police. According to the Township Supervisors Association, the proposal for the Commonwealth to charge municipalities for Pennsylvania State Police services was first made in the 1990s and intensifies in tough budget years. Regionalization of law enforcement services is one solution as "the trend of municipalities disbanding police forces and falling back on state troopers is dangerous."[122]

Police dispatching has also been viewed as a candidate for service consolidation. In 2011, the City of Harrisburg closed its dispatching center and routed all calls to the Dauphin County dispatching center, and in 2012, Middletown Borough followed suit. According to Dauphin County officials, "there were lots of municipalities that at one time had their own dispatch centers but there is a cost benefit to having everything under one roof." In May 2003, the Pennsylvania State Police announced that five consolidated dispatching centers would be constructed around the state to "put more troopers on the road, improve delivery of law enforcement services... faster response times and an enhanced level of officer safety."[123] Pennsylvania State Police dispatching previously occurred through each barracks location.

Regionalization of fire and emergency services has been the subject of several studies, including LBFC's 2003 report, *The Feasibility of Regionalizing Pennsylvania's Volunteer Fire Companies* and the 2004 report of a Senate commission to improve the delivery of emergency services in the Commonwealth. Both reports recommended additional regionalization of fire and EMS. Pennsylvania has 2,378 fire companies, according to information provided by the Office of the State Fire Commissioner, and all but 24 are volunteer.[124] The Pennsylvania Fire and Emergency Services Institute reported 60,000 volunteer firefighters in 2013, which is a decrease from the 72,000 reported in 2003, and the 150,000 reported in 1985.[125]

The General Assembly has provided a variety of incentives to encourage consolidation and collaboration of local services. Chapter 78 of Title 35 of the Pennsylvania Consolidated Statutes, relating to grants to fire companies and volunteer services, includes an incentive for the consolidation of two or more fire companies within a municipality by authorizing grants equaling the combined total of the grants that the companies were eligible for when they were separate, for

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[122] Moriah Balingit, "Bill to charge for state police service raises ire," Pittsburgh Post-Gazette, July 10, 2008, http://www.post-gazette.com/stories/local/neighborhoods-east/bill-to-charge-for-state-police-service-raises-ire-401662/; Ben Wolfgang, "House bill would mean increased fees for state police coverage, *The Republican Herald*, July 3, 2009, http://republicanherald.com/news/house-bill-would-mean-increased-fees-for-state-police-coverage-1.102880.

[123] "Pennsylvania State Police Break Ground for First of Five Consolidated Dispatch Centers," May 6, 2003, http://www.prnewswire.com/news-releases/pennsylvania-state-police-break-ground-for-first-of-five-consolidated-dispatch-centers-that-will-use-latest-technology-to-speed-troopers-to-incidents-55548772.html; PSP, Bureau of Technology Services, http://www.psp2.state.pa.us/bts/aboutus.html.

[124] Legislative Budget and Finance Committee, "The Feasibility of Regionalizing Pennsylvania's Volunteer Fire Companies," June 2005; "Report to the Senate of the Commonwealth of Pennsylvania: As required by Senate Resolution 60," November 2004.

[125] Pennsylvania Fire and Emergency Services Institute, "Testimony before the House Veterans Affairs and Emergency Preparedness Committee," February 2, 2013; LBFC, "The Feasibility of Regionalizing Pennsylvania's Volunteer Fire Companies."

five years after the merger.[126] Consolidated volunteer fire companies are also eligible for a one-percentage point interest rate reduction on loans from the Volunteer Companies Loan Fund for equipment purchases and facilities upgrades.[127] A recent amendment to the Tax Reform Code provides an exemption from the realty transfer tax for a transfer between two volunteer fire, rescue, or EMS entities.[128] The regulations on EMSOF funding priorities list "costs associated with the actual merger or consolidation of services" and "costs associated with investigating a potential merger or consolidation of services, includ[ing] consulting fees, studies, legal fees and statistical analysis" as two of the ten priorities.

Despite these incentives and much discussion of merger proposals, consolidation is rarely undertaken. Fire company and ambulance services are a source of local pride and serve as a social hub for many small communities. Their connection to the community spans generations of family service, and a sense of protection that is afforded to the citizens by their presence.[129] Most often, the strongest opposition to consolidation comes from local governments themselves. Even when funding is cut and budgets are strained, local governments try to retain local institutions and are reluctant to surrender them absent dire economic necessity. After consolidation, however, a community may benefit from improved service.[130] The pool of volunteers may grow, which can quicken response times and improve services.

Despite initial misgivings, municipalities such as Marietta Borough in Lancaster County, Hazelton, Luzerne County, East Pennsboro Township, Cumberland County, or Conemaugh Township, Somerset County have each navigated mergers for various reasons and enjoyed successful transitions that strengthened service to all the communities involved.[131]

Many providers predict that EMS is moving toward 24 hours per day coverage staffed by paid employees. The National EMS Assessment poll of services found, overwhelmingly, that volunteer services are declining in favor of some form of paid service.[132] This development will likely require partnership among services to provide adequate staffing, assure financial health, and provide necessary service coverage. Some services have taken the lead in fostering cooperative

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[126] § 7813(b)(3).
[127] § 7814.
[128] Act of July 9, 2013 (P.L.270, No.52), *amending* §§1101-C and 1102-C.3 of the Tax Reform Code.
[129] Pennsylvania Fire and Emergency Services Institute, meeting with Commission staff, March 14, 2013; teleconference with the Office of the Fire Commissioner, March 14, 2013.
[130] Pennsylvania Fire and Emergency Services Institute; Meeting with Rob Brady, Pete Zug and Sean Anderson, DCED Center for Local Government Services, March 7, 2013.
[131] Marietta Boro Council, "Minutes of Meeting held June 9, 2009," http://www.boroughofmarietta.com/Marietta_PA/Council_Minutes/2009percent20minutes/0609.pdf; Kelly Mounitz, "Fighting fire through cooperation," The Citizens' Voice, April 1, 2013, http://citizensvoice.com/news/fighting-fire-through-cooperation-1.1466041; Sam Galski, "City mulls fire regionalization," The Standard Speaker, August 15, 2012, http://standardspeaker.com/news/city-mulls-fire-regionalization-1.1358994; Chris Foreman, "Pa. fire departments look to merge or close," *The Pittsburgh Tribune Review*, October 31, 2011; Robyn Sidersky, "East Pennsboro Township fire companies to merge Jan. 1," *The Patriot News*, December 17, 2010 http://www.pennlive.com/midstate/index.ssf/2010/12/two_east_pennsboro_twp_fire_co.html; WJACTV, "Pa Fire Companies Finalize Merger," March 10, 2010, http://www.firehouse.com/news/10469175/pa-fire-companies-finalize-merger.
[132] The 2011 National EMS Assessment, "Poll: Volunteer Services are Declining in Favor of Mixed/Paid Volunteer/Call Services," 54,55.

agreements, including dual dispatch, mutual aid, ALS intercept, mobile intensive care units, and shared staffing and equipment.

An example of cooperative servicing is the arrangement between Lewisburg's Evangelical Community Hospital (EVAN) and area ambulance services that cover the counties served by the hospital system. EVAN provides the staffing and restocks supplies, while the local ambulance companies provide the vehicles and maintain the station. Revenue is shared through agreements that ensure ambulance memberships are honored and communities are served.[133] In 2013, Lehman Township Fire Rescue-EMS and Dallas Fire and Ambulance formed Back Mountain Regional Fire and EMS in Luzerne County.[134] West Shore EMS, which serves Cumberland, Perry, and Franklin Counties with ALS intercept coverage, also supports local BLS services in six area counties and is affiliated with Holy Spirit Hospital in Camp Hill.[135] Lancaster EMS grew into a regional service between 1996 and 2012, with nine stations currently serving 19 municipalities.[136]

Other states have considered regionalizing government services to save money and increase efficiency. Conclusions of those studies have been mixed. The Regional Advisory Commission in Massachusetts examined initiatives there and in other states, including shared school systems and health services. The report revealed a great deal of local suspicion for any new proposal and a perceived loss of control. Massachusetts Lt. Governor Timothy Murphy, chair of the commission, stated: "I appreciate what hometown pride is all about. In Massachusetts, we cherish our individual communities and rightfully so. Yet, at the same time, as lieutenant governor of the entire Commonwealth, I know that building partnerships can also benefit cities and towns." Regionalization is about working together and creating partnerships large and small, to get the job done. "Municipalities can engage in shared services, inter-municipal agreements, municipal collaborations, consolidations, mutual aid, and regional planning." The report also highlighted the benefits of creating "better means for accomplishing services municipalities need and also lead to cost savings and more efficient processes. Pooled resources will help preserve essential services and streamline service delivery."[137]

New York created the Commission on Local Government Efficiency and Competitiveness by executive order in 2007 to review regionalization and local government efficiencies. The commission was "charged with reviewing ways that New York State's over 4,200 local governments can save taxpayer dollars and become more efficient by sharing services and undertaking regional collaboration.'[138] Governor Eliot Spitzer stated that "[t]he sheer number of taxing jurisdictions has led to a significant degree of overlap in public services, which has had a devastating effect on local tax burdens."[139]

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[133] Meeting on Pre-Hospital Services, Evangelical Community Hospital, Lewisburg, PA, January 15, 2013.
[134] http://citizensvoice.com/news/fighting-fire-through-cooperation-1.1466041
[135] West Shore EMS, https://www.wsems.org/.
[136] Meeting with LEMSA on December 5, 2013; http://lemsa.com/.
[137] "Study Makes Case for Regionalization," *Newport News*, May 20, 2010 http://www.newburyportnews.com/opinion/x2023213020/Study-makes-case-for-regionalization/print.
[138] The Business Council of New York State, "Governor creates commission to study government consolidation," April 24, 2007 http://www.bcnys.org/whatsnew/2007/0424consolidation.htm.
[139] *Id*.

The final report encouraged targeted centralization of municipal services at the county level, providing flexibility and incentives to local and county governments to share services, empower the Commissioner of Education to force school consolidation, and improve local financial data for benchmarking and informed voters.[140]

Community Paramedicine

Community paramedicine is a relatively new concept for delivering healthcare to individuals who need nonemergency medical assistance. EMS personnel are often dispatched to treat and transport individuals with chronic illnesses and recurrent intensive healthcare needs. These patients are at a high risk for hospital readmission. New pilot programs around the country are working to bring community members to provide in-home visits to reduce costs for providers and reduce hospital readmissions. These programs lower the burden on EMS providers, and ultimately benefit patients. In a recent pilot project in Maine, "the patients would be referred [to community medical resources] by a doctor, emergency room, or other care provider. Paramedicine professionals would maintain a list of referred individuals and then determine appropriate times for visits." The paramedics evaluate the patients by checking vital signs, and monitor patients' compliance with medication and treatment plans. This low cost, managed care approach, utilizing the communities' EMS resources, is intended to reduce the chances that a patient will need emergency care or be hospitalized again.[141]

The Robert Woods Johnson Foundation funded a 2010 study on public health service delivery and regionalization that reviewed thousands of regional programs across the United States. Findings focused on best practices overcoming barriers, shared services, and financial incentives. Models for successful collaborations in government services were identified in the following areas: education, public safety, economic development, and water management services. "Sharing services may be more difficult for smaller communities due to their stronger ties to local identity, generations of tradition and the brand identity." Managing economies of scale between organizations and shared services is key to managing system challenges.[142]

In Pennsylvania, regionalization of services has met strong resistance. Regionalizing of services in the Lehigh Valley suffered a setback with the rejection of a two-county Lehigh Valley Health Department."[143] "Leaders in communities — from tiny boroughs such as Fallston [Township, Beaver County] to cities such as Harrisburg — are struggling with a cycle of shrinking populations and revenue with few options other than tax increases to fund employee pension funds and fire, police and other services." However, Fallston rejected a merger referendum in the municipal primary. Since 2000, 17 municipalities rejected mergers and only 12 approved. While mergers often make financial sense, DCED observes that "consolidations, which create a new

[140] http://nyslocalgov.org/pdf/LGEC_Final_Report.pdf?pagemode=bookmarks.
[141] Jen Lynds, "New community paramedicine law looks to improve healthcare, cut costs," *Bangor Daily News*, April 5, 2012.
[142] Nancy Kaufman, "Regionalization of Government Services: Lessons Learned & Application for Public Health Service Delivery," *The Strategic Vision Group*, July 2010
http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf70952.
[143] Andrew McGill, "Local Governments Say No to Regionalization," *The Morning Call*, August 17, 2010 http://articles.mcall.com/2010-08-17/news/mc-county-consolidation-20100817_1_caltagirone-municipalities-northampton-county; House Bill 2431 of 2010, Pr.'s No.3570.

municipality and mergers are a hard sell." The main obstacles are often turf, the reluctance to lose one's identity, regardless of the challenges facing municipalities trying to boost revenue amid population declines. "Quite frankly, there are too many egos involved… I don't see a merger happening. I see us sharing services," said one official. While resistance to consolidation is often depicted negatively in the press, it is not always true that the better course lies in sacrificing community institutions for the sake of economy. Particular circumstances may determine the best course of action.

The EMS system is one of several public health services that are provided by municipal, county, and state governments. Like EMS, many of these other public health services are managed at the local level, and are coordinated and administered by higher levels of government. From local emergency response to widespread natural disasters, local, county, and state agencies each have responsibilities to ensure that public health resources and assets are in the right place at the right time.

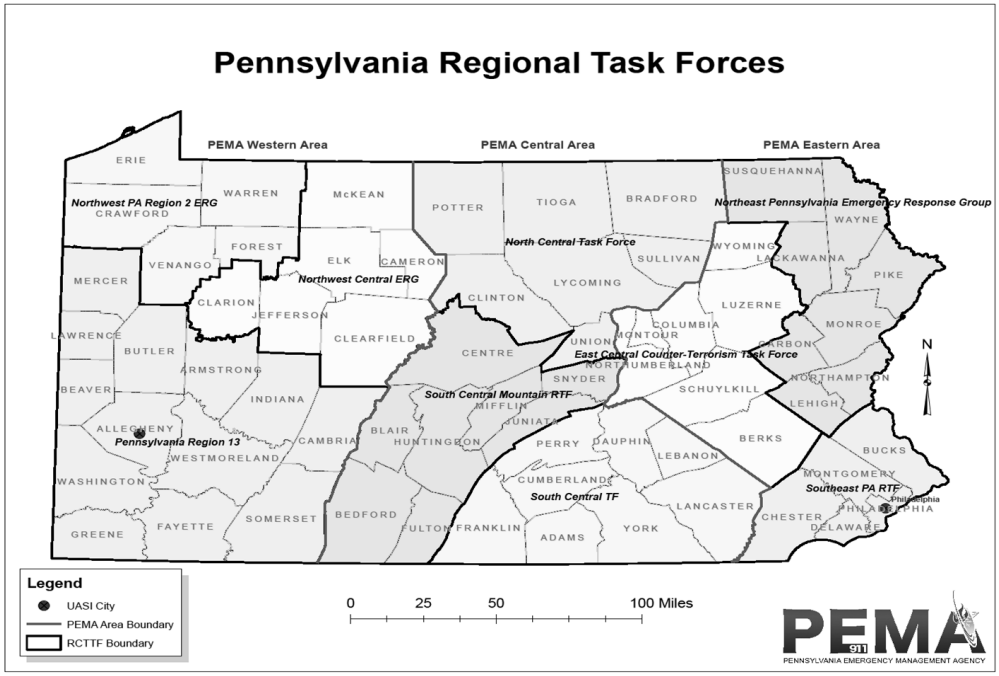
PEMA

The State Office of Civil Defense was created in 1951, during the Cold War, and evolved into PEMA in 1978.[144] Its primary responsibilities are to maintain an Emergency Management Plan, coordinate emergency preparedness and response activities, prevent and minimize injury and damage caused by disaster, and to provide "prompt and effective response to disaster emergency relief and recovery."[145] In addition, PEMA coordinates the Commonwealth's emergency communication systems. Sharing of information and weather emergency notifications among the National Weather Service, contiguous state emergency management offices, local emergency management coordinators, the Pennsylvania State Police, local police departments, private relief organizations, and other appropriate organizations.[146]

The state Office of Homeland Security (OHS), created after the attacks on September 11, 2001, was merged with PEMA and recently moved its operations to the State Police headquarters.[147] The State Police Commissioner serves as the Governor's Homeland Security Advisor. Although PEMA was organizationally folded into OHS, PEMA remains responsible, by statute, for its emergency management operations. PEMA now coordinates the activities of nine regional task forces, which are staffed by contract employees whose duties include counterterrorism planning, preparedness, and response by coordinating with federal, state, and local agencies. The primary mission of the task forces is to work to "protect the health, safety and welfare of emergency responders, public officials and the general public from actual or potential natural or manmade disasters."[148] More specifically, regional teams are designated to plan and coordinate the deployment of public safety assets when needed, and to organize disaster preparedness exercises.

[144] Act of March 19, 1951 (P.L.28, No.7); Act of November 26, 1978 (P.L.1332, No.323).
[145] § 7313(1).
[146] § 7312(h).
[147] Pennsylvania Office of Homeland Security, Executive Order 2002-11; "Pennsylvania Governor Corbett transfers homeland security office to state police," November 23, 2011, http://www.gsnmagazine.com/article/25075/pennsylvania_governor_corbett_transfers_homeland_s.
[148] *Id.*

The EMS function of PEMA's task forces is met through cooperative agreements with existing EMS providers. One example of cooperation between PEMA and EMS is the South Central PA Task Force (SCTF) EMS Subcommittee. The south-central region of Pennsylvania is the only region where a PEMA Task Force and an EMS Region are coterminous. EMS agencies have come together to form five EMS task forces across the region (Cumberland/Perry, Adams/Franklin, Dauphin/Lebanon, Lancaster and York). Each of those task forces can mobilize five transport vehicles with crews, 20 personnel, and a mass causality trailer. The SCTF EMS Subcommittee's mission is to complement all-hazards EMS capability for large-scale incidents in south-central Pennsylvania, including hospital evacuations, natural disasters, large-scale planned events, and mass causality incidents that may overwhelm local EMS capabilities. Twenty-two agencies are members of subcommittee.[149]



PEMA is responsible for overseeing one of the only county-based structures that is directly linked to state government. It coordinates with 68 designated managers of emergency services, one in each county plus the City of Pittsburgh. In addition, each municipality in the Commonwealth has a designated emergency management coordinator.[150] PEMA's responsibility extends to 9-1-1 coordinators based at each of 69 public safety-answering points (PSAPs), one in each county, plus one each in Allentown and Bethlehem.

