7th Annual EMS Law & Policy Symposium

Widener University
Commonwealth Law School

Program Materials
January 15, 2026

Widener University
Commonwealth Law School

Legal Pathways to EMS System Sustainability

The Seventh Annual Widener University Commonwealth Law School
Emergency Medical Services Law & Policy Symposium
Thursday, January 15, 2026 – 8:00 a.m. – 3:00 p.m.

OVERVIEW

The Seventh Annual EMS Law and Policy Symposium at Widener Law Commonwealth is focused on the survival and sustainability of EMS systems throughout the United States. The traditional model of rapid deployment and emergency department transport for virtually all EMS patients is both unsustainable and not reflective of the substantial body of clinical evidence that points to the urgent need for new models, methods and modalities in EMS and mobile healthcare.

Many legal obstacles – both real and perceived – pose barriers to effective and efficient delivery of EMS in the United States. As examples: incorrect assumptions regarding legal duties of care may prevent pre-dispatch dispositions for law acuity 911 calls that would derive no benefit from an EMS response. Outdated and inaccurate notions of patient abandonment may impede treat-in-place, telehealth or other non-transport modalities. Incorrect interpretations of EMTALA cause EMS agencies to expend countless unit hours of service while needlessly waiting to transfer patient care in hospital EDs. Some state regulatory agencies narrowly interpret the scope of practice of EMS clinicians in ways that stifle community paramedicine/mobile integrated healthcare programs. The Seventh Annual EMS Law and Policy Symposium is focused on establishing a valid legal framework for EMS system transformation and "setting the legal table" for EMS innovation.

AGENDA

8:00 am **Registration and Coffee**

8:30 am **Welcome and Introduction**
andré douglas pond cummings, *Dean, Widener Law Commonwealth*
Christian Johnson, *Professor of Law, Widener Law Commonwealth*

8:35 am **Keynote Address: The Evidence-Based Case for EMS System Transformation**
Matt Zavadsky, MHA, *EMS & Mobile Healthcare Consultant, PWW Advisory Group*

9:50 am **Break**

10:00 am **Identifying Legal Barriers to EMS System Transformation**
Douglas M. Wolfberg, Esq. '96*, Founding Partner, Page, Wolfberg & Wirth, LLC and Adjunct Professor, Widener Law Commonwealth*

11:30 am **Buffet Lunch**

12:00 pm **The "People" Side of Change: Leading the EMS Workforce to a Transformative EMS System**
Stephen R. Wirth, Esq., *Founding Partner, Page, Wolfberg & Wirth, LLC*

1:00 **Break**

1:15 pm **State and Federal EMS Legislation**
Donald Dereamus, *Legislative Chair, Ambulance Association of Pennsylvania*
Douglas M. Wolfberg, Matt Zavadsky, ***Stephen R. Wirth***

2:30 pm **Closing Thoughts – How to Go Forth and Transform Your EMS System**
Matt Zavadsky, MHA, Stephen R. Wirth, Esq. and Douglas M. Wolfberg, Esq.

3:00 pm **Conclusion**
Dean cummings, Professor Johnson

This program is offered live at Widener Law Commonwealth and will be offered online. Participants are entitled to up to five (5) substantive and one (1) ethics Continuing Legal Education (CLE) credits for attending the program – subject to approval.

EMS continuing education credits are also available; please let the registration desk know of your interest in receiving these.

Many thanks to the co-sponsors of today's program
Widener Law Commonwealth Law & Government Institute
Page, Wolfberg & Wirth LLC
Ambulance Association of PA

For more information on Widener University Commonwealth Law School and its Law & Government Institute, please visit our website:
commonwealthlaw.widener.edu

7th Annual EMS Law and Policy Symposium

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2026 Symposium Sponsors

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Continuing Education Announcements

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Attorneys

Complete the Form and Submit at End of Program

4

EMS Clinicians

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PA EMS Providers

- Today's symposium is eligible for 6 hours of "other" Pennsylvania EMS continuing education credit
- For in-person attendees, please sign in on the EMS continuing education credit sign-in sheet at registration

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PA EMS Providers

- For virtual attendees, email the following information to mkonya@pwwemslaw.com
  - First, middle initial, and last name
  - Certification level
  - Certification number
  - Email address

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EMS Providers Outside of PA

- Submit materials to your state EMS education accreditation agency
  - Of course, we cannot guarantee that your EMS agency will accept these credits
- Contact mkonya@pwwemslaw.com if we can assist

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About the Symposium

This year's theme:

Legal Pathways to EMS System Sustainability

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Today's Agenda – Morning

8:35 – 9:50	Keynote Address: *The Evidence-Based Case for EMS System Transformation*
10:00 – 11:30	Identifying Legal Barriers to EMS System Transformation
11:30 – 12:00	Lunch

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Today's Agenda - Afternoon

12:00 – 1:00	The "People" Side of Change: *Leading the EMS Workforce to a Transformative EMS System*
1:15 – 2:30	State and Federal EMS Legislation
2:30 – 3:00	Closing Thoughts

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Keynote Address:
The Evidence-Based Case for EMS System Transformation

Matt Zavadsky, MHA

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Overview

- Dispel common 'myths' about "EMS"
- Highlight the current staffing and economic crisis in EMS
  - And likely causes
- Identify barriers to patient-centered, evidence-based EMS system transformations that enhance
  - Clinical proficiency
  - Operational effectiveness
  - Economic sustainability
- *Learn why dads (and granddads!) should not be left alone with children!*

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- 911 EMS requests are for time-sensitive, life-threatening emergencies
- EMS response times make a difference in patient outcomes
  - *Therefore, lights and siren (HOT) responses are necessary to save lives*
- An Advanced Life Support (ALS) paramedic is necessary on every EMS response
  - *More paramedics = better system*
- EMS response volume is largely unpredictable
- Patients who call 911 for EMS need to go to the hospital

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Most 911 EMS requests are for time-sensitive, life-threatening emergencies...

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10-year % change of overall call volume...

Call Type	% Increase
Interfacility	**11.32%**
Sick Person	**10.37%**
Falls	5.87%
Unc Person	5.20%
Assault	4.21%
Convulsions	4.16%
Psyc.	3.76%

Call Type	% Decrease
Abd Pain	2.83%
Traum Inj.	3.71%
Chest Pain	7.97%
MVA	**10.38%**
Breath. Prob.	**10.48%**

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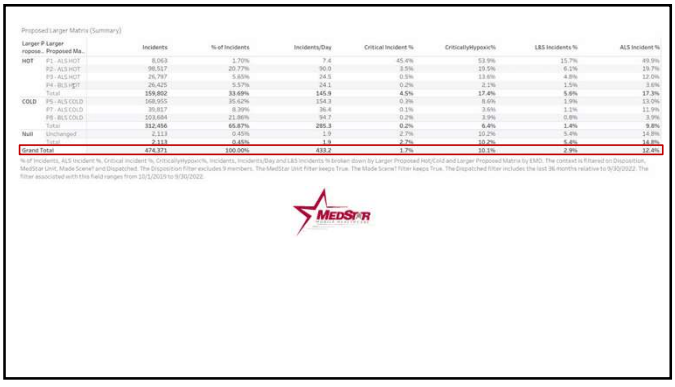

Proposed Larger Matrix (Summary)

Larger P Larger ropos...	Proposed Ma...	Incidents	% of Incidents	Incidents/Day	Critical Incident %	CriticallyHypoxic%	LBS Incidents %	ALS Incident %
HOT	P1 - ALS HOT	8,063	1.70%	7.4	45.4%	53.9%	15.7%	49.9%
	P2 - ALS HOT	98,517	20.77%	90.0	3.5%	19.5%	6.1%	19.7%
	P3 - ALS HOT	26,797	5.65%	24.5	0.5%	13.8%	4.8%	12.0%
	P4 - BLS HOT	26,425	5.57%	24.1	0.2%	2.1%	1.5%	3.6%
	Total	159,802	33.69%	145.9	4.5%	17.4%	5.6%	17.3%
COLD	P5 - ALS COLD	168,955	35.62%	154.3	0.3%	8.6%	1.9%	13.0%
	P7 - ALS COLD	39,817	8.39%	36.4	0.1%	3.6%	1.1%	11.9%
	P6 - BLS COLD	103,684	21.86%	94.7	0.2%	3.9%	0.8%	3.9%
	Total	312,456	65.87%	285.3	0.2%	6.4%	1.4%	9.8%
Null	Unchanged	2,113	0.45%	1.9	2.7%	10.2%	5.4%	14.3%
	Total	2,113	0.45%	1.9	2.7%	10.2%	5.4%	14.3%
Grand Total		474,371	100.00%	433.2	1.7%	10.1%	2.9%	12.4%

"# of Incidents, ALS Incident %, Critical Incident %, CriticallyHypoxic%, Incidents, Incidents/Day and LBS Incidents % broken down by Larger Proposed Hot/Cold and Larger Proposed Matrix by EMD. The context is filtered on Disposition, MedStar Unit, Made Scene? and Dispatched. The Disposition filter excludes 9 members. The MedStar Unit filter keeps True. The Made Scene? filter keeps True. The Dispatched filter includes the last 36 months relative to 9/30/2022. The filter associated with this field ranges from 10/1/2025 to 9/30/2022.