[149] South Central Pennsylvania Task Force, "Emergency Medical Services Subcommittee" pamphlet, 2012; SCTF and White Rose Ambulance, "Letter of Commitment," June 3, 2011; Grant Agreement between Emergency Health Services Federation Med. White Rose Ambulance, June 3, 2011.

[150] PEMA, "County EMS/9-1-1 Coordinators," http://www.pema.state.pa.us/portal/server.pt/community/county_ema_9-1-1_coordinators/4629.

Although PEMA had oversight of PSAPs, existing law allowed it little authority to make changes to the system. The PEMA system needed the authority to improve the way it distributed funds, to create a more centralized auditing function, and to reduce disparity in per-call costs.[151] A recently-enacted law (Act of May. 21, 2013 (P.L.29, No.9)) is aimed at facilitating regionalization and encouraging efficiencies for counties through joint purchasing and other cost-saving measures that can be achieved through standardized operations. The new law is designed to "provide counties with plans that contain cost saving measures that provide joint purchasing opportunities and facilitate regionalization of technology and consolidation of PSAPs and their operations" and provides that "[t]he agency shall provide suggested industry-acceptable and uniform standards for levels of staffing and uniform standards of operation."[152]

EMS, fire and police services, 9-1-1 dispatch, and the regional task forces need to work in harmony for PEMA to fulfill its mission to prepare for, prevent, respond to, and recover from man-made and natural all-hazard emergencies and acts of terrorism.[153] While a review of the Commonwealth's overall public emergency system is outside the ambit of HR315, the research done by the Commission staff for this report shows friction in that system. Discussions between Commission staff, EMS personnel, and PEMA evidenced a lack of cooperation and coordination between various emergency management agencies, levels of government, and EMS services. Commission staff were not able to determine the extent of this problem because PEMA did not respond to numerous requests for information, but observers commented that PEMA is too isolated from local emergency management agencies. Most EMS regions seemed cautiously optimistic about their participation on homeland security task forces, and their communication with local PSAPs and emergency managers. Many emergency management leaders are members of EMS regional councils. Nevertheless, the public emergency system seems to marginalize EMS in favor of firefighting, law enforcement, and emergency managers.

PEMA officials observed that EMS providers have not chosen to coordinate with statewide emergency management. They believe PEMA has attempted to integrate EMS but do not find PADOH receptive to those overtures. In their view, PADOH needs to take a greater leadership role in making EMS a part of the shared process of public emergency response.[154] EMS is not currently part of PEMA's state response plans or overall disaster planning, and is not coordinated with PEMA. For instance, PEMA personnel have limited opportunities to plan or train with EMS personnel. While homeland security task forces have EMS committees, the opinions expressed by EMS providers reflected a sense of disconnection between EMS and PEMA, neglect of providers' role in planning, and little coordination between task forces and EMS regional councils. EMS providers complain disconnects lead to duplication of effort and that both the EMS regional councils and homeland security task forces would benefit by better interaction. A designated emergency preparedness liaison officer within those regions may be particularly helpful.

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[151] Legislative Budget and Finance Committee, "Pennsylvania's 911 Emergency Telephone System: Funding, Expenditures, and Future Challenges and Opportunities," May 2012; Pennsylvania Department of the Auditor General, Bureau of Special Performance Audits, "Wireless E-911 Emergency Services Program," October 2008.

[152] §§ 5311.2(a), 5311.5(b), (c), and (d).

[153] PEMA, "Mission and Authority" http://www.portal.state.pa.us/portal/server.pt?open=512&objID=4480&&PageID=457735&mode=2.

[154] Meeting with Commission staff and Glenn Cannon, PEMA Executive Director and Bob Full, PEMA Chief Deputy Director, December 6, 2012.

EMS Strike Teams

EMS Strike Teams began taking shape in 2004, and by fiscal year 2012-2013, there was a Strike Team in each EMS region, including approximately 150 ambulance crews statewide; statewide funding totaled $750,000.[155] Under the National Incident Management Systems, Strike Teams are defined as five ambulances deploying together. They are trained for all-hazards incident response to mobilize for up to two weeks on short notice. Each Strike Team is contracted with its regional council, is managed and coordinated by its respective council, and Strike Teams are not managed on a statewide coordinated basis. Statewide training exercises have been held, some in conjunction with regional counter-terrorism task forces. Funding has been largely federal since 2007, through the Bureau of Public Health Preparedness.[156]

Activation of the Interstate Strike Team commences when a request for assistance is received by PADOH, either directly from another state or through PEMA. PADOH works through PEMA to develop an Emergency Management Assistance Compact to identify the assets needed, the duration of the need, and to ensure reimbursement. Intrastate requests for emergency assistance come from local emergency management officials through the county to PEMA, which notifies PADOH if the needs include EMS. If mutual aid responses cannot assist in the locale, a PEMA mission number is issued to authorize deployment of Strike Teams, as confirmed by BEMS.

Deployments within or outside of the Commonwealth have taken place on several occasions, including Hurricanes Katrina, Rita, Gustav, Ike, and Irene. In the early deployments, providers were unprepared and unable to sustain themselves. Hampered by poor communications and planning for housing and supplies, the teams became "part of the problem rather than part of the solution."[157] Meetings with PEMA and PADOH indicated a lack of coordination between the agencies during Strike Team deployments. Other deployments were responses to Tropical Storm Lee and Hurricane Sandy, the H1N1 flu outbreak, where Strike Teams provided personnel to administer vaccines in community health centers, and to respond to power outages at nursing homes. The Sandy deployment was both inside and outside Pennsylvania. While PADOH did not provide an after-action report to Commission staff as requested, interviews with both regional council staff and providers involved in the deployments made it clear that Strike Teams have benefited from experience, but better planning and execution are still needed.

According to interviews with Strike Team providers, administrators, regional EMS staff and councils, BEMS, and PEMA, Strike Teams are to serve "as an eligible resource for emergency response... to catastrophic events that exceed local capacity." Strike Team goals, guidelines for training, requirements for EMS regional councils, and services are all clearly established. What is most significant, however, is the absence of guidelines for Strike Team deployment. While not specifically authorized under the EMS Act, Strike Teams have been formed through PADOH's planning and coordination to assure EMS regions' capabilities "to provide or secure EMS during mass casualty situations, natural disasters and declared states of emergency."[158]

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[155] Legislative Budget and Finance Committee, "Matrix of SAF Amendments."
[156] Interviews with Emergency Medical Services Institute and Eastern Region EMS.
[157] Interview with EMSI.
[158] § 8104(a)(14).

FEMA has provided general guidance, but each EMS region is required to designate a regional planning coordinator to assist, assess, and coordinate "functions in the event of a potential or actual disaster," and "coordinate with the local Department of Health District Offices to integrate the Department of Health's portable hospital systems, medical surge equipment caches, and related public health resources."[159] Under the Department of Health and Humans Services system, each coordinator is tasked with "building relationships with federal, state, local officials…healthcare representations (partners and stakeholders) in order to conduct planning for effective federal emergency response, and to facilitate coordinated preparedness response activities for public health and medical emergencies." The current Health Lead Emergency Preparedness Liaison Officer is under the Office of Public Health Preparedness, providing a link between those inter-department assets. The coordinator would serve as the liaison between PEMA, Homeland Security Task Forces, county, and municipal emergency management officials in order to enhance or facilitate training sessions, lead deployments of Strike Teams, and manage distribution of EMS and public health preparedness assets.

According to the Strike Team guidelines, "[t]he Ambulance Strike Team will be dispatched as a resource request to the State Emergency Operations Center (SEOC) through the Pennsylvania Emergency Management Agency (PEMA) to the Department of Health Lead Emergency Preparedness Liaison Officer (EPLO) to the Bureau of Emergency Medical Services if the incident has warranted state involvement." The EPLO is under the Office of Public Health Preparedness, and to date, all incident commanders have been regional EMS council executive directors. The EPLO does not report to an overall PEMA incident commander, and the EMS command structure has been wholly separate from other emergency response resources. The separation leads to a lack of communication and coordination when deployed, and assets have been deployed without advance planning and preparation for housing, food, and logistics.

Typical deployments do not involve entire Strike Teams, but rather individual assets are deployed, making it difficult for services and providers to plan. Reimbursement for services and supplies continues to be a struggle, as are individual rates for wages paid by services, including overtime. Problems with recent deployments, and having EMS Regional Directors assigned as Strike Team deployment commanders rather than a designated provider, is contributing to tension on many Strike Teams. Some services were so dissatisfied with the deployment to New Jersey for Hurricane Sandy that they stated publicly their intention to withdraw their crews from further Strike Team service.

Grant agreements between EMS Regional councils and BEMS have been funded entirely by the federal government through Regional Planning, Centers for Disease Control and Prevention, and Hospital Preparedness programs. Assets purchased under these grants include mobile kitchens, medical surge equipment caches, casualty collection point systems, and mobile medical surge system portable hospital trailers and shelters. Various components have been deployed separately from Strike Teams by regional council staff, which is another example of an operational function that competes with their regulatory duties.

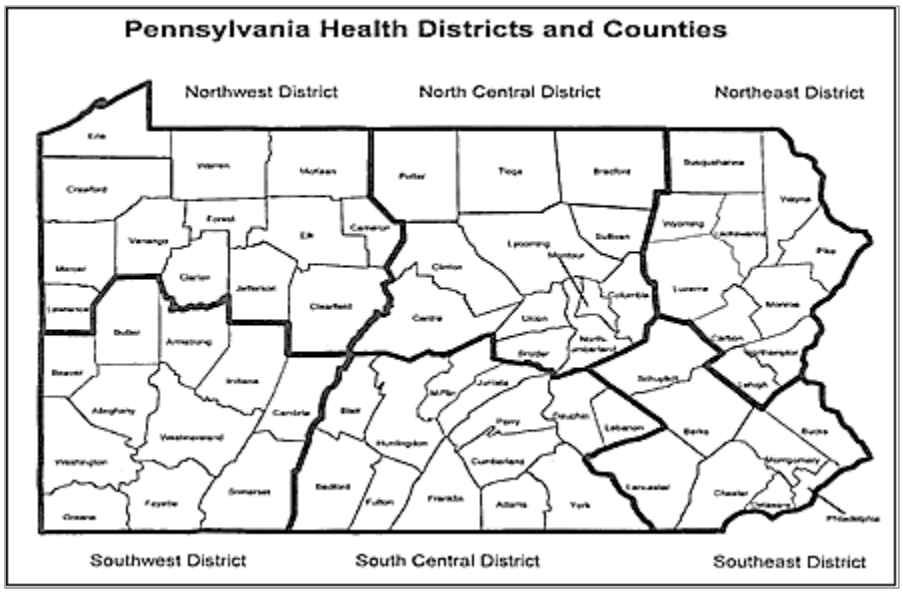
[159] Commonwealth of Pennsylvania, "Federal Funding Accountability and Transparency Act Sub-recipient Data Sheet," SAP Document #4100045911 SAF5.

Regional planning and coordination grants, upkeep of assets, and other miscellaneous funding can be passed to regions through BEMS. There is a system in place to fund the EMS regions with a minimum amount for each fiscal year based on demographics and land area, but there is no such formula for Strike Teams. While PADOH guidelines exist for state EMS Strike Teams, the distribution of funds to regions appears arbitrary and without guidelines. The BEMS director has wide-ranging powers to distribute Strike Team grant funding. In fiscal year 2011-12, the total base amount for regions was $10,482,008, and the supplemental grant funding total was $2,287,392. Supplemental funding totals per region ranged from a high of $455,512 to a low of $14,200. It is clear that more standardization and oversight of EMS Strike Teams is needed.[160] Most large equipment and supplies purchased using Strike Team monies is titled to and maintained by regional councils.

There are clearly frictions and inefficiencies among EMS providers, BEMS, and PEMA, particularly in interagency cooperation, strategic planning, and deployment. Commission staff recommend that PADOH reorganize regional Strike Teams to designate, in advance, some component providers as primary responders and the others as alternate responders that would only be called if no primary responders are available. Otherwise, for the reasons stated above, the analysis of the Strike Teams in this report is incomplete and its recommendations are not fully developed.

Health Districts

The Pennsylvania Office of Public Health Preparedness within PADOH is responsible for preparedness, response, recovery, and mitigation efforts in response to natural disasters and terrorist attacks. OPHP's responsibilities include "coordination of planning efforts across the grants and [to ensure] that there is no duplication of efforts or expenditures." OPHP administers six regions, as shown by the following map.



[160] PADOH, "Pennsylvania Emergency Medical Services Strike Team Guidelines," May 23, 2006; BEMS, "PA EMS Strike Team, 2012-2013," November 2012.

Through the six health districts, 60 county-based State Health Centers, and six county and four municipal health departments, OPHP coordinates delivery of services "in a high quality, effective, and responsive manner.[161]

In March, 2013 PADOH announced plans to close State Health Centers in 25 counties across the state, but most affected are rural counties where services will be merged with those of neighboring counties. Closures began in May 2013. Centers slated for closure include Adams, Armstrong, Beaver, Blair, Carbon, Clinton, Columbia, Crawford, Forest, Fulton, Greene, Jefferson, Lawrence, McKean, Mifflin, Montour, Perry, Pike, Potter, Snyder, Somerset, Susquehanna, Union, Westmoreland, and Wyoming. An injunction halted the closures on the grounds that a lawsuit is pending that challenges closures made without legislative approval.[162]

Health officials described the state health center system as "ineffective" and an "outdated model from the 1980s," and that the delivery model for public health has shifted.[163] To be more effective in serving the public health, the system and nurses need to be mobile, allowing greater access to communities underserved by some health centers, to reach people at public events, community centers, health fairs, and even through in-home visits.[164]

Realignment of EMS Regions

EMS regions have been realigned twice, but there have been no substantial changes since 1985. An ad hoc committee consisting of the Deputy Secretary of Health Planning and Assessment, the BEMS director, and two regional council executive directors was formed in 2012. Considerations include training infrastructure, numbers of services and providers, breakdown of urban and rural populations, efficiencies of current regional operations, patient flow, synergies with emergency management, and current potential for shared services. The committee recognizes that more consistency and efficiency is needed across the regions.

The largest region, in terms of land area and population, is EMSI. The committee chose to use that region as a model, and incorporated industry best practices and standards in its design as it considered input from local stakeholders while maintaining a strong statewide EMS plan. The committee developed many realignment options, ranging from retaining the current 15 regional councils, to a three-region east-central-west structure. No proposals have been presented by the Bureau as of the publication of this report.

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[161] Pennsylvania Department of Health, "Bureau of Community Health Systems, http://www.portal.state.pa.us/portal/server.pt/community/communities/14133.

[162] *SEIU Healthcare Pennsylvania et al. v. Commonwealth of Pennsylvania et al.*, No. 38 MAP 2013.

[163] Marcus Rahut, "Nearly 30 health centers in Pa. may close," Chambersburg Public Opinion, April 26, 2013 http://www.publicopiniononline.com/latestnews/ci_22724074/nearly-30-health-centers-pa-may-close.

[164] David Wenner, "Corbett plan to close health centers: needed modernization or public health time bomb?," PennLive, April 9, 2013, http://www.pennlive.com/midstate/index.ssf/2013/04/corbett_health_centers_nurses.html.

Many changes have occurred since 1985 in demographics, delivery systems, service capabilities, and technological advances. It appears, however, the PADOH analyses have considered the EMS regions and six health regions separately. Neither OPHP's nor BEMS's plans moved toward sharing resources or coordinating functions. These ideas should be explored; both entities serve under the same department, which may redraw the maps.

In discussions with Commission staff, PADOH rejected a realignment that merged EMS regions based on the six health districts. The reasons for rejecting a merged realignment include the perceived losses of control over hybrid county/municipal health departments and quality assurance. Because of the differences in purpose, function, and operation, evolution of the systems may be hampered if they were linked.[165]

[165] Meeting with Department of Health, Deputy Secretary for Health Planning and Assessment, and Directors of the Bureaus of EMS and Community Health Systems, March 19, 2013.

CONCLUSION

Pennsylvania's EMS system developed organically from the common interest to provide emergency assistance for those in need. During the 1960s, public attention, medical technology, and government involvement coalesced into a structured delivery system that was eventually overseen by PADOH. Continuing to evolve over the past several decades, the EMS system that once provided basic ambulance transportation services is now capable of deploying highly sophisticated emergency care units that may soon rival a hospital's emergency care. The rapid growth of the EMS system challenges everyone involved.

First responders must master complicated equipment and skill protocols as demands grow for more intensive levels of care. Front line managers are pressured to continually lead their organizations through the evolving environment while simultaneously stewarding often scarce resources. Local, regional, and state administrators must fulfill challenging responsibilities in order to maintain consistent oversight. Optimally, PADOH relies on expert EMS advisors and feedback, evaluation, and analyses of providers to provide the strategic leadership that puts appropriate resources to appropriate uses.

Pennsylvania's EMS system works. Despite the challenges described in this report, residents of Pennsylvania are not facing an epidemic of roadside deaths for lack of adequate care. From the top down, Pennsylvania's decentralized EMS system allows first responders throughout the Commonwealth to provide the best care regardless of local conditions. Nonetheless, improvements are demanded at every level of the system. This report discusses the recommendations made by people who work in system, from volunteer EMTs to medical officers to decision makers at BEMS. Each fulfills a necessary role and has firsthand knowledge of his or her sphere of responsibility, and each is committed to ensuring that the quality of care continue to improve.

Realigning the regional council structure, establishing independence of the State Advisory Board, and defining BEMS's lines of communication and command will bolster the system against mounting pressures of resource allocation and technological advances. Greater cooperation and collaboration is vital, both between regional councils and across state departments. PADOH and PEMA, both exemplary in their emergency preparedness and planning, need to cooperate more closely so that communications are clear. Up to this point, lags in communication and disputes over authority have been compensated by the skills, resourcefulness, and dedication of first responders. Moreover, where resources are scarce, regional councils in particular need to work together to share what they can.

Based on discussions conducted by Commission staff throughout this study, it is evident that stakeholders at each level are committed to improve the system. Where operational missions diverge, however, motivation to collaborate lags, and weak points exist. Solutions point to the top. Effective leadership, expressed through clarity of strategy and direction, can be sustained by free flowing communications to and from BEMS; these components are particularly elemental in overriding local and regional hesitancy to establish collaborations.

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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 315 Session of 2011

INTRODUCED BY CAUSER, BARRAR, SAINATO, BAKER, CALTAGIRONE, COHEN, DAY, DENLINGER, EVERETT, FARRY, FLECK, GABLER, GINGRICH, GOODMAN, GRELL, HENNESSEY, HORNAMAN, KULA, O'NEILL, PICKETT, QUINN, RAPP, ROCK, SONNEY, STERN, SWANGER, TALLMAN, THOMAS, VULAKOVICH AND MURT, JUNE 2, 2011

AS AMENDED, HOUSE OF REPRESENTATIVES, JUNE 12, 2012

A RESOLUTION

Directing the Legislative Budget and Finance Committee and the Joint State Government Commission to study the financial and administrative effectiveness of the emergency medical services system.

WHEREAS, The Emergency Medical Services System Act was enacted as 35 Pa.C.S. Ch. 81 (relating to emergency medical services system) to replace the former act of July 3, 1985 (P.L.164, No.45), known as the Emergency Medical Services Act; and

WHEREAS, The enactment of the Emergency Medical Services System Act was the culmination of years of research and preparation to update the emergency medical services delivery system in this Commonwealth; and

WHEREAS, The Emergency Medical Services System Act changed the emergency medical services delivery system from a system based on national standards to a system based on curriculum; and

WHEREAS, The Commonwealth should continually assess and

revise the statutes and regulations which govern the functions of emergency medical services agencies and providers and other components of the emergency medical services system; and

WHEREAS, It is the public policy of the General Assembly to ensure that the emergency medical services system adapts to changing needs of the residents of this Commonwealth and promotes the recruitment and retention of persons willing and qualified to serve as emergency medical services providers in this Commonwealth; and

WHEREAS, The General Assembly finds it to be in the public interest to ensure readily available and coordinated emergency medical services of the highest quality to the citizens of this great Commonwealth; and

WHEREAS, There have been many changes in technology and organizational administration since the inception of the former Emergency Medical Services Act, such as the advent of the community college system, online computer courses, national associations and local area programs for emergency medical services training; and

WHEREAS, Changes in technology, systems management, infrastructure and communications capabilities allow for the Commonwealth to explore more beneficial approaches for the provision of the highest quality system for the delivery of emergency medical services, training and planning, as well as all-hazard emergency preparedness and disaster response training and planning; and

WHEREAS, The approximate $11,800,000 in annual funding for these emergency medical services under the Emergency Medical Services Operating Fund may be more effectively used under a more streamlined system which uses existing training, planning

and infrastructure resources; and

WHEREAS, The Commonwealth's Regional Counter-Terrorism Task Force infrastructure is a model for the country and may serve as a model for streamlining the current emergency medical services system in this Commonwealth; therefore be it

RESOLVED, That the House of Representatives direct the Legislative Budget and Finance Committee to conduct a performance review of the financial administration of the emergency medical services system under the Emergency Medical Services Operating Fund. The performance review shall include an analysis of the Bureau of Emergency Medical Services, the Pennsylvania Emergency Health Service Council and the 16 regional emergency medical services councils; and be it further

RESOLVED, That the Joint State Government Commission explore enhancing the current system for the delivery of the Commonwealth's emergency medical system through the use of existing government and private sector programs, institutions, facilities and infrastructure resources and nationally recognized associations and organizations and that the commission especially explore the feasibility of using the Commonwealth's many colleges and universities and community colleges, taking into account the availability of online services and courses and the use of adjunct professors; and be it further

RESOLVED, That the Joint State Government Commission examine the possibility of streamlining and restructuring the regional emergency medical services system and examine the feasibility of matching the regional emergency medical services councils to the current regional counter-terrorism zones within this Commonwealth to minimize the duplication of services and

overlapping jurisdictions; and be it further

RESOLVED, That the Legislative Budget and Finance Committee prepare a comprehensive listing of both the expenditures of the Emergency Medical Services Operating Fund and a comprehensive listing of all compensation packages of all employees of the regional emergency medical services councils including the Pennsylvania Emergency Health Services Council; and be it further

RESOLVED, That both the committee and commission make recommendations for a more streamlined delivery model based on their findings; and be it further

RESOLVED, That the Joint State Government Commission develop legislation based on their findings; and be it further

RESOLVED, That both the committee and commission issue a joint report of their findings and recommendations to the Chief Clerk of the House of Representatives by ~~November 30, 2012~~ JUNE 30, 2013. ←

This table compares the Emergency Medical Services System Act of 1985 (Act of July 3, 1985 (P.L. 164, No. 45)) to the Act of August 18, 2009 (P.L.308, No.37) to demonstrate the "new" provisions that have been added. Those sections, as indicated, help to show the growth in some areas, including new licensing categories, while showing few changes to the duties of the PADOH.

Emergency Medical Service Act (EMSA) (1985-45); 35 P.S. § 6921–6938 ***Source Table***	
35 Pa.C.S. Ch. 81	**EMSA**
§ 8101	§ 1
§ 8102 (1)	EMSA § 2(a)
§ 8102 (2)	New
§ 8102 (3)	New
§ 8102 (4)	New
§ 8102 (5)	New
§ 8102 (6)	New
§ 8102 (7)	New
§ 8102 (8)	EMSA § 2(b)(1)
§ 8102 (9)	EMSA § 2(b)(2)
§ 8102(10)	New
§ 8102(11)	New
§ 8103 "Advanced emergency medical services"	New
§ 8103 "Advanced emergency medical technician"	New
§ 8103 "Advanced life support squad vehicle"	New
§ 8103 "ALS"	New. See EMSA § 3 "Advanced life support"
§ 8103 "Ambulance"	EMSA § 3 "Ambulance"
§ 8103 "Ambulance attendant"	EMSA § 3 "Ambulance attendant"
§ 8103 "Basic EMS"	New
§ 8103 "Basic life support squad vehicle"	New. See EMSA § 3 "Basic life support services"
§ 8103 "BLS"	New. See EMSA § 3 "Basic life support services"
§ 8103 "Board"	New
§ 8103 "Commonwealth EMS medical director"	EMSA § 3 "Commonwealth emergency medical director"
§ 8103 "Department"	EMSA § 3 "Department"

Emergency Medical Service Act (EMSA)
(1985-45); 35 P.S. § 6921–6938

Source Table

35 Pa.C.S. Ch. 81	**EMSA**
§ 8103 "Emergency"	EMSA § 3 "Emergency"
§ 8103 "Emergency medical responder" (EMR)	New
§ 8103 "Emergency medical services" (EMS)	EMSA § 3 "Emergency medical services"
§ 8103 "EMS agency"	New
§ 8103 "EMS agency medical director"	New
§ 8103 "EMS provider"	New
§ 8103 "EMS system"	EMSA § 3 "EMS system"
§ 8103 "EMS vehicle operator"	New
§ 8103 "Emergency medical technician" (EMT)	EMSA § 3 "Emergency medical technician"
§ 8103 "Facility"	New. See EMSA § 3 "Facility"
§ 8103 "Foundation"	EMSA § 3 "Foundation"
§ 8103 "Hospital"	EMSA § 3 "Hospital"
§ 8103 "Medical command facility"	EMSA § 3 "Medical command facility"
§ 8103 "Medical command order"	EMSA § 3 "Medical command"
§ 8103 "Medical command physician"	New
§ 8103 "Medical monitoring"	New
§ 8103 "Paramedic"	EMSA § 3 "Emergency medical technician-paramedic"
§ 8103 "Patient"	EMSA § 3 "Patient"
§ 8103 "Peer review"	New
§ 8103 "Physician"	New
§ 8103 "Prehospital EMS physician"	New
§ 8103 "Prehospital physician extender" (PHPE)	New
§ 8103 "Prehospital registered nurse" (PHRN)	EMSA § 3 "Prehospital registered nurse"
§ 8103 "Quick response service" (QRS)	New
§ 8103 "Regional EMS council"	New
§ 8103 "Regional EMS medical director"	New
§ 8103 "Review organization"	New
§ 8103 "Rural area"	EMSA § 3 "Rural area"
§ 8103 "Special care unit"	EMSA § 3 "Special care unit"
§ 8103 "Trauma center"	EMSA § 3 "Trauma center"
§ 8104(a)	EMSA § 4
§ 8104(b)	New
§ 8105(a)	EMSA § 5(a)
§ 8105(b)	EMSA § 5(b)
§ 8105(c)	EMSA § 5(c)
§ 8106(a), (b)	EMSA § 5(b)(3)
§ 8106(c), (d)	New
§ 8106(e)	EMSA § 5(b)(3)
§ 8106(f)	New

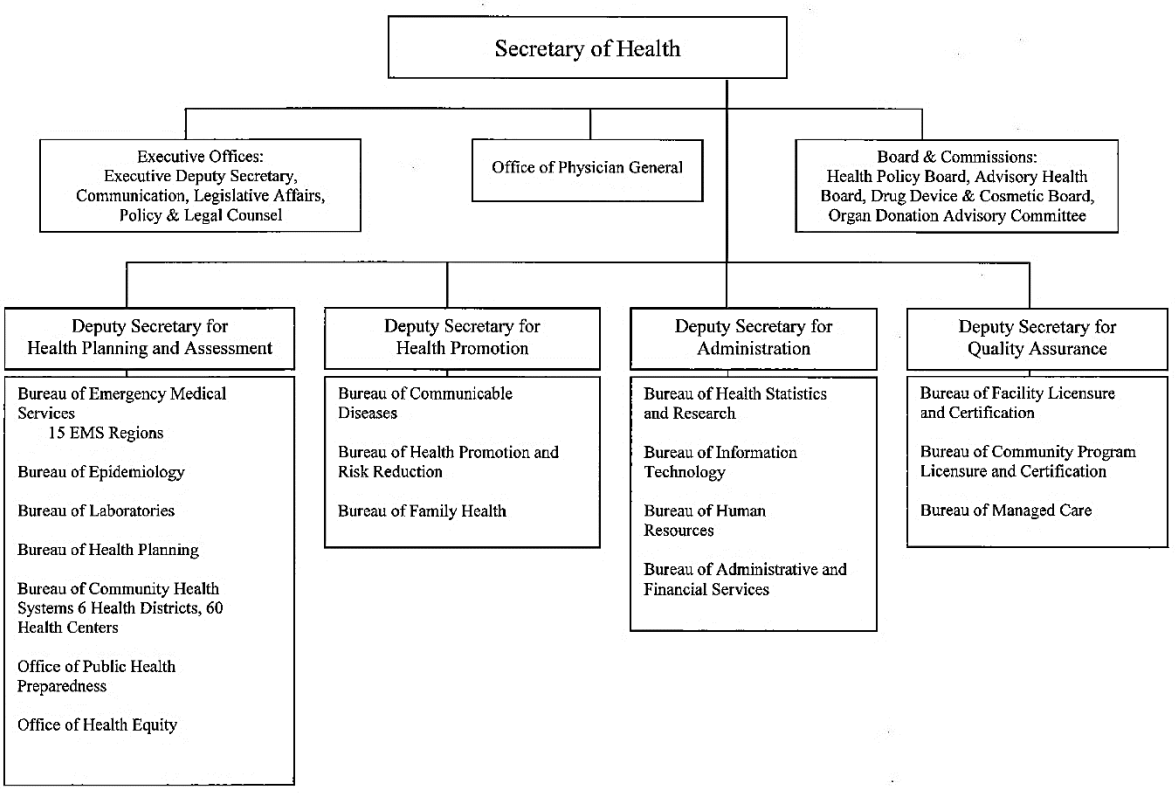
Emergency Medical Service Act (EMSA)
(1985-45); 35 P.S. § 6921–6938

Source Table

35 Pa.C.S. Ch. 81	**EMSA**
§ 8107(a), (b)	EMSA § 6(a), (b)
§ 8107(c)	EMSA § 6(e)
§ 8107(d)	New
§ 8107(e)	EMSA § 5(b)(14)
§ 8108	EMSA § 7
§ 8109(a), (b)	EMSA § 8(a), (b)
§ 8109(c)	EMSA § 8(c)
§ 8109(d)	New
§ 8111(a)(1)	EMSA § 9(a)
§ 8111(a)(2)	New
§ 8111(b)	EMSA § 9(b)
§ 8111(c)(1)	EMSA § 9(c)
§ 8111(c)(2)	New
§ 8111(d)	EMSA § 9(d)
§ 8111(e)	New
§ 8112(a), (b)	EMSA § 10(a), (b)
§ 8112(c)	EMSA § 10(c)
§ 8112(d)-(j)	EMSA § 10(d)-(j)
§ 8112(k)(1)	EMSA § 10(k)
§ 8112(k)(2)	New
§ 8112(l)	New
§ 8113(a), (b)	New
§ 8113(c)	EMSA § 11(a.1)(2)(i)
§ 8113(d)	EMSA § 11(a)
§ 8113(d)(1)	EMSA § 11(a)(1)
§ 8113(d)(2)-(4)	New
§ 8113(e)-(o)	New
§ 8114(a)-(c)	EMSA § 11(a.1)
§ 8114(d), (e)	New
§ 8115(a)	New
§ 8115(b), (c)	EMSA § 11(b)
§ 8116	New
§ 8117(a)	New
§ 8117(b)	EMSA § 11(c)
§ 8117(c)	EMSA § 11(d)(1)
§ 8117(d)	New
§ 8118(a)	New
§ 8118(b)	EMSA § 11(e.1)(1)
§ 8118(c)	New
§ 8119	New

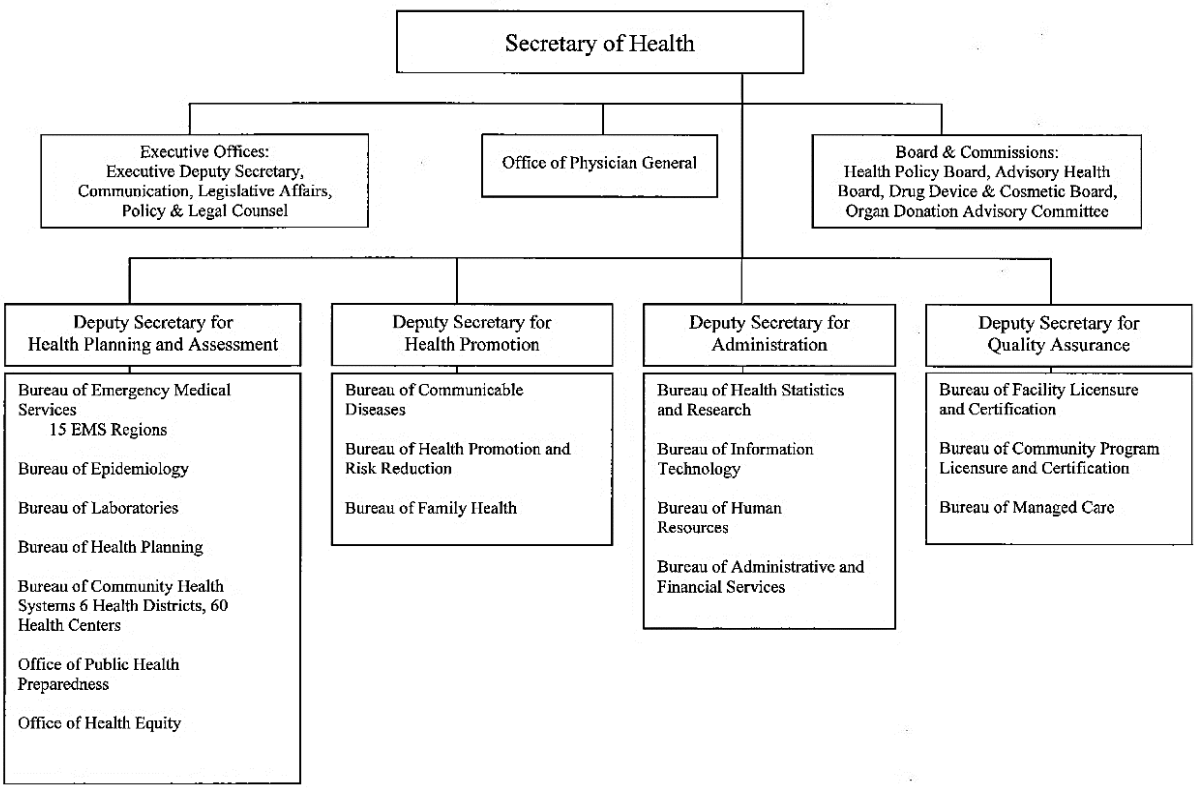
Emergency Medical Service Act (EMSA) (1985-45); 35 P.S. § 6921–6938 ***Source Table***	
35 Pa.C.S. Ch. 81	**EMSA**
§ 8120	New
§ 8121(a), (b)	EMSA § 11(j.1)(1)
§ 8121(c), (d)	New
§ 8122	New
§ 8123	New
§ 8124	New
§ 8125	New
§ 8126	New
§ 8127	New
§ 8128	New
§ 8129	New
§ 8130(a)	New
§ 8130(b)	EMSA § 12(g)
§ 8131	New
§ 8132	New
§ 8133(a)	New
§ 8133(b)	EMSA § 12(e)
§ 8134(a)	New
§ 8134(b)	EMSA § 12(e)
§ 8135	New
§ 8136	New
§ 8137	New
§ 8138	New
§ 8139	New
§ 8140	EMSA § 12(n)
§ 8141(a)	EMSA § 12(o)
§ 8141(b)	New
§ 8142	EMSA § 12(l)
§ 8151	EMSA §§ 11(j), 13
§ 8152	New
§ 8153	EMSA § 14
§ 8154	EMSA § 15
§ 8155	New
§ 8156(a)	EMSA § 16
§ 8156(b), (c)	New
§ 8157	New