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Metric	#	%	Per Day
All Patient Contacts	**52,741**		**107.6**
Crew Selected - ALS Care	17,880	33.9%	36.5
Crew Selected - BLS Care	31,287	59.3%	63.9
Crew Selected - Critical Care	186	0.4%	0.4
Crew Selected - EMS and Other Health-Care Staff	6	0.0%	0.0
Crew Selected - No Care Provided	24	0.0%	0.0
Crew Selected - Not Applicable	5	0.0%	0.0
Crew Selected - Integrated Healthcare	4	0.0%	0.0
Crew Selected - Blank	3,349	6.3%	6.8

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	#	% of All Patient Contacts	% of Meds Administered
Meds Administered	8,846	16.8%	
BLS Meds (i.e.: Aspirin, Glucose, Oxygen, Nitro, Tylenol, Zofran ODT, etc.)	4,322	8.2%	48.9%
ALS Meds (Atropine, Epi, Lasix, etc.)	4,524	8.6%	51.1%

Most Common Meds / Combo Meds Administered	#	% of All Meds
DuoNeb, Oxygen, ODT (BLS)	1,092	12.3%
Ondansetron, Oxygen (BLS)	723	8.2%
Aspirin, DuoNeb, Nitro (BLS)	1,064	12.0%
Fentanyl w/All Combos	1,075	12.2%
Naloxone, Oxygen, ODT (BLS)	148	1.7%
Normal Saline (0.9% NaCl) Only	1,056	11.9%
Oxygen Only (BLS)	703	7.9%

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Critical Procedures	#	Per Day	% of Patients
Intubation	268	0.5	0.51%
Ventilator (IFT)	49	0.0	0.09%

Critical V/S (Not per Patient, *any/all* of the below)	#	% of All Patients
HR < 60	2,723	5.2%
HR > 130	1,734	3.3%
RR < 10	342	0.6%
RR 30 - 60	829	1.6%
BP < 100	3,752	7.1%
BP > 180	3,424	6.5%
SaO2 < 80	762	1.4%

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ALS Procedures	#	% of Total	% of Patient Contacts	Avg. Pts Per Day
IV	557	60.4%	25.9%	1.53
Cardiac Monitor/12 Lead EKG	328	35.6%	15.3%	0.90
IO	18	2.0%	0.8%	0.05
Orotracheal	11	1.2%	0.5%	0.03
I-Gel	8	0.9%	0.4%	0.02
Total	**922**	**100.0%**	**42.9%**	**2.53**

	#	% of All Patient Contacts	% of Meds Administered	Avg. Pts Per Day
Meds Administered	492	22.9%		1.35
BLS Enabled Meds (i.e.: Albuterol, Aspirin, DuoNeb, Naloxone, etc.)	184	8.6%	37.4%	0.50
ALS Meds (Atropine, Epi, Lasix, etc.)	308	14.3%	62.6%	0.84

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Using Red Lights and Sirens for Emergency Ambulance Response: How Often Are Potentially Life-Saving Interventions Performed?

Objective: To describe the frequency and nature of 911 calls that result in potentially life-saving interventions (PLSI) during the call.

Methods: Using data from ESO (Austin, Texas, USA), a national provider of EMS electronic health records, we analyzed all 911 calls in 2018. We abstracted the use of RLS, call nature, and interventions performed. A liberal definition of PLSI was developed a priori through a consensus process and included both interventions, medications, and critical hospital notifications. We calculated the proportion of calls with RLS response and with PLSI performed, both overall and stratified by call nature.

Results: There were 5,977,612 calls from 1,187 agencies included in the analysis. The majority (85.8%) of calls utilized RLS, yet few (6.9%) resulted in PLSI. When stratified by call nature, cardiac arrest calls had the highest frequency PLSI (45.0%); followed by diabetic problems (37.0%). Glucose was the most frequently given PLSI, *n* = 69,036. When including multiple administrations to the same patient, epinephrine was given most commonly PLSI, *n* = 157,282 administrations).

Conclusion: In this large national dataset, RLS responses were very common (86%) yet potentially life-saving interventions were infrequent (6.9%). These data suggest a methodology to help EMS leaders craft targeted RLS response strategies.

Jarvis J, Taigman M. Using Red Lights and Sirens for Emergency Ambulance Response: How Often Are Potentially Life-Saving Interventions Performed? Prehospital Emergency Care, 25(4), 549–555.

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EMS response times make a difference in patient outcomes

Therefore, lights and siren (HOT) responses are necessary to save lives

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Where Did This "Need for Speed" Come From?

Cardiac Resuscitation in the Community

Importance of Rapid Provision and Implications for Program Planning

"If ***CPR*** was initiated within ***four*** minutes **and** if ***definitive care*** was provided within ***eight minutes***, *43% of patients survived*. If either time was exceeded, the chances of survival fell dramatically.

The time to initiation of CPR and ***definitive care*** are factors directly influenced by emergency medical service program decisions.

A realistic option to improve time to initiation of CPR is widespread citizen CPR training. A possible option to improve the time to ***definitive care*** is the training of emergency medical technicians in ***defibrillation***."

JAMA. XXXX May 4;241(18):1905-7. doi: 10.1001/jama.241.18.1905

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Jarvis J, Taigman M. Using Red Lights and Sirens for Emergency Ambulance Response: How Often Are Potentially Life-Saving Interventions Performed?
Prehospital Emergency Care, 25(4), 549–555.
https://pubmed.ncbi.nlm.nih.gov/32678993/
Conclusions: *In this large national dataset, RLS responses were very common (86%) yet potentially life-saving interventions were infrequent (6.9%). These data suggest a methodology to help EMS leaders craft targeted RLS response strategies.*

Price L. Treating the clock and not the patient: ambulance response times and risk.
Qual Saf Health Care. 2006;15(2):127–130.
https://pubmed.ncbi.nlm.nih.gov/16585114/
Conclusions: *The results of this study suggest that the 8 minute response time is not evidence based and is putting patients and ambulance crews at risk. There is a need for less simplistic quality indicators which recognise that there are many stages between a patient's call for help and safe arrival in hospital.*

Lights and Siren Use by Emergency Medical Services (EMS): Above All Do No Harm
NHTSA Study & Report by Dr. Doug Kupas
https://www.ems.gov/assets/Lights_and_Sirens_Use_by_EMS_May_2017.pdf
Summary: *The time saved by using L&S during response and transport has been evaluated by several studies. These all show that a relatively short amount of time is saved by L&S use. While this may be of clinical importance to patient outcome in critical time-sensitive conditions like cardiac arrest, the consensus among the researchers in this field is that the time is not significant in most of the responses or transports.*

Pons P, Markovchick V. Eight minutes or less: does the ambulance response time guideline impact trauma patient outcome?
J Emerg Med. 2002;23(1):43–48.
https://pubmed.ncbi.nlm.nih.gov/12217471/
Conclusions: *After controlling for other significant predictors, there was no difference in survival after traumatic injury when the 8 min ambulance RT criteria was exceeded (mortality odds ratio 0.81, 95% CI 0.43-1.52). There was also no significant difference in survival when patients were stratified by injury severity score group. Exceeding the ambulance industry response time criterion of 8 min does not affect patient survival after traumatic injury.*

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Efficacy of Response Times

Empirical Response Time Research Summary

Author	Density	Sample Size	Response Time Threshold	Does Response Time Impact Patient Outcome
Blackwell (2002)	ALS Urban	5,424	5 minutes	Yes > 5 minutes; No > 5 minutes
Pons (2005)	ALS Urban	9,359	4 minutes & 8 minutes	No > 8 minutes; Yes > 4 minutes in intermediate/high risk of mortality
Blackwell (2009)	ALS Urban; BLS MFR	746	10:59	No > or = 10:59
Blanchard (2012)	ALS Urban	7,760	8 minutes	No > or = 8 minutes
Weiss (2014)	Metro/Urban and Rural	569	N/A Continuous Variable	No relationship between time and clinical outcomes
Pons (2016)	ALS Urban	3,490	8 minutes	No > or = 8 minutes after controlling for severity of injury
Newgard (2019)	ALS Urban	9,856	4 minutes & 8 minutes and Golden Hour	No time intervals were statistically related to mortality including response time, on-scene time, transport time, or total EMS time
Bond (2014)	ALS Urban; BLS MFR	4,122	N/A Continuous Variable	Adjusted for severity of injury, no significant difference between P2i and EMS. In patients with severe injuries, gunshot, or stabbing more likely to survive if transported by P2i/LCE.

Relevant Information
- The prevailing result is an institutional belief that faster is better, where patient outcomes positively correlate with response times.
- Evidenced-based clinical research coalesces around a response time of 5 minutes or less to have a statistically significant impact on the risk of mortality for the small proportion of high-acuity incidents.
- Response time changes above 11 minutes have limited clinical return on investment and are largely a policy decision.

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https://www.fortworthtexas.gov/departments/fire/ems

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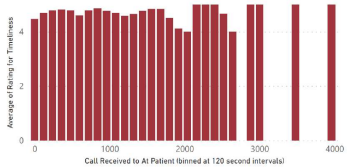
Yes, but what about "patient satisfaction"?

Analysis of EMS Survey Team "Ambulance Arrived in a Timely Manner" Rating and Ambulance Response Time for Priority 3 (non-lights and siren) Response Times

MedStar's Business & Data Analytics Manager, Whitney Morgan, merged data between the response times for Priority 3 (non-lights and siren) responses and our EMS Survey Team customer experience survey data.

The charts and graphs below provide a summary of the data analysis:

Average Survey Response per 2-minute binned response time



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Swor R, Cone D. Emergency medical services advanced life support response times: Lots of heat, little light.
Acad Emerg Med. 2002;9(4):320–321.
https://pubmed.ncbi.nlm.nih.gov/11927458/
Conclusions: *In this observational study, emergency calls where RTs were less than 5 minutes were associated with improved survival when compared with calls where RTs exceeded 5 minutes. While variables other than time may be associated with this improved survival, there is little evidence in these data to suggest that changing this system's response time specifications to times less than current, but greater than 5 minutes, would have any beneficial effect on survival.*

Pons P, Haukoos J, Bludworth W, Cribley T, Pons K, Markovchick V. Paramedic response time: Does it affect patient survival?
Acad Emerg Med. 2005;12(7):594–600
https://pubmed.ncbi.nlm.nih.gov/15995089/
Conclusions: *A paramedic response time within 8 minutes was not associated with improved survival to hospital discharge after controlling for several important confounders, including level of illness severity. However, a survival benefit was identified when the response time was within 4 minutes for patients with intermediate or high risk of mortality. Adherence to the 8-minute response time guideline in most patients who access out-of-hospital emergency services is not supported by these results.*

Jarvis J, Johns D, Ratcliff T, et. al. The impact of using time critical intervention-based dispatch thresholds on lowering lights and siren use to EMS 911 incidents.
JACEP Open 2024;5:e13232
https://doi.org/10.1002/emp2.13232
Conclusions: *Using Time Critical Intervention-based dispatch thresholds, we decreased L&S use and increased accuracy with minimal increased response time. Our results support the use of this methodology to determine EMS response modes.*

Jensen, J.T., Møller, T.P., Blomberg, S.N.F. et al. Racing against time: Emergency ambulance dispatches and response times, a register-based study in Region Zealand, Denmark,
2013–2022. Scand J Trauma Resusc Emerg Med 32, 108 (2024).
https://doi.org/10.1186/s13049-024-01284-0
Conclusions: *Even though response times increased during the study period, improving these may not be a solution to improve overall patient outcomes, because the diagnoses where shorter response times are important ultimately represent only a smaller proportion of the patients that are dispatched to an emergency ambulance.*

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Position Statement

Joint Statement on Lights & Siren Vehicle Operations on Emergency Medical Services Responses

Douglas F. Kupas, Matt Zavadsky, Brooke Burton, Shawn Baird, Jeff J. Clawson, Chip Decker, ...show all
Pages 459-461 | Received 04 Feb 2022, Accepted 16 Feb 2022, Published online: 10 May 2022

This document is a joint position statement with the Academy of International Mobile Healthcare Integration, American Ambulance Association, American College of Emergency Physicians, Center for Patient Safety, International Academies of Emergency Dispatch, International Association of EMS Chiefs, International Association of Fire Chiefs, National Association of EMS Physicians, National Association of Emergency Medical Technicians, National Association of State EMS Officials, National EMS Management Association, National EMS Quality Alliance, National Volunteer Fire Council, and Paramedic Chiefs of Canada.

https://pubmed.ncbi.nlm.nih.gov/35475941/

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The sponsoring organizations of this statement believe that the following principles should guide L&S use during emergency vehicle response to medical calls and initiatives to safely decrease the use of L&S when appropriate:

- The primary mission of the EMS system is to provide out-of-hospital health care, saving lives and improving patient outcomes, when possible, while promoting safety and health in communities. ***In selected time-sensitive medical conditions, the difference in response time with L&S may improve the patient's outcome***.
- EMS vehicle operations using L&S pose a significant risk to both EMS practitioners and the public. Therefore, during response to emergencies or transport of patients by EMS, ***L&S should only be used for situations where the time saved by L&S operations is anticipated to be clinically important to a patient's outcome***. They should not be used when returning to station or posting on stand-by assignments.
- ***Communication centers should use EMD programs developed, maintained, and approved by national standard-setting organizations with structured call triage and call categorization to identify subsets of calls based upon response resources needed and medical urgency of the call. Active physician medical oversight is critical in developing response configurations and modes for these EMD protocols. These programs should be closely monitored by a formal quality assurance (QA) program for accurate use and response outcomes, with such QA programs being in collaboration with the EMS agency physician medical director.***

https://pubmed.ncbi.nlm.nih.gov/35475941/

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The sponsoring organizations of this statement believe that the following principles should guide L&S use during emergency vehicle response to medical calls and initiatives to safely decrease the use of L&S when appropriate:

- ***Municipal government leaders should be aware of the increased risk of crashes associated with L&S response to the public, emergency responders, and patients. Service agreements with emergency medical response agencies can mitigate this risk by using tiered response time expectations based upon EMD categorization of call. Quality care metrics, rather than time metrics, should drive these contract agreements.***

https://pubmed.ncbi.nlm.nih.gov/35475941/

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Position Statements

Joint Position Statement on EMS Performance Measures Beyond Response Times

Douglas F. Kupas, Matt Zavadsky, Brooke Burton, Chip Decker, Robert Dunne, Peter Dworsky, ...show all
Pages 1068-1069 | Received 19 Jun 2024, Accepted 27 Jun 2024, Published online: 01 Oct 2024

Emergency Medical Services (EMS) exist to provide safe and effective out-of-hospital medical care to communities.

Historically, response time has been the primary measure used to assess the performance of an emergency medical services (EMS) system/agency. Public policymakers have adopted response time because it is objective, quantifiable, and easily understood, however, this standard is derived from the need to respond quickly to cardiac arrest and time-sensitive conditions. While it is essential to continue to monitor and promote effective response, the majority of 911 EMS responses do not require a response time under ten minutes. Reliance solely on response time performance increases the cost of EMS and the risk of EMS vehicle crashes. It also prevents communities from evaluating other EMS system quality measures that demonstrate system effectiveness for patient care, experience, and outcomes.

This joint statement encourages EMS systems and community leaders to implement an approach to EMS system performance that prioritizes patient-centered care and uses a broad, balanced set of clinical, safety, experiential, equity, operational, and financial measures to evaluate the effectiveness of EMS systems.

https://www.tandfonline.com/doi/full/10.1080/10903127.2024.2375739

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- ✓ Academy of International Mobile Healthcare Integration
- ✓ American Ambulance Association
- ✓ American College of Emergency Physicians
- ✓ American Paramedic Association
- ✓ Center for Patient Safety
- ✓ International Academies of Emergency Dispatch
- ✓ International Association of EMS Chiefs
- ✓ International City/County Management Association
- ✓ National Association of EMS Physicians
- ✓ National Association of Emergency Medical Technicians
- ✓ National Association of State EMS Officials
- ✓ National EMS Management Association
- ✓ National EMS Quality Alliance
- ✓ National Volunteer Fire Council
- ✓ Paramedic Chiefs of Canada

Examples of EMS System Performance Domains and Potential Measures for Consideration

Domain	Potential Type of Measure for Consideration	Source/Benchmark
Clinical	• Out-of-Hospital Cardiac Arrest • STEMI • Stroke • Trauma • Hypoglycemia • Asthma/COPD • Seizure/Status Epilepticus • Invasive Airway Management • Special Mental Health Crisis Management	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies. National EMS Quality Alliance (NEMSQA) published measures. NEMSQ Public Dashboards. Cardiac Arrest Registry to Enhance Survival (CARES) Other evidence-informed EMS clinical, protocol, or other community clinical indicators
Safety	• % of responses and transports using lights and siren (L&S) • Crash rate/100,000 miles • Job-related injuries/100,000 hours worked. • Job-related illness/100,000 hours worked. • Reviews of all dispatch priority assignments. • EMS recall rate after a non-transport response.	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies. National EMS Quality Alliance (NEMSQA) published measures. NEMSQ Public Dashboards
Operational	• The number of produced unit hours compared to scheduled unit hours • Miles driven per 100,000 miles. • Response times, for high-acuity clinical responses, measured from the time the call is placed to a communication center, to the time of patient contact. • QA assessments to insure reliability of prioritization of responses.	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies.
Experiential	• Patient experience surveys • Hospital experience surveys • First Responder Organization (FRO) experience surveys • Community experience surveys • Employee turnover/retention • Emergency dispatcher engagement surveys	Validated, externally conducted patient and provider experience surveys, such as: • EMS Survey Team • Press Ganey Fusion • Press Ganey Alternatively, internal surveys could be conducted by the agency or local jurisdiction.
Financial	EMS system costs and revenues, reported per: • Staffed Unit Hour • Response • Patient Contact • Transport • Dispatch staffing deficits vs. fully staffed periods.	Internal agency data trended over time. Benchmarked to the Academy of International Mobile Healthcare Integration (AIMHI) survey of EMS systems, or other national data sources.

*These examples are not meant to be all-inclusive; communities should establish patient-centric and evidence-based performance measures based on value to their local stakeholders.

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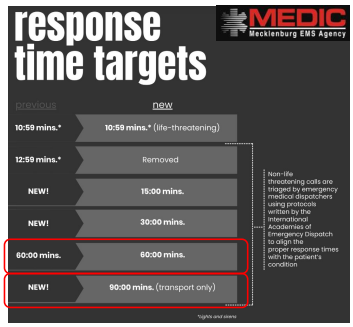

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An Advanced Life Support (ALS) paramedic is necessary on every EMS response

More paramedics = better system

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Where did this all-ALS thing come from?

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The Impact of the Public Utility Model

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ALL ALS - The Rationale

A substantial percentage of all ambulance calls received by dispatchers are "borderline" -- that is, from the information available on the telephone, it is impossible to determine with certainty whether the call should be classified as a life-threatening emergency, a non-life-threatening emergency, or a request for nonemergency routine transportation.

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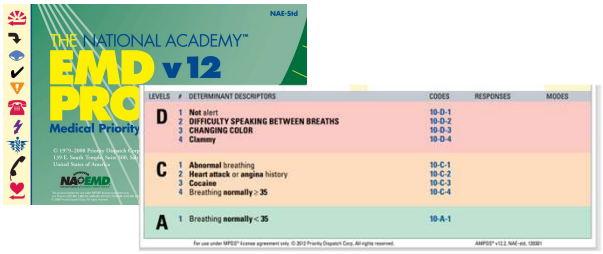
The *NEXT* Year...



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Paramedic Exposure to Out-of-Hospital Cardiac Arrest Resuscitation Is Associated With Patient Survival

Kylie Dyson , Janet E. Bray , Karen Smith , Stephen Bernard , Lahn Straney , and Judith Finn

Abstract
Although out-of-hospital cardiac arrest (OHCA) is a major public health problem, individual paramedics are rarely exposed to these cases. *In this study, we examined whether previous paramedic exposure to OHCA resuscitation is associated with patient survival.*

Results
During the study period, there were 4151 paramedics employed by AV, and 48 291 OHCAs attended (Table 1). During the 7-year outcome analysis period (2006–2012), paramedics (n=3590) attended 34 494 OHCAs. Of these, 15 362 cases (45%) had resuscitation attempted by paramedics. Typically 4 paramedics (interquartile range [IQR] 2–4) attended OHCAs where resuscitation was attempted and 2 paramedics (IQR 2-2) attended cases where resuscitation was not attempted. During the outcome analysis period (2006–2012), survival to hospital discharge in cases where resuscitation was attempted was 12% overall and 30% in patients presenting in a shockable rhythm (initial cardiac arrest rhythm of ventricular fibrillation or ventricular tachycardia). The majority of paramedics were employed fulltime (86%), and 18% was working in intensive care paramedic roles.