Pennsylvania Department of Health Administrative Structure



Compiled by JSGC staff, March 1, 2013 from the Department of Health website, www.health.pa.state.us

Pennsylvania Department of Health Administrative Structure



Compiled by JSGC staff, March 1, 2013 from the Department of Health website, www.health.pa.state.us

Appendix D
COMMONWEALTH OF PENNSYLVANIA
REGIONAL INFORMATION WITHIN STATE GOVERNMENT

Commonwealth of Pennsylvania
Regional Infrastructure within State Government

Department	Title	Number of Regions[166]
Agriculture	Regional Offices	7
Attorney General	Regional Office	3
Insurance Fraud Section	Regional Office	3
Environmental Crimes Section	Regional Office	3
Criminal Prosecution Section	Regional Office	3
Medicaid Fraud Control Section	Regional Office	3
Appeals and Legal Services Section	Regional Office	2
Asset Forfeiture and Money Laundering	Regional Office	8
Drug Strike Force Section	Regional Office	8
Organized Crime Section	Regional Office	2
Bureau of Criminal Investigations	Regional Office	2
Bureau of Narcotics Investigation and Drug Control	Regional Strike Forces	8
Bureau of Consumer Protection	Regional Office	6
Charitable Trusts and Organizations Section	Regional Office	3
Torts Litigation Section	Regional Office	6
Financial Enforcement Section	Regional Office	2
Litigation Section	Regional Office	3
Auditor General[167]	Regional Office	4
Banking		
Bureau of Consumer Institutions	Regional Office	2
Civil Service Commission	Regional Office	2
Community and Economic Development		
Governor's Action Team	Regional Field Offices	6
Center for Local Government Services	Regional Field Offices	4
Community Affairs and Development	Regional Field Offices	5
Conservation and Natural Resources		
Bureau of State Parks	Regional Park Offices	4
	Regional Engineering Offices	4
Bureau of Forestry[168]	Forest District Offices	20
Bureau of Recreation and Conservation	Regional Offices	6
Corrections		
State Correctional Institutions	Regions	3
Community Correction Centers	Regions	3
Education		

[166] Regional Office information was obtained from a combination of sources, including agency websites, *The Pennsylvania Manual* and the *Commonwealth Telephone Directory*.
[167] Josh Fatzick, "Pennsylvania auditor general gives 67 layoff notices," *Pittsburgh Post-Gazette*, May 22, 2013, http://www.post-gazette.com/stories/local/state/pennsylvania-auditor-general-gives-67-layoff-notices-688601/.
[168] Includes partial counties.

Commonwealth of Pennsylvania Regional Infrastructure within State Government		
Department	**Title**	**Number of Regions[166]**
Veterans Education	Field Office	3
Bureau of Early Intervention Services	Operations and Monitoring	2
Bureau of Special Education	Compliance and Monitoring	3
Intermediate Units	Regional Education Service Agencies	29
Emergency Management		
Field Operations	Area Office	3
EMA Coordinators	County	68
911 Coordinators	County	69
Fire Commissioner	Regional Training Supervisor	2
Homeland Security	Task Force	9
Environmental Hearing Board	Office	3
Environmental Protection		
Chief Counsel	Regional Counsel	6
Bureau of Waterways, Engineering and Wetlands	Area Office	3
Bureau of Mine Safety	Mine Rescue Station	
Bureau of Abandoned Mine Reclamations	District Office	2
Bureau of District Mining Operations	District Office	6[169]
Field Operations	Region Office	6
	District Office	20
Ethics Commission		
Investigations	Regional Office	2
Executive Offices		
Governor's Office	Regional Office	4
Human Relations Commission	Regional Office	3
Fish and Boat Commission		
Bureau of Law Enforcement	Regional Office	6
Office of Field Operations	Regional Outreach/Education Coordinators	6
Bureau of Hatcheries	Division	2
Game Commission	Regional Office	6
Gaming Control Board		
Bureau of Investigations and Enforcement	Regional Office	2
General Services		
Bureau of Risk and Insurance Management	Regional Office	3
Bureau of Minority and Women Business Opportunities	Region	2
Bureau of Construction	Regional Office	3
Health	Districts	
Bureau of Community Health Systems	County/Municipal Health Departments	10
	Health Districts	6[170]
Bureau of Facility Licensure and Certification[171]	Field Office	
Division of Acute and Ambulatory Care	Field Office	9
Division of Safety Inspection	Field Office	5
Division of Nursing Care Facilities	Field Office	9
Bureau of Community Program Licensure		

[169] One Mining District Office focuses on underground subsidence, in any county, as needed.

[170] As of May 1, 2013, with number of counties by Health District and number of State Health centers per district in parenthesis.

[171] Many Field Offices are shared between the various Divisions within the Bureaus of Facility Licensure and Certification and Community Program Licensure and Certification. In addition, three State Health Centers serve as Field Offices for the Division of Home Health.

Commonwealth of Pennsylvania Regional Infrastructure within State Government		
Department	**Title**	**Number of Regions[166]**
and Certification		
Division of Home Health	Field Office	9
Division of Intermediate Care Facilities	Field Office	5
Bureau of Emergency Medical Services	Regions	15
Higher Education Assistance Agency	Regions	9
Pennsylvania School Services	Offices	2
Historical and Museum Commission		
Bureau of Historic Sites and Museums	Division	2
Housing Finance Agency	Offices	2
Inspector General		
Bureau of Special Investigations	Regional Office	2
Bureau of Fraud Prevention and Prosecution	Regional Office	4
PENNVEST	Regions	4
Insurance		
Bureau of Consumer Services	Regional Service	2
Judicial Conduct Board		
Investigations	Regional Office	3
Labor and Industry		
Bureau of Worker's Compensation	Regional Office	4
Labor Relations Board	Regional Office	1
Unemployment Compensation Appeals Board	Program Managers	4
	Referee Offices	20
Bureau of Mediation	Regional Office	3
Bureau of Labor Law Compliance	District	5
Bureau of Disability Determination	Administrators	3
Office of Adjudication	Districts	4[172]
State Workers' Insurance Fund	Regions	8
Office of Unemployment Compensation Tax Services	Regional Offices	3[173]
Office of Unemployment Compensation Benefits	Service Centers	8
Bureau of Workforce Development	Regional Offices	3
	Rapid Response Coordinators	2[174]
	Career Link Offices	66
Bureau of Vocational Rehabilitation Services	District Offices	15
Bureau of Blindness and Visual Services	District Offices	6
Office for Deaf and Hard of Hearing	District Offices	3
Liquor Control Board[175]		
Bureau of Real Estate	Regions	3
Bureau of Regional Retail Operations	Operations Region	3
Bureau of Licensing	Regional Office	3
Bureau of LBC Services	Audit Regions	4
Office of Administrative Law Judge	Districts	3
Patient Safety Authority	Regional Safety Liaisons	5

[172] Districts are assigned to serve various counties. The number of offices serving each region is listed, followed, in parentheses, by the number of counties each region serves from those offices. Some offices serve parts of the same counties.

[173] Regional Offices, through Field Offices, serve all 67 counties, with each Regional Office also hosting a Field Office. Wilkes- Barre houses two Field Offices at its location.

[174] Rapid Response Coordinators are deployed in five western and seven eastern offices respectively, each serving the number of counties listed in parentheses.

[175] While some offices are shared across all four regions and Administrative Law Districts, the only matching regional structures exist between Real Estate and Regional Operations.

Commonwealth of Pennsylvania Regional Infrastructure within State Government		
Department	**Title**	**Number of Regions[166]**
Probation and Parole		
	Regional Office	3
	District Office[176]	10
	Sub-Offices	11
Public School Employee Retirement System		
Bureau of Communications and Counseling[177]	Field Service Offices	8
Public Utility Commission		
Office of Administrative Law Judge	Regional Office	4
Bureau of Audits	Regions	2
Bureau of Investigation and Enforcement	Districts	4
Public Welfare[178]		
Bureau of Administrative Services	Area Office	3
Bureau of Adult Residential Licensing	Regional Office	4
Bureau of Equal Opportunity	Regional Office	3
Bureau of Financial Operations	Field Office	4
Bureau of Hearings and Appeals	Field Office	4
Bureau of Program Integrity, Health Insur. Payment Section	Offices	5
Office of Chief Counsel	Regions	3
Bureau of Certification Services	Regional Field Offices	7
Bureau of Children and Family Services	Regions	4
Bureau of Juvenile Justice Services	Regions	3
Bureau of Child Support Enforcement	Field Offices	4
Bureau of Operations		
Staff Development Field Offices	Field Offices	5
Division of Field Management	Areas	6
Bureau of Program Evaluation		
Division of Quality Control	Field Offices/Outpost	4
Division of Corrective Action	Field Offices	2
Bureau of Program Support	County Assistance Offices	97
Bureau of Community and Hospital Operations	Field Offices	6
Bureau of Support for People with Intellectual Disabilities	Regions	4
HealthChoices Program	Zones	5
Revenue		
Bureau of Audits	Regional Office	7
Bureau of Taxpayer Collection Services[179]	Regions/Districts	3
Bureau of Motor Fuel Taxes	Enforcement Districts	4
Pennsylvania Lottery[180]	Area Marketing Offices	7
Securities Commission		
Division of Enforcement, Litigation and Compliance	Offices	3
State		
Bureau of Enforcement and Investigation	Regional Offices	4

[176] The Philadelphia District Office has four Divisional offices around the City.
[177] Includes partial counties.
[178] While a few field offices occupy different suites at the same address, the vast majority of DPW Regional entities are in separate locations serving different counties.
[179] The number of district offices within each of the three regions is listed, followed in parentheses, by the number of counties served within each region. Some districts have multiple units serving different types of taxes, they are often in different locations, and some regional and district offices only serve portions of a county.
[180] Includes partial counties.

Commonwealth of Pennsylvania Regional Infrastructure within State Government		
Department	**Title**	**Number of Regions[166]**
State Employees Retirement System	Counseling Centers[181]	8
State Police		
Bureau of Communications and Information Services	Consolidated Dispatch Centers	2
Bureau of Forensic Services	Regional Laboratories	6
Bureau of Criminal Investigations	Interdictions Units	3
Bureau of Training and Education	Training Centers	4
Bureau of Gaming Enforcement	Sections	2
Bureau of Emergency and Special Operations	Aviation Patrol Units	7
	Canine Sections	2
Bureau of Liquor Control Enforcement	Districts	8
Field Installations[182]	Areas	3
	Troops	16
	Stations	90
PennDOT		
Chief Counsel	Regional Offices	3
Bureau of Office Services		
Facilities Management Division	Regions	4
Engineering Districts[183]	Regions	12
Maintenance Districts	County based	68
Intelligent Transportation Systems	Regions	9
Turnpike Commission	Operations Area	2
Treasury	Regional Offices	3
Unified Judicial System		
Supreme Court	Administrative Office	2
	Districts	3
Disciplinary Board of the Supreme Court	District Office	4
Superior Court	Districts	3
Commonwealth Court	Districts	
	Filing Office	2
Courts of Common Pleas	Judicial Districts	60[184]
Minor Courts	Magisterial Districts	60[185]
Judicial Conduct Board	Regional Investigations Offices	3

[181] Includes partial counties and one out-of-state servicing center based in Harrisburg.
[182] There are a few instances of sharing of locations between the various level of Field Offices and Laboratories.
[183] Several Engineering District Offices are shared with Maintenance Districts. Allegheny County has two Maintenance Districts while all others have one.
[184] County based with seven dual-county districts.
[185] Same as Common Pleas, but 535 districts plus Pittsburgh and Philadelphia Municipal Courts, and Philadelphia Traffic Court.

Index of Meetings/Interviews of the Pennsylvania Department of Health Regional Emergency Medical Services Councils
Note:[186]
Bucks County
Jeryl Degideo, Regional Director
John Scott, Assistant Director and Training Coordinator
Scott Bahner, Council President, Chief of Bristol Borough EMS
Chester County
Edward Aitkins, Director, Department of Emergency Services
Steve Webb, Deputy Director for Field Services
Harry Moore, Regional ALS Coordinator
Keith Johnson, Council President, Ambulance Chief, Malvern Fire Company
Attended January 30, 2013 Regional Council Meeting
Delaware County
Maureen Hennessey Herman, Director, Intercommunity Health Coordination
Robert Reeder, Council President, Director of EMS Unit –South, Crozer-Chester EMS
James Jeffrey, Council Vice-President, Treasurer/Firefighter/EMT, Media Fire Company
Larry Smythe, Council Secretary, Chief of EMS/Paramedics, Mercy Fitzgerald Hospital
Attended January 5, 2013 Regional Council Meeting
Eastern PA EMS
Everitt Binns, Ph.D, Executive Director/CEO
James Conrad, Council President, Deputy Chief/EMS Manager, City of Reading EMS
Attended December 12, 2012 Regional Council Meeting
Emergency Health Services Federation
C. Steven Lyle, Executive Director
Maureen Gallo, Council President, Citizen Board Member with No Affiliation
Attended February 12, 2013 Regional Council Meeting
EMMCO-East
John Weidow, Executive Director
Don Fortney, Education Director
Mike McAllister, Council President, Elk County Office of Emergency Management
EMMCO-West
Bill McClincy, Executive Director
Christopher Heile, Assistant Director
Charles Ramsey, Council President, Safety Manager at Hamot Medical Center, and Chief at Harborcreek Volunteer Fire Department

[186] *PEHSC Member
+Regional Council Board Member.

Index of Meetings/Interviews of the Pennsylvania Department of Health
Regional Emergency Medical Services Councils

Emergency Medical Services Institute
Tom McElree, Executive Director
Brian Shaw, Council President, Chief, Noga Ambulance Service, Inc.
Lycoming, Tioga, Sullivan EMS Council
Wendy Hastings, Acting Director
Darla Krotzer, Regional EMS Field Coordinator
John Getty, Council President, Operations and Training Coordinator, Tioga County Emergency Services
Montgomery County
David Paul Brown, Deputy Director-EMS, Montgomery County Dept. of Public Safety
Dr. Ben Usatch, Council Member, Council Medical Director and Narberth Ambulance Medical Director, Emergency Physician at Lankenau Hospital
Roundtable discussion with Regional EMS staff at Public Safety Training Campus
Northeastern PA EMS
John Campos, Executive Vice-President
Bart Burne, Council President, Provost and Vice President of Academic Affairs at Luzerne County Community College
Jack Lasky, First Vice-President, EMS Coordinator, Geisinger Wyoming Valley Medical Center
Attended February 1, 2013 Regional Council Meeting
Philadelphia EMS Council
George Butts, Chief, EMS Regional Director
Stephanie Allen, EMS Program Specialist
Lt. Alleyne, Licensure Coordinator
Seven Mountains EMS Council, Inc.
Timothy Nilson, Executive Director
James Urban, EMS Program Specialist
Mark Wolfgang, EMS Education Coordinator
Mick Abrashoff, Council President, Deputy Chief, Fame Emergency Medical Service
Attended January 17, 2013 Regional Council Meeting
Southern Alleghenies EMS Council, Inc.
Carl Moen, Acting Director
Gary Watters, Council President, Deputy Director, AMED Authority
Susquehanna EHS Council, Inc.
Richard Gibbons, Executive Director
Amanda Krebs-Stancavage, System Coordinator
Scott Lynn, Council President, Executive Director, Danville Ambulance Service
Christine Mull, Council Secretary, President, DH&L Ambulance League
Attended January 15, 2013 Regional Council Meeting
Pennsylvania Emergency Health Services Council
PEHSC Staff
Janette Swade, Executive Director
Butch Potter, EMS System Specialist
Steve Mrozowski, EMS Specialist & EMS for Children Program Director
Executive Committee of the PEHSC Board of Directors