Conclusions
Patient survival after OHCA significantly increases with the number of OHCAs that paramedics have previously treated.

Circulation
https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.115.002317

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Does the Number of System Paramedics Affect Clinical Benchmark Thresholds?

Kristin M. Vrotsos , BS, Ronald G. Pirrallo , MD, MHSA, Clare E. Guse , MS & Tom P. Aufderheide, MD
Published 02 Jul 2009

Methods
This was a retrospective review of annual experience profiles for paramedics working during 2001–2005 using the MCEMS patient care record (PCR) database. The number of patient contacts, role as team leader/report writer, adult and pediatric endotracheal intubations, adult and pediatric intravenous (IV) access initiations, medication administration, and12-lead electrocardiogram (ECG) acquisitions were analyzed. ***Over the five-year study period, 1,215 paramedic profiles gleaned from 107,524 PCRs documented a total of 297,900 patient contacts.***

Results
All comparable experiences decreased significantly between the 1997 analysis and the current study, except medication administration, which increased 25%.

Conclusion
These data show a decreased opportunity and a wide variability in the frequency of successfully completed paramedic technical skills and experiences in this EMS system.

https://doi.org/10.1080/10903120802101355

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Cardiac arrest survival as a function of ambulance deployment strategy in a large urban emergency medical services system

David E. Persse, Craig B. Keyd, Richard N. Bradley, Charles C. Millerc, Atul Dhingraa
October 2003

Introduction: This study examines the effect of paramedic deployment strategy on witnessed ventricular fibrillation (VF) cardiac arrest outcomes. ***Our null hypothesis was that there is no difference in survival between an EMS system using targeted response (TR) and one using a uniform or all advanced life support (ALS) response (UR) model. We define targeted response as a system where paramedics are sent to critical incidents while ambulances staffed with basic EMTs are sent to less critical incidents. A secondary outcome measure was paramedic skill proficiency between the systems.***

Results:. There were 181 patients in the TR group and 24 in the UR group. Units in the TR area were able to demonstrate shorter response and time to defibrillation intervals than in the UR area. ***Rates for return of spontaneous circulation (ROSC), admission to the ward/intensive care unit (ICU), survival to discharge and survival to 1 year were all better in the cohort of patients cared for in the TR area than those in the UR area. Rates for successful intubation and IV initiation were also better in the TR areas than in the UR areas.***

Conclusion: ***This study shows improved outcomes for a subset of patients with cardiac arrest when they are cared for in an area that uses TR compared to an area that uses a UR EMS system.***

RESUSCITATION
https://www.resuscitationjournal.com/article/S0300-9572(03)00178-3/fulltext

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Fewer paramedics means more lives saved

Study: Constant use sharpens critical skills
By Robert Davis, USA TODAY
May 21, 2006

Cities that deploy fewer paramedics -- who in turn treat more victims of sudden cardiac arrest -- save more lives, according to a new study.

"Our data seem to show that cities with the fewest number of paramedics for a given population are more likely to have higher survival rates," says Michael Sayre of the emergency-medicine department at Ohio State University in Columbus. ***"Having a smaller number of paramedics who are very highly trained is probably a better strategy for delivering good patient outcomes."***

In fact, new study found that more lives are saved in the cities with fewer paramedics even when those responders arrive as much as five minutes later than less-trained rescuers.

Among the 50 largest cities in America, those that save the highest percentage of cardiac-arrest victims -- Seattle, Boston, Oklahoma City and Tulsa -- use such a tiered response, USA TODAY found in an investigation published in 2003.

USA TODAY
https://www.firefighterclosecalls.com/fewer-paramedics-means-more-lives-saved/

43

Sanghavi P, Jena AB, Newhouse JP, Zaslavsky AM. Outcomes after out-of-hospital cardiac arrest treated by basic vs advanced life support.
JAMA Intern Med. 2015 Feb;175(2):196-204.
https://pmc.ncbi.nlm.nih.gov/articles/PMC4314335/
Conclusions: *Patients with out-of-hospital cardiac arrest who received BLS had higher survival at hospital discharge and at 90 days compared with those who received ALS and were less likely to experience poor neurological functioning.*

Band RA, Salhi RA, Holena DN, Powell E, Branas CC, Carr BG. Severity-adjusted mortality in trauma patients transported by police.
Ann Emerg Med. 2014 May;63(5):608-614.e3
https://pmc.ncbi.nlm.nih.gov/articles/PMC5912155/
Conclusion: *We found no significant overall difference in adjusted mortality between patients transported by the police department compared with EMS but found increased adjusted survival among 3 key subgroups of patients transported by police. This practice may augment traditional care.*

Levy, M. J., Crowe, R. P., Abraham, H., Bailey, A., Blue, M., Ekl, R., … Myers, J. B. (2024). Dispatch Categories as Indicators of Out-of-Hospital Time Critical Interventions and Associated Emergency Department Outcomes.
Prehospital Emergency Care, 1–6.
https://www.tandfonline.com/doi/full/10.1080/10903127.2024.2342015
Conclusions: *In general, Determinant levels aligned with time-critical responses; however, a notable minority of lower acuity Determinant level Protocols met criteria for unsafe to hold. This suggests a more nuanced approach to dispatch prioritization, considering both Protocol and Determinant level factors.*

44

Dyson K, Bray J. Paramedic Exposure to Out-of-Hospital Cardiac Arrest Resuscitation Is Associated With Patient Survival
Circulation: Cardiovascular Quality and Outcomes Volume 9, Number 2
https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.115.002317
Conclusions: *Patient survival after OHCA significantly increases with the number of OHCAs that paramedics have previously treated.*

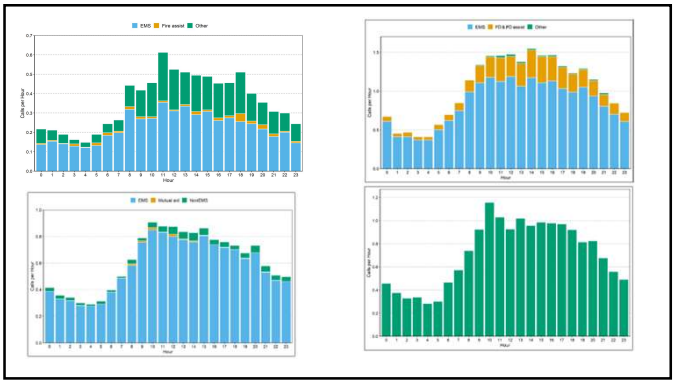
Vrotsos, K. M., Pirrallo, R. G., Guse, C. E., & Aufderheide, T. P. (2008). Does the Number of System Paramedics Affect Clinical Benchmark Thresholds?
Prehospital Emergency Care, 12(3), 302–306.
https://www.tandfonline.com/doi/full/10.1080/10903120802101355
Conclusions: *These data show a decreased opportunity and a wide variability in the frequency of successfully completed paramedic technical skills and experiences in this EMS system.*

Persse, David E. et al. Cardiac arrest survival as a function of ambulance deployment strategy in a large urban emergency medical services system
Resuscitation, Volume 59, Issue 1, 97 – 104
https://www.resuscitationjournal.com/article/S0300-9572(03)00178-3/abstract
Conclusions: *This study shows improved outcomes for a subset of patients with cardiac arrest when they are cared for in an area that uses tiered response compared to an area that uses a uniform response EMS system.*

45

EMS response volume is largely unpredictable

46



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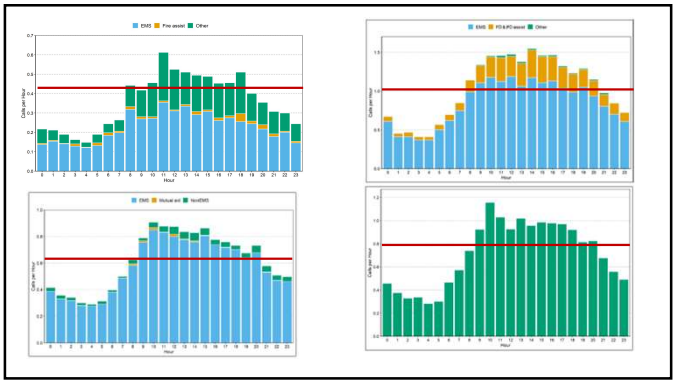

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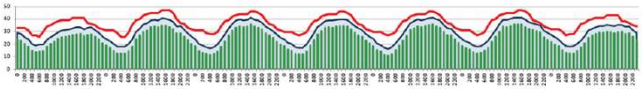

Not just WHEN – But WHERE…

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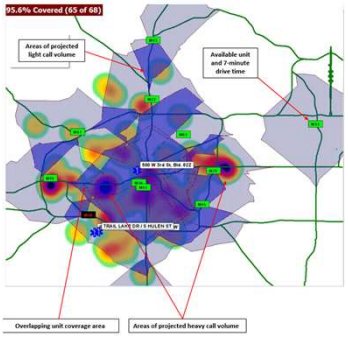

People are mobile!