Index of Meetings/Interviews of the Pennsylvania Department of Health Regional Emergency Medical Services Councils
+J. David Jones, President
Jean Bail, Vice-President
Robert Bernini, Secretary
Ronald Roth, Treasurer
+J.R. Henry, Immediate Past President
Arthur Hayes, Richard Gibbons and +John Getty, Members-at-Large
Meetings attended by The Commission staff include:
• Annual meeting of the Board of Directors
• Teleconference with Board President
• State Plan Task Force meeting
• Medical Advisory Committee meeting webinar
• PEHSC Board of Directors Meeting & meeting with Executive Committee
• CCT Workgroup meeting
• EMSC Committee Meeting
• EMS Information Task Force Meeting
• Board of Directors meeting
• PEHSC Level IV Trauma Triage Workgroup Meeting
• Meeting with Executive Director and Board President
• Executive Committee of the Board of Directors
In total, including both individual and group meetings, The Commission met with no less than 12 members of the Pennsylvania Emergency Health Services Council Board, 37 organizations represented on PEHSC's Council and Affiliate Member's Lists. These meetings are listed under the name of the participating organizations.
Other Related Groups
Ambulance Association of Pennsylvania
+Dean Bollendorf, President – Network Ambulance
*Don Dereamus, Legislative Chair – Medic 9 Paramedic Service
+Chuck Cressley, Secretary – Citizens Ambulance
Heather Sharar, Executive Director
Roundtable discussion with providers at the 2012 Ambulance Association of Pennsylvania Leadership Conference in Hershey
Pennsylvania Department of Health
Martin Raniwoski, Deputy Secretary for Health Planning and Assessment
Joe Schmider, Director, Bureau of Emergency Medical Services
Dan Howell, Director, Bureau of Community Health Systems
Bob Cooney, EMS Program Manager – Quality & Data Evaluation Manager, Bureau of EMS
Jay Taylor, EMS Emergency Preparedness and Response Manager, Bureau of EMS
Catalina Arazia, Office Manager – Contract/Grant Management, Bureau of EMS
Department meetings with The Commission staff included:

Index of Meetings/Interviews of the Pennsylvania Department of Health Regional Emergency Medical Services Councils
• Teleconference with Deputy Secretary Raniwoski and Director Schmider
• Regional Council Directors meeting with Deputy Secretary Raniwoski and Director Schmider
• Six individual meetings with Director Schmider
• Teleconferences with Bob Cooney, Jay Taylor and Catalina Arazia
• Meeting with Deputy Secretary Raniwoski Director Schmider
• Teleconference with Deputy Secretary Raniwoski and Director Schmider and Director Howell
Providers of Emergency Medical Services
South Central EMS, Dauphin County
Jason Campbell, Chief and CEO
Center for Emergency Medicine of Western Pennsylvania
Dan Swayze, Vice-President and Chief Operating Officer
Susquehanna Valley Emergency Medical Services, Lancaster County
Michael Fitzgibbons, President/CEO
Burholme EMS, Philadelphia
+Timothy Hinchcliff, Managing Director
Lackawanna Ambulance Services, Inc., Lackawanna County
Sean Buckman, President/CEO
Cetronia Ambulance Corps, Lehigh County
Larry Wiersch, CEO
Horsham Fire Company, Montgomery County
*Duane Spencer, Firefighter/Paramedic
Mutual Aid Ambulance Service, Westmoreland County
+William Groft, Director of Operations
Lower Allen EMS, Cumberland County
Christopher Yohn, Captain/Division Chief
Newberry Township Fire Department & EMS, York County
Tim Stevens, Captain/EMS Chief
Healthfleet Ambulance, Inc., Philadelphia
+Dean Bollendorf, Vice President
University Ambulance Service, Penn State University
*+J. David Jones, Manager
Josh Fremberg, EMS Supervisor/Instructor
Highmark, Inc.
+Bob McCaughan, Vice-President, Pre-hospital Services (Chief, Pittsburgh EMS 2004-12)
Pinnacle Health, Community LifeTeam, Harrisburg
+John Logan, Director of Operations
John Brindle, Education Coordinator
Kevin Dalpiaz, LifeTeam Supervisor & President of Perry County EMS Council
Lancaster Emergency Medical Services
C. Robert May, Executive Director
*Dr. Michael Reihart, Lancaster General Hospital Emergency Department, Lancaster EMS Medical Director and Emergency Health Services Federation Regional Medical Director

Index of Meetings/Interviews of the Pennsylvania Department of Health Regional Emergency Medical Services Councils
Penn State Hershey Emergency Medicine, Life Lion EMS
*David Lindstrom, Director for Emergency Preparedness
Dr. Jeffrey Lubin, Division Chief, Transport Medicine
Scott Buchle, Manager, Life Lion EMS
Dr. Thomas Terndrup, Chair, Department of Emergency Medicine
Fame Emergency Medical Service, Mifflin County
*Patrick Shoop, EMS Chief
+Mick Abrashoff, Deputy Chief
Greater Valley EMS, Bradford County
Charles Bement, Executive Director
Meadville Area Ambulance Service, Crawford County
+Eric Henry, Manager/Owner
EmergyCare, Erie County
Todd Steele, Director of Operations
Albion Fire Department
Scott Hyde, Fire Chief
STAT Medical Transportation, Delaware County
Ronald Beradocco, Owner
Cameron County Office of Emergency Services
+Kevin Johnson, Director
St. Luke's Hospital & Health Network, Lehigh County
+*Brian Evans, Pre-Hospital Liasion,
American College of University Physicians
*+Dr. Alex Rosenau, President, Sr. Vice-Chair of Emergency Medicine, Lehigh Valley Health Network
Centre County Emergency Management Services
+Randy Rockey, Coordinator
Lycoming County Department of Public Safety
+John Yingling, Director
Reliance Hose Company, Middleburg, Snyder County
Ashley Houtz, Assistant Ambulance Captain
Americus Hose Company, Sunbury, Northumberland County
+Robert Hare, Director of Operations
Evangelical Community Hospital, Lewisburg, Union County
+Nick Klose, Director, Pre-Hospital Services
Training Institutes
Pennsylvania Commission for Community Colleges
Diane Bosak, Executive Director
Bucks County Community College, Dept. of Public Safety Training & Certification
Barbara Miller, Vice-President of Continuing Education, Workforce Development & Public Safety
Robert Grunmeier, Executive Director, Contracted Public Safety and Industrial Training
Rob Freese, Executive Director, Public Safety Training and Certification
Harrisburg Area Community College, Shumaker Public safety Center

Index of Meetings/Interviews of the Pennsylvania Department of Health Regional Emergency Medical Services Councils
*Robert Bernini, Instructional Program Coordinator, EMS Programs
Michael Tonkay, Education Specialist, EMS
Pennsylvania College of Technology
Carl Shaner, Director, College Health Services
Mark Trueman, Director of Paramedic Technology Programs
Other related stake holder groups
Pennsylvania Fire and Emergency Services Institute
*Don Konkle, Executive Director
Pennsylvania Department of Community and Economic Development, Governor's Center for Local Government Services
Robert Brady & Sean Anderson, Local Government Policy Specialists
Peter Zug, Policy Manager
Pennsylvania Emergency Management Agency
Glenn Cannon, Director
Bob Full, Chief Deputy Director
Office of the State Fire Commissioner
Ed Mann, State Fire Commissioner
Pennsylvania Trauma Systems Foundation
*Juliet Geiger, Executive Director,
Pennsylvania State Association of Township Supervisors
Elam Herr, Assistant Executive Director
County Commissioners Association of Pennsylvania
Lisa Schaefer, Government Relations Manager
South Central Pennsylvania Regional Counter-Terrorism Task Force
Gregory Noll, Program Manager
Levittown-Fairless Hills Rescue Squad
Christopher Reif, Chief of Operations and Chief of Bucks County EMS Council (a council of local providers)
The Hospital and Healthsystem Association of Pennsylvania
Paula Bussard, Sr. Vice-President of Policy and Regulatory Affairs
Scott Bishop, Sr. Vice-President for Legislative Affairs
Lynn Leighton, Vice President of Health Services
*+Tom Grace, Vice President of Emergency Preparedness
NON- Pennsylvania Sources
Arizona House of Representatives
Paul Boyer, State Representative
Senate of Florida
David Loe, Legislative Analyst, Health and Human Services Appropriations Subcommittee
Georgia House of Representatives
Margie Coggins Miller, Senior Budget and Policy Analyst, Budget and Research Office

Index of Meetings/Interviews of the Pennsylvania Department of Health Regional Emergency Medical Services Councils
Maryland Institute of EMS Services
Patricia D. Gainer, Deputy Director
Massachusetts Executive Office of Health and Human Services
Ridgley Ficks, Massachusetts Ambulance Trip Record Information System Manager
Michigan Department of Community Health
Sue Malkin, Budget Division Director
National Association of State EMS Officials
Dia Gainor, Executive Director
New Jersey Department of Health
Candace Gardner, Office of EMS
New York State Department of Health
Lee Burns, Director, Bureau of EMS
North Carolina Department of Health and Human Services
Donnie E. Sides, Operation Manager, Office of EMS
Ohio Division of EMS
John E. Sands, Chief of EMS Operations
Tennessee Department of Health
Donna G. Tidwell, EMS Director
Texas Department of State Health Services
Greg Wilburn, Division for Regulatory Services, Office of EMS/Trauma Systems
Wisconsin Department of Health Services
Helen Pullen, EMS Licensing Coordinator, Emergency Medical

To obtain information that represented the spectrum of responsibilities and experiences, Commission Staff sought feedback from providers at various points of the EMS system. Staff conducted interviews both in person and via teleconference, attended meetings, and made numerous site visits to EMS stations around the Commonwealth.

The comments reproduced below are unattributed to protect the identity of the respondent. Comments were drawn from the meetings listed under the "Providers of Emergency Medical Services" heading of Appendix F, the *Index of Meetings and Interviews*. These comments reflect the most relevant dialogue regarding topics addressed in House Resolution 315. Topics of discussion were organized into the most prominent areas of feedback, which included structure, funding, operations, and training.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Structure
PA DOH needs to think more strategically, and prioritize, like access to service in rural areas, enhanced care and rural trauma development. Quality of EMS care is also a concern, protocols need to be in place but funding is needed to execute, training and preparedness. Should consider an annual participation fee for licensees.
PA has a strong EMS system, and one of more comprehensive EMS statutes and good leadership. Community level decision making but need standardization and accountability at regional level, is key to success. Has a high volunteer population, which can cause headaches in management. System relationship issues can cause disconnect is present between hospitals and why patients taken where.
EMS should be modeled after Fire Commissioners office, with a Commonwealth EMS Commissioner and independent agency of EMS.
EMS is a hybrid field, touching aspects of not only EMS, but public health and public safety. It is also most people's first entry into the healthcare system and is pre-hospital care. Emergency Management and Medicine do not take EMS as seriously as other fields, and they often resist incorporating them into organizational structure, strategic planning or expanding scope of practice.
Data is not provided to services, and outcomes are tough to assess and improve upon.
Transfer of care forms in written versus verbal form will challenge providers and ER staff. Is an unnecessary burden and redundant with trip sheets. Why can't a nurse or paramedic not down notes.
Regions should be more involved in coordinating medical direction amongst the services, and matching up that direction versus letting every physician/institution set its own policies. PADOH should hold more stakeholder meetings with services.
The state EMS plan rarely impacts providers but offers guidance for operations.
Department does not consistently follow what is in the statute, taking on responsibilities that are for PEHSC and transferring duties to PEHSC and Councils that should be done by PADOH.
Need to do a better job with collecting data, need to get outcome data to providers for QA.
A need based, population bases system needs to reflect the metrics of industry best practices.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Structure
Department implements mandates that are good, like Medical Director requirement for ALS services, but do not fund them making them burdensome.
Pennsylvania EMS has many layers, which equals more chances for communications to break down, and makes for a disjointed system
The system is built out, but the system is changing and providers need to change/grow with it. DOH is often slow to react to changes for scope of practice, equipment and data.
Need better use of data being collected and more feedback to providers on outcome data. Providers are interested in treating patients not filling out mountains of paperwork.
Too much focus on regionalizing services around hospital systems. That is a false premise as hospital systems have EMS organizations to pull-in business.
Councils have more career people on them and need more volunteer representation from small EMS services to be representative.
States are usually regulatory authority, not cheerleaders. The North Carolina model has unit of responsibility at the county level
A lack of integration of statewide efforts has perpetuated a fragmented system of 15 independent regions. This leads to inconsistency with enforcement of regulations, varying programs and outreach, and EMSOF fund distribution.
Would be better off without Regional councils. They serve to support their services, it is not effective, there's no accountability and they communicate poorly with services.
Regions are very different and need more consistency. In Philly region, some councils only interact with services when time for inspection/licensure and input, if any, is ceremonial. Others have a lot of dialogue with other regions, providers and councils actively collaborate and seek operational input.
Philadelphia's focus is solely on fire, and EMS operates to supplement fire with income. Fire and EMS totally integrated. No other services are permitted to respond to EMS calls in the city as primary or mutual aid.
Need more accountability and consistency between regions. If councils went away most services would not miss them. Leadership, bureaucracy are not always customer friendly. Sometimes it feels like a good old boys club that likes to meet and be in charge but make little headway with items that would have a big impact on services like group purchasing of supplies, equipment, narcotics and insurance, standard trip sheets and vendors between providers and regions.
Communication with providers needs to improve as some regions have little to no contact outside of inspections.
Regional councils and staff should be eliminated in current form and all should be state employees. Licensing and training functions are done by staff, or self-reported and councils not needed.
Delivery system is fragmented at regional council level and PADOH allows this. Services can come and go too easily, especially for-profit transports. Need a mechanism to require staffing levels for transports as do with ALS/BLS emergency responders, and new companies should have to demonstrate need.
Regions need more standardization, bylaws should have consistent number of meetings and members, have shared personnel, enhanced flow of information and use more shared services and personnel. Regional initiatives in funding should be consistent across regions.
Regions are supposed to be the link between providers at the grass roots level and the state, but regions are not always responsive. Need more statewide initiatives, better flow of information and accountability.
Work well with regional councils and committees.
Regions act as operational entities not just as regulators. They should focus on preparedness and system integration and build relationships not competition. Regions suffer from strong staff leadership and weak

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Structure
board leadership, or vice versa, but not consistent. Flow of information from PADOH to regions to providers is poor.
Regions should be restructured to reflect patient flow and delivery model factors and not geo-political. Regional contracts should be opened up for bids.
Regions have a good purpose just need less of them. More spot inspections would improve the industry.
EMS needs to think regionally, smaller companies need to work together to harness their resources and overcome manpower, training and finances. They needlessly compete with each other rather than sharing the system to serve the community more efficiently. Stronger leadership is needed at PASOH and in the regions to help services think and plan strategically, to give the region direction, and communicate better with providers.
Regional councils should be realigned. They serve an important function as the eyes and ears of the department, to make sure the system is doing well, and have evolved into a much better group that is helpful and engaged with services; however, 15 is too many.
Regions provide a boots on the ground for the state, allow providers to give immediate feedback to PADOH, but they lack standardization.
Some regions have gotten more accessible, open, and responsive but were not always that way.
Regions are a good way to organize the system, but would like to see less of them and no single county regions. No benefit to matching specifically with PEMA or Task Force regions. Eliminating the conflicts of interest on the Regional councils, where board members can approve funding for their own organizations would be a great benefit.
Regions are fraught with conflicts of interest and are very problematic, but conflicts do not need to be there if managed properly. The former Bradford-Susquehanna region had to regulate the hospital that was the regional contract holder, regulators receive input from providers and can hold items over their heads.
EMSOF monies are not very regulated and fund ambulance services that are struggling with over saturation. Projects could be better used for system improvements, strategic initiatives with a regional focus. Grant distribution should be centralized within the Bureau. Certificates of need don't really save any money and just politicize the process.
The current region and state advisory board structure are not the best way to do business and present a lot of duplication. Structure just does not make sense, is not efficient but does present a good sounding board for state level protocols.
Regional councils are good for building cooperation, not completion amongst providers. The greatest inefficiencies exist in competition for calls, even though most services are now paid.
PEHSC has better perspective and input from stakeholders.
Better input from PEHSC than from the Department of Health. Has had a very positive impact since 1985. Most regions in the state just layers of the Department's Bureaucracy. All regions operate differently. Most PEHSC discussions are operational and vetting of regulations and legislation while regions are focused on licensure and advocacy. Value in venue of having multiple views at the table, providing input from reality and practice not data, quality of input. HAP does its own advocacy and does not go through PEHSC. Would lose much if PEHSC not around, and smaller organizations would lose the opportunity for input. PESHC's biggest downside is discussion not always efficient and timely with responses, structure has not been updated since it's formalization in 1985.
PEHSC should focus on research and grant writing and need to offer advice and subcommittees should add regional representatives to help change the make-up and focus.
Provides a good global view and brings people from across the state together but passes a lot of protocols and required equipment that are unfunded mandates to services.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Structure
No value to PEHSC as few providers work with them. They marginalize themselves by giving untimely, undeveloped responses.
PEHSC held to different standard than regions with contracts/grants, secondary income/corporations.
VTR's are a long process to vet issues, which affords time for great discussion but causes the PADOH to bounce short term issues off other groups, like the Ambulance Association of PA. Individual interest groups that are represented on PEHSC, like the Hospital Association or representatives of a particular health system will often contact PADOH directly with their feedback.
PEHSC is a dinosaur, very antiquated with no value to the system.
PEHSC is asked for advice by PADOH but how seriously do they take that advice.
PEHSC should not be imbedded in the PADOH. Their members are independent but they are marginalized by the Department and underfunded.
A big believer in PEHSC as the best advocate for EMS. Other advocates, associations have been ineffective engaging providers and maintaining viability. Committees are engaging of hospital systems and emergency physicians.
PEHSC could do more/sponsor evidence based research projects.
Developing independent advice for DOH but everything needs to go through DOH and controlled by DOH. Without a dedicated funding source outside of EMSOF there's an opportunity for PADOH to punish PEHSC for advice that conflicts with their opinion. Clearly, personalities are coming to a head between PEHSC and PADOH, and their standing has eroded within the Department.
PEHSC not valued as a partner with PADOH, are not at the table for major policy initiatives, are shunned from the inner circle
PEHSC would like to use its secondary income fund to establish an organization to advocate for EMS, separate from the role of the advisory board.
The Department often turns to other organizations, like the Ambulance Association of Pennsylvania, for advice on issues, and members of PEHSC like the American Red Cross or the Hospital and Health Systems Association provide their feedback directly to the Department or Governor's Office. PEHSC is focused on grass roots approach of provider feedback up to PADOH.
PEHSC offers a broad perspective and is unique in brining numerous opinions from across the state together. It brings focus to the broad tasks within the state plan.
PADOH is required to acknowledge VTR's it receives from PEHSC but not to respond. Acknowledgements are typically boiler plate letters stating the Department agrees with these suggestions but does not indicate an implementation strategy or timeline.
PEHSC is constantly reinventing themselves in an attempt to stay relevant. What can PEHSC do that Regions cannot do? There is a lot of overlap.
PEHSC is a good system in theory but not in practice. The state plan is a similar document that establishes a good plan but does not help implement changes. Difficult to get stakeholder buy-in.
First priority for change would be to match scope of practice with patient care and protocols. State Mac Committee is a great example of getting local participation at state level. Practitioners need more oversight than ever and committees are a good way to get input.
Community Paramedicine is a new way of thinking and acceptance to break from traditional EMS roles. It is gaining more traction as agencies/organizations/individuals recognize the potential to get into the community, help people, and directly interact with them. This is a relationship that EMS has lacked, and Fire and Police have excelled. Has the potential to help with reimbursements, recruitment and retention, and improve outcomes through in-home visits. With the Affordable Care Act penalties for hospital readmission, Community Paramedicine has the potential to provide follow-ups for hospitals, have safe landing visits, and wellness programs to improve outcomes. The biggest issues to overcome are scope of