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Patients who call 911 for EMS need to go to the hospital…

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Table 4. Mode of arrival at emergency department, by patient age: United States, 2021

Age group (years)	Number of visits in thousands	Patient's mode of arrival		
		Total[1]	Ambulance	Other
			Percent distribution (standard error)	
All visits	139,781	100.0	17.6 (0.9)	79.7 (1.2)
Under 15	24,644	100.0	5.1 (0.7)	91.3 (1.8)
Under 1	3,676	100.0	* …	**90.0 (5.1)
1–4	9,396	100.0	4.9 (1.0)	92.6 (1.2)
5–14	11,572	100.0	5.8 (0.9)	90.7 (2.1)
15–24	17,604	100.0	10.7 (1.0)	87.0 (1.2)
25–44	38,561	100.0	13.7 (0.8)	83.4 (1.2)
45–64	31,863	100.0	20.8 (1.0)	77.0 (1.2)
65 and over	27,109	100.0	35.2 (1.6)	62.1 (1.7)
65–74	13,191	100.0	27.9 (1.8)	68.9 (2.0)
75 and over	13,918	100.0	42.2 (2.0)	55.7 (2.0)

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National Hospital Ambulatory Medical Care Survey: 2021 Emergency Department Summary Tables — Table page 1 of 2

Table 24. Emergency department visits resulting in hospital admission, by selected patient and visit characteristics: United States, 2021

Patient and visit characteristics	Number of visits (standard error) in thousands	Percent distribution (standard error)	Mean length of stay[1] in days (standard error)	Admissions as percent of visits (standard error)
All admissions	18,312 (1,777)	100.0 …	5.2 (0.3)	13.1 (1.1)
Age group (years)				
Under 15	*1,220 (470)	* …	5.9 (1.7)	* …
15–24	1,078 (181)	5.9 (0.9)	4.6 (0.5)	6.1 (0.9)
25–44	2,866 (312)	15.6 (1.3)	4.7 (0.4)	7.4 (0.7)
45–64	5,225 (578)	28.5 (1.4)	5.2 (0.3)	16.4 (1.5)
65–74	3,220 (372)	17.6 (1.1)	5.2 (0.4)	24.4 (2.1)
75 and over	4,703 (606)	25.7 (1.8)	5.5 (0.4)	33.8 (2.9)
Residence				
Private	16,070 (1,515)	87.8 (2.5)	5.1 (0.3)	12.4 (1.0)
Nursing home	1,116 (243)	6.1 (1.0)	6.5 (1.0)	42.7 (5.4)
Homeless	* …	1.2 (0.3)	7.1 (0.9)	13.6 (3.0)
Other	* …	1.1 (0.4)	7.0 (1.1)	* …
Unknown or blank	*690 (445)	* …	5.0 (0.4)	* …
Expected sources of payment[2]				
Private insurance	5,633 (675)	30.8 (2.7)	5.3 (0.5)	12.5 (1.3)
Medicare	8,011 (1,058)	43.7 (3.3)	5.6 (0.3)	28.8 (2.4)
Medicaid or CHIP[3] or other state-based program	5,046 (597)	27.6 (2.2)	5.1 (0.3)	9.7 (1.0)
No insurance[4]	523 (138)	2.9 (0.7)	4.0 (0.5)	5.6 (1.1)
Mode of arrival				
Ambulance	8,080 (867)	44.1 (2.1)	5.7 (0.4)	32.9 (2.2)
Other	10,233 (1,069)	55.9 (2.1)	4.8 (0.4)	8.9 (0.8)

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Patients who call 911 for EMS need to go to the hospital…

- 66% of the patients EMS bring to the ED are NOT admitted
- What can we do for the OTHER 46% of the patients?

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EMS-Based MIH

- **911 Dispatch Triage**
  - Nurse Navigation
  - Telehealth/telemedicine
- **Alternate response**
  - Community Paramedic/Nurse Practitioner
  - Crisis Incident Team (behavioral health)
- **Alternate Disposition**
  - Treatment in Place (TIP)
  - Transport to Alternate Destination (TAD)
  - Telehealth/Telemedicine
- **Prevent the call!**
  - Community Paramedic/Nurse Practitioner

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EMS Related News Reports

Summary: Jan 11, 2021 - November 30, 2025
Article Count: 3,715

Keywords	Tag Count	% of Total
Staffing	1,314	35.4%
Funding, Tax Levy	1,631	43.9%
Total	**2,945**	**79.3%**

Other	Tag Count	% of Total
Closure/Takeover	341	9.2%
Response Time	341	9.2%
Staffing+Response Time	**1,655**	**44.5%**
Staffing+Funding+Response Time	**3,286**	**88.5%**

https://aimhi.mobi/news

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Ambulance systems straining to meet needs of Hoosiers
"EMS is at a crossroads," it begins. "Run volume has increased substantially. The shortage of active clinicians does not meet demand. Funding does not meet the needs."
https://indianapublicmedia.org/news/ambulance-systems-straining-to-meet-needs-of-hoosiers.php

Keene Fire Department staffing 'unsustainable,' leaders say
"Nearly every single day, sometimes multiple times a day, the department recalls off duty personnel to handle emergencies that are happening in the city or to backfill additional apparatus that are not staffed to attempt to maintain the number of available units needed to handle additional emergencies in the city,".
https://vtdigger.org/2024/10/16/brattleboro-struggles-with-firefighter-staffing-spending-after-ems-takeover/

Wis. county's EMS agencies believe they will fail to staff rigs in 2026
A survey of Chippewa County EMS agencies finds that more than half believe they will have trouble with staffing, call volume and transport times next year
https://chippewa.com/news/local/government-politics/emergency-services-crisis-chippewa-county/

Fire chiefs: EMS response in N. Central Mass. 'on verge of collapse'
They described a dire situation including skyrocketing overtime costs because local ambulances must take longer drives to the nearest hospitals in Leominster, Concord, Lowell and Nashua, New Hampshire.
https://www.msn.com/en-us/news/us/fire-chiefs-ems-response-in-n-central-mass-on-verge-of-collapse-after-hospital-closing/ar-AA1x3CDT

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Economic Challenge…

- Methods of EMS Funding
  - Fee for service (ambulance transport)
  - Tax subsidy
- When *cost* is more than revenue generated from user fees
  - Tax subsidy

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Economic Challenge…

- **Cost Drivers**
  - **Response time**
    - Faster = More cost
    - 'Slower' = Less cost
  - **ALS vs. BLS**
    - All ALS = More cost
    - Tiered (ALS & BLS) = Less cost
  - **Deployment Model**
    - Fixed (24/48, or 48/96 schedule) = More cost
    - Flexible (10's & 12's, peak staffing) = Less cost

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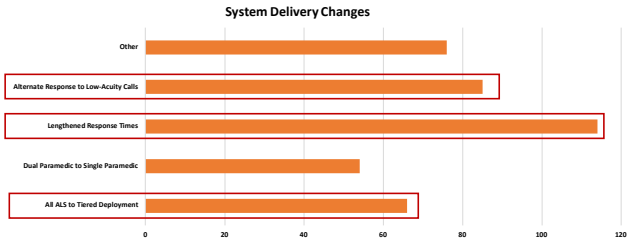
Long Overdue System Design Changes



https://naemt.org/docs/default-source/ems-data/ems-economic-and-operational-models-survey-02-20-2023-final.pdf

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System (re)Design = Tiered Response

2022 High-Performance EMS Benchmarking Study
Part 1: System Demographics and Operational Performance

The AIMHI benchmarking studies perform a fundamental service to EMS by providing tools through which we can continue to learn about the successes and opportunities of today's emergency care system, ensure its progress and growth, and work to expand the reputation and efficiency of EMS nationally and internationally. The 2022 study is the latest addition to the body of knowledge required for effective service delivery and improvement.

Since the first study in 1998, AIMHI has developed valuable *evidenced-based* studies to share *clinical, operational, and economic* data across EMS systems serving diverse geographic and demographic communities. Our goal is to provide the EMS community, elected and appointed officials, and regulators with tools, data, and outcomes that demonstrate the value of high-performance, high-value mobile healthcare as the initial point of entry to, and the safety net of, the healthcare continuum.

Agency Name	Organizational Structure
Emergency Medical Services Authority (Oklahoma City, OK)	Public Utility Model: Self-Operated
Emergency Medical Services Authority (Tulsa, OK)	Public Utility Model: Self-Operated
Mecklenburg EMS Agency (Charlotte, NC)	Public Utility Model: Self-Operated
Medic Ambulance (Solano, CA)	Private
MEDIC EMS (Davenport, IA)	501c3
MedStar Mobile Healthcare (Fort Worth, TX)	Public Utility Model: Self-Operated
Metropolitan EMS (Little Rock, AR)	Public Utility Model: Self-Operated
Niagara Emergency Medical Services (Region of Niagara, CA)	Third Service Model
Northwell Health Center for EMS (Syosset, NY)	Health System Based EMS Agency
Novant Health New Hanover EMS (New Hanover County, NC)	Hospital-Based
Pinellas County EMS - Sunstar (Pinellas County, FL)	Public Utility Model: Contracted
Pro EMS (Cambridge, MA)	Contractor
Regional Emergency Medical Services (Reno, NV)	Public Utility Model: Self-Operated
Richmond Ambulance Authority (Richmond, VA)	Public Utility Model: Self-Operated

https://aimhi.mobi/page-18073

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Table 1: EMS System Delivery Changes

Agency	What was the change?
Emergency Medical Services Authority (Oklahoma City, OK)	Transitioned from a contracted provider to a self-operated PUM. Changed from all ALS to tiered ambulance deployment.
Emergency Medical Services Authority (Tulsa, OK)	Transitioned from a contracted provider to a self-operated PUM. Changed from all ALS to tiered ambulance deployment.
Mecklenburg EMS Agency (Charlotte, NC)	Changed response time goal for low-acuity medical responses.
MedStar Mobile Healthcare (Fort Worth, TX)	Changed from all ALS to tiered ambulance deployment.
Niagara Emergency Medical Services (Region of Niagara, CA)	Recent update to MPDS v13.3 Omega included a determinant-by-determinant review that included linked hospital outcome data. This data was used in to update response priorities based on information such as aggregate 1- and 7-day mortality, number of ER interventions, length of stay, SCU admissions and length of stay.
Pinellas County EMS - Sunstar (Pinellas County, FL)	Changed from all ALS to tiered ambulance deployment.
Regional Emergency Medical Services (Reno, NV)	Changed from all ALS to tiered ambulance deployment. Additional further utilization of Nurse Health Line for low acuity call determinants.

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Key Metrics & Takeaways

- **36%** of the HP/HVEMS systems have **transitioned from an all-ALS ambulance deployment to a Tiered Deployment (ALS/BLS)** to better match resources with emergency needs and enhance ALS provider utilization and experience.
- **64%** of HP/HVEMS systems **do not use Medical First Response on all calls**, reserving MFR for calls with a higher medical acuity, based on EMD determinants derived through an accredited communications center.
  - Across these systems, **an average of 52% of EMS calls do not receive Medical First Responders**.
- **61%** of the emergency responses in the HP/HVEMS systems **receive a lights & siren (HOT) response**.
  - **9%** of the patients transported to hospitals receive a **HOT transport**.

https://aimhi.mobi/page-18073

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2024 High-Performance EMS Benchmarking Study

Part 1: System Demographics, Operational Performance, Clinical Outcomes & Total Quality Management

Key Metrics & Takeaways

- **100%** of the participating HP/HVEMS systems have **transitioned from an all-ALS ambulance deployment to a Tiered Deployment (ALS/BLS)** to better match resources with emergency needs and enhance ALS provider utilization and experience.
- **ALL** the participating HP/HVEMS systems use a **flexible deployment strategy** to match resources with predicted response volume.
- **ALL** the participating HP/HVEMS systems **triage Medical First Response (MFR), not using MFR on all calls**, reserving MFR for calls with a higher medical acuity, based on EMD determinants derived through an accredited communications center.
  - Across these systems, **an average of 42% of EMS calls receive MFR, with a low of 13% (Harris County, TX) to a high of 95% (Pinellas County, FL).**

https://aimhi.mobi/page-18073

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Table 7: Response Time Goal

Agency Name	High Acuity Call Compliance Standard	Low Acuity Call Compliance Standard
Emergency Medical Services Authority (Oklahoma City, OK)	90% < 10:59	90% < 24:59
Emergency Medical Services Authority (Tulsa, OK)	90% < 10:59	90% < 24:59
Mecklenburg EMS Agency (Charlotte, NC)	90% < 10:59	90% < 60:00
Medic Ambulance (Solano, CA)	9:00	25:00
MEDIC EMS (Davenport, IA)	90% < 07:59	90% < 14:59
MedStar Mobile Healthcare (Fort Worth, TX)	85% < 11 minutes, no more than 1.5% > 16:30	85% < 17 minutes, no more than 1.5% > 25:30
Metropolitan EMS (Little Rock, AR)	90% < 08:59	90% < 12:59
Northwell Health Center for EMS (Syosset, NY)	90% < 12:00	90% < 30:00
Novant Health New Hanover EMS (New Hanover County, NC)	N/A	90% < 19:59
Pinellas County EMS - Sunstar (Pinellas County, FL)	91% < 10:00	No Standard
Pro EMS (Cambridge, MA)	90% < 14:59	No Standard
Regional Emergency Medical Services (Reno, NV)	8:59	90% < 20:59
Richmond Ambulance Authority (Richmond, VA)	90% < 8:59	90% < 29:59

https://aimhi.mobi/page-18073

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The Case for EMS Reimbursement for TIP and TAD

NAEMT

ambulance treatment without transport claim is estimated at $358.05. Using this estimate, the number of ambulance treatment without transport claims that the $20 million expenditure represents is ~55,858 ambulance claims ($20 million ÷ $358.05). In simple terms, there were 55,858 Medicare beneficiaries who were not seen by a hospital emergency department (ED), and instead were cared for by ambulance agency personnel.

The most recent Healthcare Cost and Utilization Project (HCUP) report from the Agency for Healthcare Research and Quality (AHRQ) reveals the average expenditure for ED visit for patients aged 65 or older is $690[2]. Using this data, **the estimated savings to Medicare derived from the 55,858 Medicare beneficiaries who were NOT seen in an ED was $38,542,020 (55,858 beneficiaries × $690/ED visit). A 193% cost to savings ratio.**

The National Association of State EMS Officials (NASEMSO) identified 42 million EMS responses in 2018[3]. Medicare beneficiaries typically represent 40% of patients treated by EMS, or 16,800,000 patients. A study of Medicare beneficiaries transported by ambulance to the ED published in Health Affairs in 2013[4] found that an estimated 12.9 –16.2 percent of Medicare covered 911 emergency medical services (EMS) transports involved conditions that were probably nonemergent, or primary care treatable.

Applying the 12.9% – 16.2% of the 16.8 million EMS responses for Medicare beneficiaries in 2020 as potentially eligible for treatment in place without transport would prevent between 2.17 and 2.82 million ED visits by Medicare beneficiaries. **This represents between $1.5 and $1.95 billion annual savings to Medicare.**

1. https://www.cms.gov/medicare/payment/fee-schedules/ambulance
2. https://hcup-us.ahrq.gov/reports/statbriefs/sb268-ED-Costs-2017.pdf
3. https://nasemso.org/wp-content/uploads/2020-National-EMS-Assessment_Reduced-File-Size.pdf
4. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0741

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Emergency Triage, Treat, and Transport (ET3) Model

ET3 Model Quality Workgroup Session #2

Development of Performance-Based Payment (PBP) Eligibility and Methodology

March 21, 2023

Do not share these materials until made public by CMS

CMS | ET3 Model

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PBP Eligibility Requirements (Cont.)

2. Achieve Net Savings to Medicare (NSM)

NSM = Expected spending for ED use averted by an ET3 Intervention − Observed spending for the ET3 Intervention (including Participant and Partner payments)

- Participants must demonstrate reduced spending for CMS as a result of their implementation of ET3 Interventions.

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Review of PBP Testing Results

Average PBP and NSM per Intervention by Quartile

Quartile	Measure Score Range	PBP Percentage	Number of Participants	Number of ET3 Interventions	Average PBP per Intervention	Average NSM per Intervention
1	11.4-18.1%	3%	4	252	$11.89	$570.55
2	>18.1-20.4%	2%	3	319	$8.36	$536.79
3	>20.4-23.4%	1%	4	303	$4.19	$514.86
4	>23.4-28.9%	0%	4	120	--	$527.85

Source: Analyses of Medicare Part A and Part B claims for the period January 2021 to July 2022

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So, if the transformations necessary for EMS system sustainability are evidence-based, what's the hold up?

71

Good Thing EMS is Flexible When Evidence-Based Research Does Not Support Practices

72

- **Culture**
  - "We've always done it this way!"
  - "Change is risky!"
  - "100 years of tradition, unimpeded progress"
- **Economic Model**
  - Paid for the TRANSPORT, not the medical care or the response
  - Economic risk of change
    - ET3 Nurse Triage example

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- **Resistance from other constituencies**
  - Nurses
  - Physicians
- **Legal/Regulatory Issues**
  - State-by-state inconsistency
  - Statutory limitation on scope of practice for EMTs & Paramedics
  - Legacy statutes/regulations tied to ambulance transport
  - Requirement to respond an ambulance to every 911 call

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The Evidence-Based Case for EMS System Transformation

Matt Zavadsky, MHA

Widener University Commonwealth Law School

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Identifying Legal Barriers to EMS System Transformation

Doug Wolfberg, Esq.

Widener University Commonwealth Law School

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Transformation is No Longer Optional

- EMS systems are facing unprecedented operational, workforce, and financial pressures
- Traditional transport-only models are increasingly misaligned with patient needs and system realities

77

The question is no longer *whether* EMS must evolve, but *how quickly* it can do so

78

From the "Why?" to the "How?"

- Matt Zavadsky laid out the case for transformation: new care pathways, better patient experience, and system sustainability
- **Our focus**: the legal choke points that keep systems stuck and prevent them from evolving

79

Clinical innovation is no longer the limiting factor…the law is

80

The Barrier: Law and Regulation

- Some EMS statutes, regulations, policies have failed to keep pace with modern EMS delivery models and care modalities
- Laws should enable patient-centered care
- ***However,*** some actively prevent it

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The Barrier: Law and Regulation

- Incidentally, this is nobody's "fault" in particular
- This is really a consequence of the fact that most state EMS enabling statutes were written at a time when EMS basically had ***one, monolithic modality:***

Dispatch ➡ Response ➡ Treat ➡ Transport

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The Barrier: Law and Regulation

- Identifying these legal barriers is only the first step
- Without reform, progress in service delivery models, care modalities and innovation will stall

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The Result

- Clinically sound, patient-centered models are blocked
  - ***Merely for being "non-traditional"***
    - Based on how "EMS" was described in the laws and regulations written years – or decades - ago
- EMS sustainability is threatened
- ***Patients access to care is impaired***

84

Categories of Legal Barriers

(1) Laws that ***default to transport*** and limit clinical decision-making;

(2) Laws that ***restrict practice*** with limitations tied to setting or employment rather than clinician competence;

(3) ***Operational mandates*** that delay handoff, release, or EMS availability;

(4) ***Structural/Political Barriers*** to Efficient System Design

85

BARRIER #1: Transport Default

86

An Archaic Legal Infrastructure

- Many EMS statutes were built around the central premise that the ambulance's job is simply to transport patients to hospitals
- Non-transport is treated as a deviation and not a legitimate EMS outcome - *even when research shows transport is often NOT medically necessary*

87

The problem is *not* that EMS clinicians don't know how to identify low-risk patients…

The problem is that existing EMS laws might not *trust* them to do that

88

Transport as the Default

- Transport framed as the "legally safe" option
- Laws and regulations discourage alternatives to ED care
- Clinical judgment is constrained by fear of legal exposure and "liability"

89

EXAMPLE: ARIZONA

90

AZ Transport Persuasion Ban

- **Arizona Revised Statutes § 36-2219 -** Governs EMT and paramedic conduct related to patient transport decisions
  - Enacted through AZ House Bill 2431
  - Signed into law on April 22, 2022

91

August 2021 - How it Began

92

What the Law Says

- Statutory prohibition on counseling against transport:
  - "**An emergency medical care technician may not…[c]ounsel a patient to decline emergency medical services transportation**, except as part of a specific alternate destination or treat-and-refer program that includes quality management and comprehensive medical direction oversight."