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Structure
practice, specifically with medication and medical command, and insurance reimbursements for providers.
Very convoluted system. State Plan needs to be a living document.
Fire and police have great representation and advocates but who is advocating for EMS? There is not a strong, unified advocate. EMS is its own worst enemy with poor attendance and engagement at PEHSC. Regions and other stakeholder meetings.
PUC current regulates stretcher and wheelchair vans. That should all be done by PA DOH.
EMS is on the radar more than ever recently. Biggest system challenge is how the government interfaces with providers, and how providers fit into the state's system. There needs to be an overall structure, with accountability at the state level and interface with other providers at the local level.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Funding
Funding structures vary from vehicle registration and inspection fees to liquor taxes.
Funding is based on a formula developed in 1985 and is outdated and the system is underfunded.
Funding from municipalities and state is inconsistent but any dollars is better than none. Most municipalities contribute, but it is not required. Those contributions can fluctuate given their budgets.
Would not miss EMSOF money if it goes away as there as so little reaches providers. The biggest impact on services is Medicare and Medicaid reimbursements and Insurance payments.
Many grants available for Fire and EMS usually take a back seat. At shared services, EMS monies often support fire and most officers are fire volunteers.
Biggest funding challenge is reimbursements and payments made to policy holders/members are not always passed along to providers. EMS has no control over their calls, but only gets paid when they transport. Insurance scrutinizes their level of care and what is medically necessary treatment, as does the government for Medicare and Medicaid and reimbursements are always less than costs.
Biggest funding challenges are insurance Medicare reimbursements and their overtime pay. Eligibility for EMSOF grants should be tightened to include on non-profits or limited to only PSAP dispatched services.
Biggest challenge is financial stability and viability of services.
Not enough EMSOF dollars to make a difference across the state.
Funding from municipalities is inconsistent, few have EMS taxes, memberships vary and reimbursement funding is a volume issue, economies of scale. Not all commercial insurance has EMS coverage.
First response/QRS services are currently eligible for EMSOF $, and they should be ineligible.
Ems totally relies on third party payers, and the greatest need is predictable revenue and consistent reimbursements. Ideas include a national fee schedule.
EMS managers are usually providers who worked their way up through the ranks and very few have managerial or business experience.
Grant monies, like those under the Fire Commissioner, give services more flexibility than EMSOF.
EMSOF needs to get more $ to the providers to help offset some of the unfunded mandates from the PADOH in the form of new required equipment.
EMSOF should have a consistent funding stream for regions and grant allocation and not allow regional councils to pick winners and loser by region.
Would like to see wheelchair and stretcher van inspections transferred from PUC to PADOH. Would also be OK with inspection and license fees just cannot price them out of the business.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Funding
Need consistent funding and funding for recruitment and retentions. Grants should be focused on volunteer services. Need a mix of local, state and federal money to survive, need balance. Grants could be focused on need (less runs) or volume (more runs).

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Operations
A lot of disconnect between EMS and PEMA and very little coordination between EMS and Task Forces. EMS Councils should not be operational, and focused on advisory work and licensure. Task forces all have EMS committees. EMS needs to be a part of overall disaster planning at the state level to ensure EMS is part of the local solution and response.
Strike Teams are innovative, and PA has built a good system but has concerns with emergency management control of those assets.
There is a need for greater coordination between EMS and emergency management, communication with PEMA and integration of emergency management coordination and planning within the PADOH, but not integration with PEMA.
Prohibit fire from responding to EMS calls…are only doing so to get reimbursements. Should be separate and not integrated with EMS at all.
Strike Team deployment to Hurricane Sandy was in 3 waves, with little structure, poor command and control, no coordination with PEMA and regional assets were partially deployed as opposed to the whole strike team going from the same region. Reimbursements for provider's costs and salaries was not worked out prior to deployment causing major delays on the back end.
Task Forces have a lot of law enforcement and fire focus and do not integrate EMS as pre-hospital care or involved hospitals. They're always a second tier in planning and preparedness.
EMS should be part of Emergency Management that would allow better statewide coordination and more local planning. PADOH just doesn't "get it" on emergency planning and preparedness.
State should not issue a license if a transport service does not have a Medicare number, has been denied one or it has been revoked.
PA DOH should require a certificate of need for ALS. Too many services compete for call volume, and diluting the available talent.
Regions need to be more proactive at fostering collaboration and consolidation as a lot of providers, especially in rural areas, are competing for calls due to financial challenges.
Hospitals more involved in EMS regions, good flow of information to and from them. PADOH needs to do a better job of integrating EMS into the health system, and translation of EMS, communication and medical command and specialized care centers.
Regions need to work to reduce competition between services and help them plan for the future. Some problems are within the industry, with the providers, and their resistance to change, but the regions need to be proactive.
EMS regions need to be reduced, and Health Districts may be an option for consolidation. Lots of opportunity to be more efficient and reduce overlap. There are a lot of layers to the EMS system. Eastern and some other regions have very good, active councils. There needs to be some type of organizational at the local level as well as some standardization across the regions. Regional initiatives are good, but operations and organization and coordination of assets, including strike teams, are questionable. Medcom helps the entire region and provides very important communications links.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Operations
Medcom is very useful to keep active communication with other hospitals and practitioners, especially in organizing for regional disasters and planning.
Community Paramedicine has an opportunity to engage the public, provide education and good PR.
There are very few associations and the Bureau of EMS is a crutch that providers look to to represent their interests while they also regulate them.
Community Paramedicine is key to the future of EMS and needs to be part of integrated planning and business models.
Different expectations between rural and urban EMS providers. When people choose to live in rural areas to "get away" from the urban life, they make a choice to live where there are fewer services, and drives are longer to get to amenities. However, they often have the same expectations for quick response and quality care. Full and part time services both exist, and both can provide quality care and quick response times, but the full time paid service is more consistent.
There are too many services in urban areas, and rural areas served by volunteer fire companies rely on ambulance services for their income.
Should be more integration of services and better coordination of regions between EMS and Task Forces. Will pay big dividends in larger event and disaster planning, preparedness training and response coordination. Needs to be better communication and more consistent policy direction between PEHSC and EMS regions. Redundancies in the systems, layers and bureaucracy should be eliminated.
Collaborations are needed, and it will be do or die for services. Partnerships make the system more affordable and finance and manpower go hand in hand. Community Paramedicine helps services diversifiscal year their offerings, but cannot be limited to hospital based EMS. Reimbursements will be key.
Mutual aid utilization varies from region to region and communications between them can be spotty.
Community Paramedicine is the key to EMS's future, as post-hospital case management helps to reduce costs for insurance and health systems by lowering hospital readmissions. The reimbursement for those services needs to be worked out but it would diversifiscal year revenue and could be a service performed during "down times" when no revenue is generated.
Community Paramedicine is the key to outcome, and outcomes based data should be collected to support an integrated EMS model of pre and post hospital care.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Training
Obstacles have increased in hours, cost and travel but registration for classes has been fairly level. More options for a career, but low wages and part-time work still a concern/deterrent. EMS programs are difficult to provide online as so much of the work is practical, hands on. The National EMS certification program is pretty structured and comprehensive but Pennsylvania allows a lot of flexibility between regions. There should be a statewide course, and a statewide standard. There is also a need for dedicated public funding of safety programs, which was discontinued in 2005 caused cost to increase. Additional funding would help cover course costs and textbooks, and allow community colleges to reduce class costs and keep modern equipment and up-to-date teaching materials.
Pennsylvania certification needs to be grandfathered in. National Accreditation of training will drive people out of the system.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Training
Rural, volunteer EMS personnel need to have access to training, and the potential barriers of increased credit hours for certification, testing locations, increased cost and travel distance. Need to promote more involvement, not less.
System is still evolving as is evidence by growing pains with National Testing standards.
Inconsistencies between regional training need to be addressed as under both state and national standards there is some flexibility to the number of credit hour "add-ons" that are taught. Each region can contract for those training hours with an institution, making programs different lengths per region.
State funding for community colleges has shrunk, specific public safety monies used to provide reimbursements for practical training aids, materials and textbooks, which have increased costs passed on to students. Travel is never too much of an issue and numerous NEMSIS testing locations will be available in each region. Some rural areas may have longer commutes as they do now but not much of a concern for one-time testing.
Overall, the national registry requirement will be good for all students, full time and volunteers. Some volunteer organizations may struggle to reimburse for increased costs and time may be a deterrent for volunteer services. Inconsistency between regions in oversight of instructors, training requirements and planning for changes to national accreditation. The Bureau should assume direct oversight of education and not delegate to the regions. The Bureau needs to provide better quality assurance.
Regions can currently accredit themselves as training institutes, but most use another region to accredit them.
Barriers to EMS include increased hours required, increased costs to courses and distance to training. Pay is poor, hours are long and EMT's and Paramedics often work multiple part-time jobs. Some go to neighboring states for better pay. Distance learning is difficult to offer with so much practical work. Blended programs may help, by combining labs with other programs like police or fire to reduce costs and travel.
Give regions more flexibility under EMSOF to purchase text books, provide scholarships and reimburse for exam costs rather than give provider grants. This is all system improvement.
Biggest concern is manpower, recruiting and retention. Increased training requirements will drive some people away and drive volunteer services out.
EMS is heading to a full time industry. There is no fix for the volunteer shortage. They help services retain a community feel/connection but you need higher volumes as a service to survive and when you have a higher call volume, volunteers become less important.
The move to the National Curriculum is a good thing for Pennsylvania.
Training for EMS continuing education has always been available within the region/county and National Registry is a good step.
Quality vs. quantity of education is key and a state educational reimbursement is needed.
Regions decide who offers classes and it is not a free market. Current flow of money from Department to regions to providers should be changed to allow direct reimbursements/incentives to students.
The training barrier that presents the most concern is cost, but we are a big believer in in more professionalism presented by move to national training standards.
Recruiting and Retention is a challenge with the pay scale. The professionalization of EMS is a good thing, but it is a calling, people want to help others and the more training and cost plus low pay and long work hours makes it less attractive compared to other fields.
Collaborative training with fire departments QRS services, who have EMT's on trucks will benefit the services and reduce costs.
Biggest challenge is that reimbursements do no keep pace with new technology. EMS going to national training standards is a great thing to keep PA pushing the front of expectations and standards.

FEEDBACK FROM INTERVIEWS WITH PROVIDERS
Training
National standards have the potential to siphon some EMTs into a higher profession like PA, LPN or RN if the number of credit hours and cost increase. Why not go for the higher degree?
Regions should focus on inspections and enforcement and let the private sector steer training.
Higher training standards are aimed at pushing higher quality but training requirements and staffing levels create barriers that will push people away.

Comments in this section are organized by topic, with names of organizations redacted to guard the identity of the unfiltered comments about all aspects of the EMS system. Topics of discussion are organized into the most prominent areas of feedback, which included Structure, Funding, Operations and Training. Each comment came from a meeting listed Appendix F the *Index of Meetings and Interviews* under the following headings: "Pennsylvania Department of Health," "Regional Emergency medical Services Councils," and "Pennsylvania Emergency Health Services Council." These comments reflect the most relevant dialogue regarding topics addressed in House Resolution 315.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Structure
Most important to be an advocate for the provider, help articulate to outsiders the needs and role of EMS. Regions are the link between providers and PA DOH, PADOH and the providers. Need to be customer service oriented, consumer friendly.
Need to blend global and local level, make them work cooperatively. Change from lead agencies at local and county level to PADOH being lead. PADOH has had good, strong leadership and encourages regions and providers to be proactive, look ahead, and stay ahead of curve.
Existing system structure is good and works well but there are conflicts of interest with providers on regional boards.
County organization greatly benefits the Council, in-kind services. EMS is integrated with 911 and other County public safety functions
PADOH should delegate enforcement to the regions so they can act to suspend immediately. Current process is cumbersome where Regions recommend action to the department and responses are often sluggish. Recently allowed to take out of service temporarily, which is a good step. Biggest challenge is training and manpower. Students have a difficulty absorbing the cost, and services cannot afford to subsidize them. Regional initiatives key to focusing on system improvements. Direct pay legislation would also help funding issues.
Regions need restructured as there are too many of them. Need a balance between keeping an area that is manageable and not look at administrative boundaries but numbers, demographics, who works together, mutual aid networks, flow of patient care, etc. EMS does not like change, for self-preservation, timidity and loss of identity. People are used to the system that has been in place but not convinced that is the best one. Could restructure regions and fold training, inspections and licensure into Regional Health Offices. Biggest gap will be in training and coordination of services.
Regions are good at passing information along but the Department does not provide frequent RC Memos or Informational Bulletins. Services need to ask for better information at stakeholders meetings.
PEHSC has almost all independent advisors and they are driving the issues for their own agendas. They are not responsive to PADOH or to the regions.
EMS is not a one size fits all system. PADOH needs to provide clear direction and objectives to the regions and let the regions have flexibility to accomplish them. EMS regions should not be operational,