A.R.S. § 36-2219(B)(2)

93

What the Law Says

- Prohibition on presumptive diagnosis for refusal decisions:
  - "An emergency medical care technician **may not…[p]rovide a presumptive medical diagnosis** and use that diagnosis as the basis for **counseling a patient to decline emergency medical services transportation**."

A.R.S. § 36-2219(B)(1)

94

What the Law Says

- Mandatory explanation of refusal risks:
  - "An emergency medical care technician **shall explain the risks and consequences** to the patient's health of **not being transported**."

A.R.S. § 36-2219(C)

95

What the Law Means

- EMS clinicians cannot guide a patient away from ambulance transport, even when transport is low-value or unnecessary, *unless* they are operating under a very specific approved alternative program

96

What the Law Means

- EMS clinicians are prohibited from using clinical impressions (i.e. "presumptive diagnosis") to explain why ambulance transport may not be needed
- The law mandates explaining the risks of not going, but effectively restricts explaining why NOT going may be reasonable

97

What the Law Presumes

- EMS clinicians are likely to ***unduly influence*** or pressure patients rather than properly educate them
- Conversations about refusal are ***inherently coercive*** (even if factual)
- Defaulting to transport is the safest legal outcome ***regardless of clinical context***

98

What the Law Ignores

- Informed refusal is a ***standard of care*** across the healthcare continuum
- EMS clinicians already ***assess capacity, explain risks and benefits, and document*** consent
- Collaborative, informed decision-making is ***evidence-based and patient-centered***

99

The Chilling Effect

- Arizona's restrictions discourage EMS clinicians from engaging in legitimate, clinically appropriate patient discussions
- Decisions shift from patient-specific clinical reasoning to pure liability avoidance
- Transport becomes the default outcome, even when it offers little/no clinical value

100

Impact on Patients

- Patients receive less *meaningful* information
- True informed choice is replaced by one-sided risk warnings

101

Impact on Patients

- Patient autonomy is reduced under the banner of "safety"
- Patients may incur significant out-of-pocket costs for ambulance transport that offers little/no clinical benefit

102

The Bigger Picture: *System-Level Consequences*

- Growth in low-acuity and clinically unnecessary ambulance transports
- Increased strain on emergency departments and EMS unit availability
- Higher costs with no corresponding improvement in patient outcomes

103

EXAMPLE: PENNSYLVANIA

104

The transport default regulatory mindset does not always blatantly appear in statutes and regulations

…it can also hide in protocols

105

De Facto Mandate to Transport

- Transport defaults do not always appear as an *explicit* transport mandate
- They can also be implicitly embedded in protocols that penalize non-transport
- ***PA Draft BLS Protocol #201*** was a clear example

106

What Was Draft BLS Protocol # 201?

- Draft protocol entitled "*Initial Patient Contact*"
- Sought to define clinician responsibility after patient contact
- Introduced the legal concept of "abandonment" into a clinical protocol

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Draft BLS Protocol #201

"Performing an initial assessment establishes a clinician-patient relationship. Once a clinician-patient relationship has been established, the EMS clinicians have a responsibility to the patient until appropriate transfer of care. Failure to adhere to applicable protocols shall be considered patient abandonment. "Abandonment" is defined as 'the act of withdrawing or discontinuing one's help or support, especially when a duty or responsibility exists.'" [Black's Law Dictionary (11th ed. 2019)].

108

This language raised immediate red flags…

109

Why so Problematic?

- "Abandonment" is not a clinical concept, it is a legal tort
- Pennsylvania EMS statutes and/or regulations do not define "abandonment"
- Protocols should not become documents setting forth legal interpretations – especially when they can have *disciplinary consequences*

110

PWW's Involvement

- Ambulance Association of Pennsylvania (AAP) requested legal review
- PWW analyzed draft Protocol # 201 for statutory and regulatory compliance
- Issued formal opinion/recommendations

111

Violated Regulatory Review Process

- Only PA General Assembly or formal rulemaking may define grounds for discipline
- Draft protocol attempted to do so via sub-regulatory guidance
- This bypassed notice, comment, and promulgation requirements

112

Violated Statutory Construction Rules

- EMS System Act separately lists:
  - Abandonment - 35 Pa.C.S. § 8121(a)(3)
  - Failure to follow protocols - 35 Pa.C.S. § 8121(a)(11)
- Draft protocol improperly equated the two
- This rendered statutory language meaningless surplusage
  - In re Employees of Student Services, Inc., 495 Pa. 42, 52 (1981); Myers v. Commonwealth, 2023 Pa. LEXIS 232;
  - 1 Pa.C.S. § 1921(b)

113

Definition Legally Incorrect

- Abandonment under PA law is a negligence tort
  - → Requires duty, breach, causation, and damages
- A clinical protocol ***cannot*** determine causation or damages

114

Misfeasance vs. Nonfeasance

- Abandonment is a tort of nonfeasance (failure to act)
- Many protocol deviations involve misfeasance (improper action)
- Draft protocol incorrectly labeled *any* deviation as abandonment

115

Why This Would be Bad

- *Every* protocol deviation could be framed as abandonment = exposing EMS to more civil lawsuits
- Plaintiffs' attorneys could weaponize protocol language in civil cases
- EMS agencies' legal defenses would be compromised

116

The Chilling Effect

- EMS clinicians would default to transport to avoid "abandonment" allegations
- Non-transport would become legally **indefensible**
- Transport becomes the "safe" option *regardless* of patient need

117

Improperly Reinforcement

- Non-transport is treated as presumptively wrongful
- Legal risk, *not* clinical judgment, drives decision-making
- Culture of transport is enforced through fear, even though it is not statutorily based

118

Outcome & Broader Lesson

- Draft language was ultimately NOT adopted
  - ***Final Statewide BLS Protocol issued 12/29/2023 - completely void of "patient abandonment" language***
- Example illustrates how even <u>well-intentioned</u> protocols can quietly and unintentionally undermine EMS transformation

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BARRIER #2: Practice Restrictions

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Practice Constrained by Context

- EMS scope of practice may not solely be defined by level of licensure or certification
- Legal authority to practice may by statute depend on where, how, and by whom the clinician is employed
- THUS → ***Context, not competency,*** determines what care may be delivered

121

Scope of Practice Non-Uniformity

- EMS licensure suggests a single, statewide scope of authority
  - However → scope can expand or contract based on workplace/setting
- This obviously creates hidden distinctions within a category of clinician licensure

122

EXAMPLE: MASSACHUSETTS

123

MA Law: Employment-Based Limits on EMS Practice

- **M.G.L. c. 111C, § 19**
  - 25-year-old statute that limits EMTs and paramedics to practicing within their EMS scope *only* when employed by a licensed ambulance service
  - Outside of those settings, EMS personnel are legally reduced to first-responder functions, regardless of licensure, training, or experience

124

What the Law Says

- "No person shall… provide EMS or hold oneself out as, or use the title of EMS first responder, emergency medical technician, or paramedic, or the acronym EMT or any other title or acronym used by the department in the certification of emergency medical services personnel under this chapter… ***other than on behalf of an EMS first response service or an ambulance service or other EMS provider*** duly licensed or otherwise approved under this chapter or chapter 111O."

M.G.L. c. 111C, § 19(a)(3)

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Enforcement and Penalties – M.G.L. c. 111C, § 19(b)

- **Civil penalties:**
  - Whoever engages in, aids, abets, causes or permits any act prohibited under this section shall be punished by a fine of not less than $100 and not more than $1,000 for each offense.
- **Continuing violations**:
  - A separate and distinct offense shall be deemed to have been committed on each day during which any prohibited act continues after written notice by the department to the offender.
- **Mandatory enforcement:**
  - The commissioner shall report each suspected offense to the attorney general for investigation and prosecution.

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MA EMS Advisory 25-11-01 (Nov 2025)

- OEMS doubled down on this decades old law:
  - EMS personnel may ***only*** function as EMTs or paramedics when ***acting on behalf of a licensed ambulance service***, EMS first response service, or approved MIH service
  - EMS certification does *not* authorize use of EMT or paramedic scope when ***working for non-EMS employers***, even if the individual holds valid state certification
  - When not acting within the EMS system, EMS personnel may ***not advertise or hold themselves out*** as EMTs or paramedics and are limited to first-responder–level functions

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MA EMS Advisory 25-11-01

- The Advisory further clarified that:
  - School districts may *not* engage individual EMTs/Paramedics to staff athletic events.
    - They must contract with licensed ambulance or EFR services, and *only* EMTs/Paramedics who are on duty and formally deployed by that licensed service at the time of the event may provide EMS-level care
    - Even when licensed health care facilities/other non-EMS entities hire certified EMTs/Paramedics those individuals are legally limited to providing care at no higher than the first-responder level

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Lieutenant Governor Commissioner

ADVISORY 25-11-01

TO: Massachusetts Certified EMTs and Paramedics (EMS Personnel)
Massachusetts Licensed Ambulance Services
FROM: Susan Lewis, NRP, Director
DATE: November 18, 2025
RE: Limits on EMS Personnel Functioning as EMTs and Paramedics

The Department of Public Health (Department) is issuing this Advisory to clarify that under the EMS statute M.G.L. c. 111C, §19(a), EMS personnel may only function as EMTs and Paramedics when they are on duty for a licensed ambulance service, licensed EMS First Responder (EFR) service (at the BLS level or above only) or a Department-approved mobile integrated health (MIH) or community EMS (CEMS) program. In any other context, certified EMS personnel may only provide services at the first responder level and may not advertise or hold themselves out as EMTs and Paramedics.