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Structure
but regulatory. Funding streams should be sorted out and made more consistent. Needs to be better coordination with PEMA. Strike Teams are a disaster waiting to happen as very different purposes and equipment needs for in-state and out of state deployments.
EMS should be in public safety not PADOH, as preparedness is the key to the system.
County based system works well with lots of integration between services. Even though counties are not required to fund EMS, advantages exist in the communication with emergency management and 911.
Biggest change in the last 20-30 years is the migration away from volunteers to the full-time professionalism of EMS.
The future is consolidation and regionalization of EMS not of hospital systems but around them and patient flow, from EMS, community projects, 911 critical care specialties, medical command and public health preparedness.
Great difference between urban and rural EMS. PADOH needs to consider the impact statewide. Combining regions without evaluation will have totally different impacts.
PEHSC is only as good as its recommendations, not very responsive and poor coordination of committees. Must be a better process to review changes and protocols.
Regional concept is good, get more face to face time with local services but the local support for the regions is not always there. Providers are given opportunities but do not always participate.
Regional changes are needed and matching them with Health Districts or Task Forces make sense as already have overlapping tasks and partner on each other's committees.
Regions need smart change, right sized, and balanced on land area and number of providers. There are a lot of pluses to integration of county 911centers, emergency management, and health departments.
Regions need to be right-sized, increase efficiency and effectiveness…need a SWOT analysis. EMS should not be integrated with PEMA, it is unorganized and dysfunctional. Health regions are not a useable option as they do not have enough continuity with current EMMS regions and have different purposes.
Biggest system change that's needed is reducing and restricting the regional system. EMS needs to manage its assets better and so does the state. Regions need more cooperation and the same cooperation that is needed amongst providers.
State plan is a huge waste of time, doesn't work for providers who are clueless and hasn't had an impact for years. Plus, national standards make it unnecessary. Not even reviewed by PADOH, just boiler plate from year to year.
Regions are unique, a quasi-regulatory body and advocate which sometimes causes tension between the regions and services. They have regulatory responsibility but no authority to make rulings, and functions as the eyes and ears of the PADOH on the local, customer service level. Regions are problem solvers, the first line of contact, but sometimes need to kick things up to PADOH.
PEHSC gets very far afield from its purpose of weighing in on topics for the PADOH, and for vetting topics. They are lobbyists, representing interests, and creates a great disconnect between them and PADOH.
If there were no regional boards there would be no ownership of the process, and the market would be dominated by services competing for business, self-serving providers and conflicts of interest. Regions can help break through that, form partnerships and get things done as they don't have a narrow view.
LTS is a very good region, with active providers, helpful regional staff, and the county/region collaboration has brought people together, helped facility mergers and bridged the gap between urban and rural districts.
Change is not always better, and some change is just for the sake of change. Pennsylvania is a very diverse state and not a one size fits all solution will solve its problems.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Structure
The PADOH has a tendency to play favorites when they distribute monies to regions for health preparedness, planning and strike teams, and when they assign training and deployment leaders.
PEHSC needs more focused meetings, need to set agendas aside and work as a team. They should focus on protocols and treatments. State plan needs measurable objectives, reasonable goals and a quality evaluation.
Regions should be clearing houses for system improvement and best practices. Need a good flow of information to providers and to build relationships. Regions also need more standardization and direction in distribution of EMSOF monies for specific equipment or regional initiatives.
Staff collaborations between regions can be increased.
PEHSC and regional committees are redundant.
System has grown from transportation to treatment and more interface with physicians.
Connection from PADOH to regions to PEHSC needs to be more formal. PEHSC system recommendations and benchmarks need to be built into the state plan to make it a more strategic document with goals easily disseminated to the regions. Regions look at EMS from the consumer perspective, always looking to improve through training and to consider the health and safety of providers as well.
Need more standardization between regions in committees, flow of information to and from PADOH, bylaws and council composition, trip sheet software, EMSOF distribution framework, and facilitating collaborations and regionalization of services.
PEHSC too detailed, gets bogged down with minutia.
Need to constantly focus on what we can do to make the system better. Collaborative projects and community paramedicine are the keys to the future.
PEHSC MAC committee works well to get physician input, and create a flow from local to statewide to produce feedback and dialogue on issues.
The four "C's" are essential to success…Communication, Cooperation, Collaboration, Consolidation.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Funding
Volunteers are waning, too many services are struggling to recruit volunteers. Funding is an issue but so is planning. Volunteer and municipal companies want to serve steak but are being paid for hamburgers.
For-profit companies have changed the face of EMS. No providers pay for inspections, and can be inspected as many times as it takes to be licensed. This takes resources away from regions, and increases time at one location. Separate emergency systems from transports as latter has no cost for readiness or funding challenges as know what costs/reimbursement will be.
EMSOF $ should be used for regional initiatives, biggest bang for buck. Training to national standards is a good thing and shifting EMS to a career path is good. Need a statewide data initiative, data set the same but not software.
Will continue to see consolidation of services due to finances and competition for staffing and personnel. Services resist as want to retain their identity, but that holds communities back from having better care.
Services do not/would not miss EMSOF monies if they went away tomorrow as there is so little to go around. Many services are not profitable and look to the regions for training, planning, etc. An increase in dollars would allow for bigger regional initiatives and quality improvement projects.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Funding
Biggest challenge for EMS is financing at provider level. Very few businessmen, business models, and EMS is moving to paid staffing due to demand for services. Have supported mergers by working with DCED and engaging services that want to merge.
For fire based services, EMS are money generators. Rural delivery of services is going to be different from urban.
Most services would not miss EMSOF if it went away as so few dollars for to the. Funding from the state needs to be more consistent. Per capita costs, a fee on vehicle registrations or licensing would help that. Direct pay would help services get insurance monies. There should also be some type of license or inspection fee for each ambulance at a service.
Biggest challenge in EMS is funding. Need to close the reimbursement gap between costs and reimbursement. The PADOH needs a statewide structure to EMSOF distribution as it appears willy-nilly. Regions need more standardization as some do regional initiatives, like bulk purchasing of supplies, while others do none.
PADOH needs a more equitable funding formula, like populations based and workloads and rural enhancement should be eliminated. System wide initiatives and injecting quality $ into the system and eliminating unfunded mandates.
Funding is critical. EMS needs to treat itself as a business, not a community service, direct pay legislation would help, and raising the reimbursements for EMS services and establishing a volunteer assessment are crucial.
Regions do what providers cannot do for themselves. Regional realignment is a solution in search of a problem. Funding problems will not go away, and EMS needs to be smart at managing its assets and utilizing its resources. Overcoming the current community minded thinking to regionalization will not be easy. Facilitating collaborations, increased planning between services to cover areas, days or crews, financial need and equipment maintenance can be done without regionalization.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Operations
Focus on Quality and readiness as workload and protocols have changed.
Benefit – medical command authorization process, provider involvement in regions, partnerships with services and other agencies. Regions are regulators, advocates, grant distributors and the local voice of EMS.
EMS is its own worst enemy when compete against each other. Needs to be some consolidation to be efficient as financial needs drive the business. Response times are a concern but should be a part of any merger discussion as coverage area expands. EMS has no clear advocate.
Certificate of need would help control fraud and set a criteria for licensure before given a provisional license. There is no consistency within regions or Bureau for decision making.
Strike Teams need standardization of deployment, reimbursements, and planning. Everyone is tied to a single level of preparedness but PADOH does not distribute funding equally between urban and rural regions so resource suffer. There is also a great dichotomy between some regions and their counter terrorism task forces, and monies and coordination are difficult to manage. Working relationships are generally good between EMS and Task Forces.
There will always be the need for a regional presence but their roles can change. Need to build networks with EMS's and Task Forces. Is a good Task Force subcommittee on EMS in the southeast?
DOH sends a mixed message as want to upgrade ALS service but create barriers to enter the industry.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Operations
Biggest problem areas are for-profit transport services in the Philly suburbs. PADOH is slow to respond to revocation recommendations by regions, and are allowed an unlimited number of re-inspections.
Regions work well with Emergency Management, 911, Task Forces and Strike Teams.
Community paramedicine is the future of EMS, along with prevention and public education.
Regions role is in service to the community, should be community boards, making sure there is a quality system, to advocate for the public to protect them. It is the role of PEHSC and the Associations to advocate. Need to build more cooperation among providers and develop better operational leadership.
Regions most important role is to facilitate partnerships, collaborations, coordination and strategic planning. There needs to be a standardized flow of information to services and more consistency. PADOH can do a better job with data, and there is a need for a state program, a state model for data.
EMS has been its own worst enemy, not all services participate in regional activities, there is no coordination like fire at the County level, and regions cannot do it well…there needs to be a will.
New state staffing requirements have EMT's and Paramedics competing against each other to treat patients, and there is a lack of critical, on the job thinking in ALS calls where EMT's only get to practice on scene.
Consistency is the key, and both PADOH and regions need to know who has responsibility for what, what the expectations are, and that provisions in the contracts are fulfilled. Multi-county regions need to operate at more of a corporate model versus single county regions that are government run. Single counties create tension of who is your boss, and can they serve multiple masters?
PADOH is asking a lot of its volunteers. Feels the state is trying to push volunteers out in favor of all paid services. Volunteers are closer to the communities and usually closer, geographically, to rural communities that are under served and under staffed.
EMS Committee at North Central Task Force integrates EMS into decision making and planning, but different areas have very different ways of thinking. Changes to LTS could destroy something very good. If regions are too large, geographically and in terms of providers, will be difficult to manage. A great example of a multi-county partnership with equal representation, and able to bring county based services to bear.
Always looking at a quality improvement and quality assurance. There is a big trust issue with providers and services. Need a buy-in, and recognition of need. Success equals a state, regional partnership. Regional duplication of services, consolidation of services and alliances are key and there is a great need to look at benchmarks and outcome data. PADOH needs to do a better job of getting data to regions and providers, and the number one priority to communicate with and get information is not always met. Bureau needs to take ownership of issues.
System has grown from transportation to treatment and more interface with physicians.
Regions should help service complement each other and work together, not compete, to fill the gaps in coverage and form partnerships. They should not be operational units, just licensing entities. Operations are not the regions role and if you want to run calls you should be with a provider.
Regions offer more consistency than task forces who have only contractors and no full-time employees. State health regions do not match and has never been a problem but the South-Central/Federation with matching regions is ideal. The system has worked but forces around it, politically, and fiscally are changing but why change now?
All incidents begin at the local level and if counties can't fill them in emergency management they look to the state and then the federal government. Strike Teams help to fill a void of EMS in emergency management.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Operations
Possibilities exist in EMT/Paramedic collaboration to lease or share crews. A lot of people resist change, and PA has given its fire and EMS a lot of autonomy they don't want to lose. Need to separate fire and EMS. Volunteer departments shoot themselves in the foot by resisting any change.
EMS needs an advocate at the state level to succeed, but its day to day advocate at the local level is the regions.
PADOH collects too many data elements and it should be quality over quantity.
No matter what the reason, if someone calls 911 they want a timely response, with quality personnel who will help solve their problem.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Training
As costs have risen providers cannot cover cost of student education, Very redundant of state to roll out national standards without having a plan to recruit and retain. National standards are the right way to go but concerns exist with recruiting new members and asking them to overcome obstacles of possibly longer distance to travel, longer training and higher cost.
People in EMS are good folks, are there because they want to be, it's a service, a calling, especially for volunteers. As we move towards higher standards for training and increased protocols and staffing requirements we're driving them away.
The volunteer system is all but dead as call volume drives to full-time. Volunteer services just cannot compete with recruitment and retention of providers with all the training requirements it's more about employment and somewhat less about service. Volunteers are aging and there is more completion for less new trainees. Services require more of a business model to be successful.
EMMCO East is the only county without a training institute within its region. They contract with Bucks County for training. No issue with continuing education as instructors need to be certified by regions and at least 15 programs. Looking to get programs in high schools and reach students through health curriculums.
Have concerns with roll-out of new, required Pierson View testing centers for National Standards. Really going to hurt smaller services, as providers are facing a diluted talent field. If costs go up, and time for classes and travel increase how many obstacles can students be expected to overcome?
EMS in northwest PA is experiencing extreme stresses in the system, volunteers are as a premium and paid services have seen a great increase in transfers from community hospitals to larger metropolitan hospitals.
Biggest concern is manpower. EMS is an aging industry that is physically demanding to move patients and provide treatment.
Biggest challenge is recruitment and retention. Feels national standards are good but smaller departments are already struggling, required levels make staffing crews difficult. Will lose community connections but better serve area. Growing pains of change are always difficult but strategic thinking will help planning to serve regions, fund system and service partnerships on things like Strike Teams.
If we're going to push paramedics into national standards with more training, scope of practice should be advanced, retraining pushed, and funding increased to help make the system more professional.
New national standards are good but testing in rural areas is a concern. A hybrid testing site between regions should be explored. Online learning is not possible as 65percent is practical and 35percent written towards exams.

FEEDBACK FROM INTERVIEWS WITH PADOH AND REGIONAL COUNCILS
Operations
Pennsylvania keeping pace with national EMS standards is good, but the costs of accreditation for institutions to get instructors will be a hidden cost, as will costs to students and services that support them. Raising the bar will mean higher quality providers, but the pool will be smaller.

In conjunction with the Commission, the Ambulance Association of Pennsylvania conducted a ten question survey of their membership. The survey was online, via Survey Monkey, and was anonymous. The questions were developed by the Commission, and focused on the topics listed in HR315. The survey was completed in September 2012, and was sent to all 204 members of licensed EMS agencies who are active members of the Ambulance Association. In total, 63 unique responses were received, and a representative selection of those comments is presented below.

FEEDBACK FROM AMBULANCE ASSOCIATION SURVEY
Question #1 - What is your opinion on the role and the effectiveness of the overall structure and organization of the Regional councils in the Commonwealth?
Their role should be to assist the squads in getting emergency services to the citizens within the Commonwealth. I am not sure they are doing this to the best of their ability. A standard of quality, via the DOH regulations should be realistic for the times of limited funding, and they are not. The overall structure is not the same in all councils.
Many times the councils have their own ideas and agendas.
Seems good but some appear more effective than others. Do we need so many, or would we consolidation be an effective alternative?
The Regional system is a holdover from a bygone era spurred by people who want to preserve their jobs and/or not release actual or perceived "power."
Consistent duplication of services is needed. Policies and procedures vary from council to council, no standardization of policy, procedures, forms or requirements.
The current regional system works well and is better able to handle issues at the local level.
The current system is effective, pro-active and there is attention to detail. With a larger/regionalized system I feel the attention to detail will be lost due to influx of the workload.
The structure seems somewhat outdated or haphazard. The multiple single county regions in the Southeast corner of the state could be combined into one without Philadelphia City/County.
By combining Bucks with 3 other major areas Philadelphia, Montgomery and Chester will lose their identity with the big group.
We have too many Regional councils to be effective.
The regional councils are useless as advocacy/coordinating/planning organizations. The PADOH shifts the cost of providing regulatory activities to the regional councils at the expense of the other activities that the regional councils should be doing.
Each region differs. Some are lean and efficient; others are too involved in trying to operate the region.
Regional councils should be more involved in a leadership role--encouraging mergers, addressing reimbursement challenges and holding subpar services accountable.
The Regional councils fulfill the roles of EMS system regulator as well as EMS disaster planner, coordinator, and responder at the state level. There is nowhere in state government where this could be accomplished for 11.8 million dollars per year. The efficiency is tremendous.

Regional councils should be eliminated and that the work should be moved to Three Offices run by the Commonwealth: one in the East, one Central and one West.
Regions have too much emphasis on strikes teams, medical reserve corp, etc... not enough emphasis on EMS and helping providers resolve problems. They are ineffective and won't or can't do anything about the problem EMS crews/personnel to resolve it. Regions should be all about EMS PERIOD!
Structure of the Regional Council is good. The quantity of them is too great. Would be far better if the number of them was reduced.
Their structure is duplicative of other agencies roles and they are becoming their own kingdoms.
Question #2 - What is your opinion on the role and the effectiveness of the Regional councils at the local level?
The role of the council should be to provide support to the EMS agencies, they need to provide consistent recommendations to all services, be fair and equal to both paid for profit and volunteer providers.
Regional councils have developed an operational arm which wastes resources and is duplicative. Various employees of the Regional Council work for EMS services within the region and there are obvious signs of favoritism toward these services. Licensure has become an exercise in absurdity.
NO CONSISTENCY with Regional councils.
The regional councils tout that they are a quasigovernment, an agent of the state; regional councils often ignore county EMA directives and efforts and set duplicative systems. When the PA DOH balks at what regional councils do, the regional councils claim they are independent and unless the DOH contract with the regional council specifically prohibits actions, the regional council can do whatever they want. The EMS agencies have difficulty trying to delineate what is state policy versus unauthorized “quirks” of the regional council. Those regional councils also receive hundreds of thousands of dollars annually, ARE NOT subject to the “PA Right to Know Law” and because the regional councils are deemed "sole source contractors,” those regional council contracts NEVER go out to bid.
Timely and professional staff that assist us with questions, training, equipment.
The regional council at the local level is a great system. The responsiveness is fast and better able to work well with the local providers.
Our regional office is out of touch and very inactive. They are governed by non EMS people who really have no interest in EMS unless there is an issue that can affect the governing body.
Councils functions very effectively and serve many roles within the Commonwealth. The training, accreditation, and oversight that these regional councils provide is imperative in maintaining the professionalism of our industry.
Our region is too large, costs our county too much to operate and is forever trying to enforce unfunded mandates that cost us more than other methods (MEDCOM).
Our regional council has no consistency or advocacy for our many struggles. They concern themselves more with arbitrary or distracting activities than addressing the real issues!
The role should be information sharing and working to provide resources and support from the state and federal agencies with which they interact - I believe that the regional council system is VERY ineffective and wastes a lot of money - due to tremendous inconsistency from council to council.
The regional council does not communicate nearly well enough with local EMS organizations. The little correspondence that we do receive seems to be about things that are not nearly as crucial as with what they could be concerned.
Each region is different. The regional council has to know and understand the individual issues and problems at the local level. The City of Philadelphia and a rural community in central PA may share some common problems, but they will also have some problems that are very different. The regional councils will hopefully understand the individual differences/problems. Lumping dissimilar areas into one regional council will not be successful.
Regional consolidation would be a better use of available resources.

Regional councils are definitely needed and can be very effective if governed correctly. There are issues that occur that need to be addressed and each service needs to be accountable for EMS to progress into a professional entity. Although the number of councils needs to be reduce their size needs the ability to be intimately involved in each services practices.
Some councils are extremely effective, but not as effective as they could be. It needs to be determined why their primary function should be, and what secondary functions they should be permitted to engage in.
EMS councils are structured poorly. They are largely self-serving and are developing into a cottage industry of their own. They lost focus of their mission to support the local EMS systems development and take more than they give. They should not have a role in the communications business, it should be the state. PEMA should be the oversight and have a Board made up of innovative service leaders that eliminates the council layer so more funds flow directly to the services.
Question #3 - What do you feel is the greatest obstacle to providing EMS in Pennsylvania?
Adequately funding to be able to provide the quality service necessary to saving and extending life. Funding is not only for the immediate costs but also for replacement of equipment and the retention of quality EMTs and paramedics. You get what you pay for.
Technology has advanced to allow tools to help us perform our tasks, some of these tools are required, as they should be. Unfortunately, they are always unfunded requirements. If technology exists to save a life, and the state approves such a method or device, it should be funded. We need to attract more providers, this will never happen until EMS is properly funded and providers are paid a fair wage.
Paperwork…Trip Sheets are way too long, drawn out and slow down the unit in getting back into service. The Trip Sheet needs to be simplified and we need to go back to work.
Regional councils promote chaos and inconsistency in EMS operations, policy & procedures.
TOO MANY RULES & REGULATIONS. TOO LITTLE REIMBURSEMENT. Trying to make EMTs into a profession by raising the hours of training in 2013 is going to kill off our volunteers. Volunteers are our first line of defense for Homeland Security.
Lack of recognition is a major obstacle.
Marginal funding, struggle to break even most years resulting in poor wages for staff members.
Lack of standardization. Despite statewide protocols there is still great variance in care and the quality of care across the Commonwealth.
The manner in which EMS is funded is the greatest obstacle to providing quality EMS. Funding should be a combination of preparedness-based (tax supported) and reimbursement-based.
Lack of funding from both local and state governments and inadequate reimbursement from Medicare and Medicaid. What other business in the state is told they can only bill a certain amount for services and are forced to write off the rest? Costs exceed the point of reimbursement.
Inconstant direction coming out of Harrisburg.
Inconsistency and lack of dependability in the regional council system.
Lack of knowledge and little innovation. Regionalization of services is a must.
Lack of reimbursement, lack of identity, now with the new paramedic training and cost, we will be faced with what is already a paramedic shortage.
Lack of support and recognition for EMS deciding what is best for EMS. Volunteer fire chiefs and politics are the biggest hindrance to effective EMS.
Municipal boarders and egos that impede coordinated EMS response plans, and payment methodologies. Medicaid has to be addressed, or it will cripple our system.
Question #4 - What is the biggest issue that is an impediment to the delivery of EMS and explain why?

a. Bureaucracy – 65.1%
Local municipalities do not take ownership, ignore EMS.
The state should decentralize control because the state population is so diverse.
DOH fails to advocate for the EMS system when it comes to funding. It seems to be a forbidden topic, they create the rules and mandates but no support in obtaining the funding to implement. EMSOF provider funding is promised but non-existent in reality.
Too many layers, duplicating efforts
Lack of consistency across the state, too much bureaucracy, too many conflicting regulations on the state level. The confusion with the PUC and DOH over who regulates wheelchair vans is a perfect example.
Government continues to ask more from the system with no additional financial help to get their goals accomplished.
Too many positions which reduces the funding. Not getting out into the field and talking to people who are doing this everyday
The provider has little over all say it what or how EMS is delivered.
Over regulation, requiring more and more standards that kill the small volunteer.
Councils need to spend less time on things that have no positive impact on day to day EMS delivery. Lots of chiefs doing all kinds of things, but something as simple as licensure can turn into a debacle.
a. Funding – 87.3%
We are losing the ability to purchase new vehicles, our building is falling apart, and we can't pay our employees what they are worth. Health insurance costs are killing us.
Funds are scarce. Put the money where it will have a real impact, such as developing shared resources and EMSOF.
Fire companies are placed at the top of the grant funding tree while EMS is allocated a mere portion of the total funds. Educating the public & lawmakers that reimbursements DON'T pay the bills is imperative to the survival of EMS.
We are constantly expected to do more with less.
Insurers including government plans do not pay enough to provide EMS workers a living wage.
Adequate payment for services rendered, allowing the EMS agency to improve services, staff skill levels, updated equipment, etc. without needing hand-out tax payer grant money to do it.
From the regional offices through EMSOF is rarely used because the inability to match funds.
Monies across state should be competitive for projects for the services. Some regions receive minimal monies to fund projects making it impossible for a lot of rural areas to propose large projects.
Direct billing is the biggest part of funding. Direct pay legislation is needed!
If I didn't need to constantly focus on worrying about income, we would be available to improve equipment, training, to provide a living wage.
b. Training – 55.6%
It was necessary at the beginning to ESTBALISH an EMS training administration system because PA higher-ed institutions could not or would not provide training, and/or could not deliver the training where need. Now the Higher-Ed schools CAN provide such and there is NOW no need to have a duplicate education management system. The PA DOH does not have state certified Medical School Instructors or state certified Nursing School instructors—so why do we have to have state certified EMS instructors regulated by the PA DOH? Now higher-ed groups can and will provide the training. This duplication eats up too much money.
Many times training event are held during the week 8am to 5 pm, the same hours many first responders work, this greatly limits the ability to get training.
Plenty of great opportunities available.
I think training goes hand and hand with the funding…Limited training due to limited budgets.
No funding to pay for training or to pay the employee's to attend.
My region has an excellent opportunity for training and continuing education with the support of our EHS office.

Training needs to be standardized. We receive paramedic students from one college who are not ever allowed to intubate in the field under supervision while other programs promote it.
Fragmented, inadequate depending on area, needs to be a national standard, performance based system. Quality of BLS students is poor requiring employers to absorb excessive costs to retrain after graduation.
Too expensive, too long, and no way to pique the interest of potential students.
With the educational standards we have seen a lower number of people willing to get into EMS. We have mixed feeling about this topic and believe it goes back to how providers are treated. We need additional funding to get wages & benefits increased. It is sad because we have been told by applicants that they can get a job at the local shopping mall making more than what they could as an EMT.
Training is only a problem for volunteers who don't wish to commit to meeting the needs of the public. People who are being paid to do a job do not complain about training requirements. Technology and advancements in EMS have evolved the business into a healthcare profession rather than a poorly trained "call and haul ambulance" as was decades ago. Our communities demand high levels of trained EMS providers who directly affect their survivability and outcomes. Those who are committed to their communities and this profession do not have a problem with training requirements.
c. Other – 28.6%
Regional Council employees should work for or volunteer with MANY EMS agencies, not just one. There is obvious favoritism going on. Furthermore, by spending time at other agencies they will identifiscal year good practices as well as potential problem areas which can be addressed in a non-confrontational manner.
Too many companies in the commonwealth. I am all about capitalism, but at the same point in time, I am against the amount of companies that are allowed to exist in the capacity that they exist. That is why there have been several companies around the state going out of service in the past few years.
Reimbursement for Medical Assistance patients is grossly inadequate and costs EMS services to provide. How are we to replace/repair equipment when there is no profit to do so?
Lack of personnel. People simply cannot give up their time for volunteer activities in this economy, nor can they live on an EMS wage.
Poorly operated/managed ambulance services, poorly trained EMTs and Paramedics. They constantly shoot themselves in the foot and make the industry look bad to the public, payers, and elected officials.
PADOH in order to keep Regional councils alive and well opted to ELIMINATE funding for training/certification exams and turned over the exams to the National Registry, a private agency with NO direct input or accountability from PADOH. The state says it wants to use the National Registry so people can work in other states but Virginia calls Maryland and Pennsylvania its training academies.
Question #5 - What changes, in your opinion, would MOST benefit the EMS System in Pennsylvania?
More funds will allow providers to put more money into our system and make it better. The status quo makes moving forward/get better/ more staffing/better equipment is unobtainable at this time.
Keep raising standards and expectations in order to raise the level of professionalism and quality in the EMS field.
Remove regional EMS councils; functions that need to be carried locally on a regular basis can be integrated with public health administration activities within the current DOH administrative districts. Set up a system whereby students can get loans from PHEAA for EMT and Paramedic training and if those students provide service to Pennsylvania for some period of time, then those loans are forgiven via transfer dollars from the EMS OP fund.
Assure that state EMS OP monies are not used to subsidize the costs of other Public Health endeavors. For example disaster equipment purchased by HRSA federal grants should be maintained and housed via costs from the PA DOH Public and Preparedness and NOT the EMSOP fund. If PA DOH cannot fund maintenance, housing and replacement of equipment and vehicles purchased with the millions of

dollars given through federal HRSA grants; then PA DOH needs to turn those "emergency/disaster assets over to PEMA. PA DOH gave this money to Regional EMS councils knowing damn well that there was no money forthcoming to maintain it after the initial purchases.
Direct pay legislation, allowing providers to collect from Insurance carriers rather than paying the patient direct. Increase in funding assistance. Recognition of EMS.
Eliminate the councils and make regional divisions under BEMS with satellite offices.
More reliable revenue streams. New state medical direction. Better outside the box revenue thinking.
Better municipal, state and federal support. Better funding, reimbursement and higher pay.
Consistent format and direction coming from Harrisburg. Consolidation of Regions and consistency between councils. Focus on Results.
Improve funding stream. If we were able to pay a competitive wage, we could attract a better quality and higher educated staff, which would reduce turnover and provide better patient care.
The EMS system would benefit from a separation of the regulatory functions from the coordinating/planning functions of the regional councils. Regulatory activities should be performed by the government regulator (DOH) and the regional councils should prove their worth as coordinating/planning entities by having to be partially self-supporting.
Require local government to be responsible for providing EMS services TO THE SAME EXTENT they must provide fire and police services.
Most EMS in PA is provided by small, independent organizations. Many of these organizations have existed for years and have not changed to keep up with the present trends in the healthcare field. They struggle financially to try to serve a small jurisdiction. Pride often gets in the way of smart business decisions. Consolidating services, appropriate levels of funding, and managing them professionally would increase the level of care while helping to reduce costs by eliminating unnecessary duplication of services in each little municipality.
A better understanding of the overall EMS system beginning at the local level by elected oficials and then educate more globally.
Structure EMS as County run and funded services. The volunteer system is archaic at best. They are very territorial and narrow minded. They do not see the broad picture of EMS and that is has to be a systemized approach. Volunteer services eat at the revenues needed for paid services to survive.
Question #6 - In your experience, where is the weakest link in the funding of the EMS System?
Other than billing a patient, there is no tax base funding for most service. EMSOF is also very inadequate. Weakest link is probably at the insurance (payer) level.
Direct billing would be the best advantage that EMS would have at its disposal. As it stands, too much money is spent attempting to get money that is sent to the patients instead of the respective services.
EMS should be placed under the direction of PEMA, NOT the Dept of Health. We are not doctor offices, hospitals, or clinics. We are EMERGENCY SERVICES. Much needed funding is diverted to PEMA where Fire Companies have greater access to the funds. Money provided to the DOH seems to trickle into the preventative community services (HIV, Pregnancy, etc) and NOT to EMS.
The tax payers pay little for the EMS System compared to other state funded programs. The general money that comes to EMS is through EMSOF funding which is not tax based.
The Bureau needs to look out for the financial welfare of EMS services in general. When we are losing so many vol. EMS services due to financial reasons, one would think the Bureau would find out why and help fix the problem. We need an advocate in Hbg.
Tax based support is the ultimate source that will keep EMS alive but local government are ignorant to EMS, the needs of the community. Poor leadership and management of EMS agencies have also hurt this process.
The insurance industries failure to pay fair value for services.
Insurance reimbursement and differentiation between Fire and EMS. Limited grant availability for EMS.

Consistency is needed across the regions. Too much money is being taken out for administration.
Poor recognition in the community as a health profession and the myriad of regulations imposed in the tax code and insurance regulations, which cause improper funding and increased costs to the system. The EMS services have very little control over what they will be paid for providing an essential service to their communities.
EMS is a municipal service and all local governments are required to assure its provision yet no responsibility for financing the system falls on the municipalities. Local government must be forced to help cover the costs of providing EMS as fee for service payments are disappearing rapidly.
The weakest link is at the municipal level, failing to recognize the benefit of EMS and those who provide the service.
Question #7 - What is your biggest challenge from a fee-for service perspective?
Getting payment... Insurance co-pays the patient and the patient doesn't pay the EMS service.... Not getting paid enough for services rendered to cover the cost of readiness!!!... 24/7 readiness and quick response times are what the citizens deserve; however, no one wants to help cover the cost.
You live and die by your payer mix.
Non-transports from treat and release situations. Lack of payment from uninsured, low Medicare and Medicaid reimbursement rates.
If EMS agencies could have the EMSOF fund pay for licensure costs, if the 75percent of EMSOP funds to go to “direct” funding of EMS agencies were truly available for EMS. If there is a notion to keep 9 million dollars to fund the current bumbling bureaucracy and ALSO charge for licensure costs then there is a major public accountability problem. However some fees to assure that any licensure/certification could minimize wasted time on people who don’t follow through on application.
Lack of direct pay legislation.
Finding, reimbursements and ever changing Medicare and insurance regulations.
Reimbursements need to actually cover costs.
Denials of payment for services actually provided. Insurers can deny payment, but EMS can't deny the provision of services, especially 911 responses.
Poor reimbursement which will lead to service closures and gaps in coverage statewide.
The cost of readiness to respond is not accounted for in the fee-for-service model.
Getting payment directly from the insurers. They continue to want us to enter into contractual relationships with them that offer such ridiculously low reimbursement, that it would cost us money to enter a contractual relationship. Since we are not contracted providers, the insurers pay the patients directly and the patients often do not forward their payment to us. This payment structure is costing PA EMS organizations millions of dollars a year.
Reimbursement from Medicare/Medicaid and now commercial insurance does not even come close to covering the cost of equipment/medications/salary but EMS is not allowed to refuse to respond. Why can these companies and patients refuse to pay?
EVERYONE thinks EMS is a free service. Education is very poor to the general public....they are told dial 9-1-1 and someone will come.
Shrinking federal and state funding mechanisms. Lack of tax subsidy (which should be linked to performance) across the Board keeping the system from being clinically excellent and innovative. Lastly, continued fragmentation of the EMS system (too many small ineffective services) and increased "for profit" services entry into the market.
Harder and harder to get what little reimbursement we get and the different insurance companies require us to get all of this information and signatures, but don't bother informing the doctors, facilities, etc., so we are left trying to educate and fight for this information.
Question #8 - What is your biggest challenge from a bureaucratic perspective?

The legislature needs to understand the importance of EMS in the public safety of residents. Until a medical emergency affects someone close to them, there is no sense of urgency to assist EMS.
The State makes rules with literally no input from street level services. Unfunded mandates such as IV pumps cost services dearly.
State & Federal Bureaucrats have made too many unfunded mandates and its killing off our volunteer EMS.
Creation of policy without input or dialogue, or having input but being ignored. EMS has no single perfect delivery model therefore DOH is trying to create rules statewide to fit everyone from Philly to very rural north central tier Pa. Impossible to accomplish unless we mandate one delivery model, i.e.; all career, regionalized agencies, professionally managed.
Provincial and Parochial attitudes is keeping the EMS system failures in place and not moving toward regionalization.
The focus on counting 4x4s and other widgets required to be present on ambulances at the expense of comprehensively evaluating an organization's fitness to provide quality EMS is impeding EMS development in southwestern PA.
Getting support when there is an issue.
The bureaucracy is a great challenge due to the fact that those in power in the department of health are virtually unreachable when it comes to issues with a regional EMS council.
Lack of support from local government.
Money for large capital items like ambulances.
The Commonwealth does not hear the voices of providers. They hear what the regional councils tell them. From local to state bureaucracy power and control comes first and not patient care.
The Federal and State government need to step up and help EMS, become more involved and see what a necessity it is to the well-being of the country.
Equality and accountability. Patients should get the same quality of care throughout the State and especially the same region. This is not true. Some services give 110percent and others do not and nothing is done to better those services. Most of those services are volunteer services that decided to go paid and they do not have the oversight to insure quality of care.
Question #9 - Are you aware of the proposed changes to the accreditation of the paramedic training program and if so, how will this change affect your organization? If not, please skip this question?
We are chasing people away from becoming ALS providers. As an educator, I recognize the value of broadening the curriculum, but we have CREATED a paramedic shortage in PA. Fewer paramedics make it harder for me to find quality people and fill shifts, which raises overtime costs.
The proposed changes to the paramedic curriculum will cause great harm to the PA EMS system. There will be fewer paramedics and labor costs will sky rocket due to demand for skilled providers.
Inconsistency in the program has led to various levels of training depending on the providers location-accreditation will allow for a standard and level the playing field.
I understand and agree that this will help the profession, but we are not getting enough interested EMTs to take the class. We are already short medics and this is going to force us to reduce services.
It will not affect my organization. It will have no impact.
Accreditation at any level is important. I applaud the efforts of all involved in seeing this project through to completion.
National accreditation of EMS training programs is long overdue. I anticipate no changes to my organization and look forward to a better educated and prepared EMS provider.
This is a step in the right direction to elevating our industry to a respectful level in healthcare. We will get better paramedics, prepared to face the challenges in the field.
I believe that the new requirements will further reduce the number of paramedic training programs and thus, the number of students entering training programs. This will have a negative impact on the number

of paramedics entering the field. PA is already facing a shortage of paramedics. Accreditation is being mandated by an agency external to PA and their mandate will only serve to exacerbate the paramedic shortage in PA.
Paramedic program accreditation is a good thing. It will provide our organization with paramedics who are trained to a national standard according to national benchmarks. Similarly, all other healthcare professions in the commonwealth are educated in accordance with national accrediting bodies.
In the long term it may be difficult to attract high quality medical professionals based on today's wages.
It will make a bad situation even worse! The pool of staff will dry up and I am sure it will cause many services to cease functioning. This will cause delays in service delivery.
Accreditation is good but will reduce the number of facilities providing paramedic education. Thus the paramedic shortage will continue and be a huge issue.
It will add tremendous cost, not only to individuals but also services that provide funding for their personnel to attend therefore fewer services will fund. As it becomes more like a college program the wages that EMS providers receive don't match the level of training and professionalism, therefore a shortage of new paramedics will continue to be steered to higher paying positions in nursing and other medicine.
Question #10 - What is your opinion of the access to and availability of training at the EMT and Paramedic levels?
National Registry is going to be cost prohibitive. Keep it within the Community Colleges which will be more available at a local level, cheaper, and if someone wants the National Registry, they can go for it! Otherwise, the cost will keep too many away from the program and we are short providers already!
EMS salaries and wages and benefits need to be upgrade to ATTRACT people into EMS and to STAY in EMS and to STAY in Pennsylvania.
There appears to be adequate access and availability of training, HOWEVER, the significantly LOW income potential inhibits participation. Why spend the time, money, and education to work for $11-15 per hour when I can work as a manager at Sheetz and make the same money but WITHOUT the added stress and worry of providing patient care, lawsuits, negligence, accidents, blood borne pathogens?
EMT programs are abundant. Paramedic programs are not, or at least not at a high level. Several paramedic and EMT programs under state standards rubberstamp a patch to a pulse.
Training availability and access is adequate for EMT's and lacking for Paramedics.
Plenty of opportunities exist within our region for EMT training but need to go out of region for a Paramedic school.
The increase in price is going to have a negative impact on our recruitment. I am already hearing fewer fire departments are going to invest in sending their volunteers and individuals interested in a new career are not interested in spending $850.
Far too expensive and hard to acquire (too many wasted hours/too few classes/classes not local) for a system that needs volunteer staffing to continue to provide reasonably adequate service.
It's getting worse - less access due to the new curriculum and demands AND the pricing/time commitment are no longer realistic for people who want to volunteer their time!
Access to EMT programs is easy. Access to Paramedic programs is difficult.
Training is readily available but getting more and more expensive.
EMT training access is poor only because the outsourcing of training to local community colleges mandates a minimum class roaster which guarantees that most EMT classes will be cancelled before they start. I don't care if 5 people show, the class should go on! This system needs them! Not enough classes! Paramedic training is so long and expensive it actually hurts the system it is trying to save. Remember rural PA has a paramedic shortage and it gets worse every day. Plus there is only one training facility in our area so we don't have an option where to attend.