Therefore, when school districts are seeking to hire EMTs to staff interscholastic football or other sports games, they must make their arrangements with a licensed ambulance or EFR service, and that service must deploy an EMT or Paramedic who is on duty for the service at the time of the game. Individual EMS personnel may not hire themselves out to staff such games as EMTs or Paramedics.

Additionally, if licensed health care facilities or other entities that are not ambulance services, EFR services or Department-approved MIH or CEMS programs, hire certified EMTs and Paramedics, they cannot deploy these EMS personnel to provide any skills or services above the first responder level.

EMS personnel or ambulance services with any questions in this regard may contact Susan Lewis, NRP, Director, at oems.ambulances@mass.gov.

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Possible Policy Rationale for Law

- **Preserves system control and accountability**
  - Limiting EMS practice to licensed EMS agencies ensures clear medical oversight, quality assurance, and regulatory responsibility *within the system*
- **Risk and liability management**
  - Restricting where EMTs and paramedics may function reduces ambiguity about clinical responsibility and legal exposure for the Commonwealth
- **Maintains clear boundaries between EMS and other healthcare sectors**
  - The law reinforces a distinction between prehospital EMS practice and care provided in facilities or other settings, which may be governed by different professional and regulatory frameworks

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What the Law Presumes

- That EMT/Paramedic skills are only safe within the traditional roles involving ambulance operations
- That non-EMS employers cannot provide adequate medical oversight for these roles
- That limiting practice is safer than regulating oversight mechanisms

131

What the Law Ignores

- EMT/Paramedic certification is state-issued and therefore standardized
- Medical direction and QA can exist *outside* ambulance services
- EMT/Paramedic competency/education is not attached to a particular employer

132

Preventing EMS Innovation

- **Blocks integration of EMS clinicians into non-EMS care settings**
  - EMTs and paramedics may not function at their licensed level outside licensed EMS agencies, preventing hospitals, clinics, and community programs from using their skills

133

Preventing EMS Innovation

- **Disincentivizes alternative care models**
  - MIH, community response, and hybrid care models become legally risky unless structured solely and exclusively within licensed EMS agencies/ambulance services

134

Why Employment-Based Limits Restrain Innovation

- Creates arbitrary and inconsistent care standards across settings
- Discourages innovative staffing models and cross-sector integration
- Confuses agencies, employers, and clinicians about what is legally allowed

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Workforce Impacts

- EMS clinicians are prevented from using skills they are trained/certified/educated to perform
  - May have detrimental financial impact to individual
- Creates frustration, inefficiency, and underutilization
- Wastes scarce clinical capacity during workforce shortages

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The Bigger Picture: *System-Level Consequences*

- New care models must be shoe-horned into this EMS regulatory framework in order to be lawful
- Innovation proceeds only through narrow carve-outs (e.g. MIH licensure); it's not organic
- This slows experimentation and favors incremental change over meaningful transformation

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Golden Opportunity?

- State EMS offices are obligated to enforce statutes on the books, even when those laws no longer reflect modern healthcare realities
- ***However*** → archaic, employment-based EMS restrictions serve no patient-centered purpose in today's modern, integrated care environment

138

Golden Opportunity?

- *This perhaps presents an opportunity for a broad coalition of EMS, hospitals, nursing, medicine, and other healthcare leaders to pursue legislative reform based on the overall healthcare system need for qualified clinicians in all settings*

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EXAMPLE: PENNSYLVANIA

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PA Regulation: Paramedic Limitations in Hospitals

- Pennsylvania law places specific limits on paramedic practice in hospital settings
- Limitations are rooted in regulation rather than clinical evidence

141

PA Regulatory Framework

- Pennsylvania EMS is governed by:
  - The EMS System Act (35 Pa.C.S. §§ 8107-8157)
  - Supporting/implementing regulations (28 Pa. Code Chapters 1021-1031)
  - But, in some cases, anachronistic regulations *outside* of the EMS context can limit EMS innovation

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28 Pa. Code § 117.30

§ 117.30. Emergency paramedic services.

In hospitals, where paramedics are employed by the hospital for treatment of patients in the emergency service area:

(1) The primary responsibility of the paramedic is to respond to emergency situations outside the hospital. Paramedics cannot be utilized as an integral part of the hospital emergency service area staff, that is, as a replacement for licensed health professionals. Paramedics may only be utilized to support and assist licensed health professionals in the care of patients in emergency situations meeting the requirements of paragraph (4).

(2) Paramedics may function in hospitals as paramedics only when the hospitals provide advanced life support services, when the paramedics are employed by an advanced life support service, or when the paramedics are functioning under paragraph (6).

(3) Paramedics may not function as paramedics, except in extraordinary life threatening situations, in an area of the hospital other than the emergency service area except for training and continuing education purposes under paragraph (6).

(4) A paramedic may function as a paramedic only in an emergency situation. In these situations, a paramedic may practice the skills for which the paramedic is certified to perform. The paramedic may only practice as a paramedic in the hospital emergency service area, when under the direct supervision of a physician, who shall be physically present in the emergency service area. An emergency situation is a situation for which an absence of intervention within hours will result in loss of life or significant impairment of body function.

(5) The paramedic's scope of practice shall be in accordance with the limitations imposed by the act of November 30, 1976 (P. L. 1205, No. 264) (35 P. S. § § 6801—6805) (Repealed) and Chapter 2, Subchapter A (Reserved).

(6) Paramedic students enrolled in a training program approved by the Department, or paramedics enrolled in a continuing education program, may function in a hospital under the direct supervision of licensed or certified personnel, operating within their legal scopes of practice, who have been assigned responsibility for specific components of the training programs. The Department may approve training programs for paramedic students in hospitals without advanced life support units. A continuing education program shall consist of a written program of instruction, designed to enhance the paramedics' skills in accordance with standards mandated by the applicable regional Emergency Health Services Council.

143

What the Regulation Says

- **Paramedicine is defined as a ***prehospital function:***
  - By stating that the paramedic's primary responsibility is to respond to emergencies "outside the hospital," the regulation makes clear that hospital practice is a secondary exception, *not* a core function of paramedicine

144

What the Regulation Says

- **Hospitals may *not* use paramedics as facility staff substitutes**
  - The regulation prohibits hospitals from using paramedics as replacements for licensed hospital professionals, even in ED
- **Paramedics are support personnel in hospitals, *not* autonomous clinicians**
  - When permitted in hospitals, paramedics may *only* support and assist licensed professionals and *only* in narrowly defined emergency circumstances

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Historical Context

- Many EMS regulations governing paramedics were adopted in the late 1970s and 1980s, as paramedicine was becoming widespread
- EMS systems at the time were transport- and trauma-focused, not integrated into broader healthcare delivery
- Paramedics were rarely embedded in hospitals, and team-based ED staffing models were uncommon

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Historical Context

- Regs initially emerged amid concerns about scope-of-practice competition
  - Organized nursing interests opposed expanded paramedic roles, fearing job displacement and erosion of professional boundaries
  - The regulations therefore reflected workforce protection concerns, not evidence about patient outcomes or team-based care

147

Ironically, most ED nurses now welcome and *even depend upon* the collaboration of their paramedic colleagues in many settings, including outside of "traditional" EMS…

148

Result: Less Authority in ED Than in Field

- Paramedics are authorized to perform advanced ALS interventions independently in prehospital settings (e.g. inside patient's living room) per EMS protocols
  - ***However*** → Once inside the ED, the *same* paramedics are limited to task-based, assistive roles rather than full clinical decision-making
  - ***Therefore*** → Scope of practice shrinks at hospital threshold regardless of patient acuity typically increases

149

IRONY ALERT

Hospitals increasingly press EMS clinicians into involuntary service inside the ED during instances of prolonged Ambulance Patient Offload Times (APOT)

150

An anachronistic and protectionist law, *not clinician competence*, drives the difference !!

151

Regulatory Framework Requires an Update

- The regulation has not meaningfully evolved to reflect:
  - Team-based ED care
  - Workforce shortages
  - Proven paramedic integration models in other states

152

BARRIER #3: Operational Mandates That Impede Clinical Flow

153

EXAMPLE: CALIFORNIA

154

APOT Matters

- Ambulance Patient Offload Time (APOT) is the interval between an ambulance's arrival at the ED and the formal transfer of patient care to hospital staff
  - Reducing APOT improves EMS availability and eases staffing demands
  - Nationally, offload delays are a major recognized crisis for EMS systems

155

California AB 40

- California Assembly Bill 40 (2023) was well-intentioned legislation to reduce Ambulance Patient Offload Times (APOT)
- Law requires the EMS Authority (EMSA) to improve APOT tracking, data, and protocols

156

California AB 40

- (1) "The authority shall develop and implement a...***requirement for an electronic signature*** for use between the emergency department medical personnel at a receiving hospital and the [EMS personnel] that captures the points in time when the ambulance arrives at the hospital emergency department bay and ***when transfer of care is executed*** ***for documentation of ambulance patient offload time***"

CA Health & Safety Code § 1797.120.5(a)(1)

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California AB 40

- (2) "The signature ***shall be collected*** when physical transfer of the patient occurs and the report is given to hospital staff and shall note ambulance arrival time at the hospital."

CA Health & Safety Code § 1797.120.5(a)(2)

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California AB 40

- The intent is clearly to establish a transfer of care data element in the state EMS Information System to be able to "document APOT"
- The "shall be collected" language in (a)(2) is intended to provide guidance on the time interval, i.e., the point when the patient "handoff" occurs

159

California AB 40

- ***However,*** the language has been interpreted as creating a substantive requirement that EMS clinicians must obtain the APOT signature ***before they are permitted to leave*** the ED

160

CA EMSA Emergency Regulations

- The state lead EMS agency in California is the California EMS Authority (CA EMSA)
- EMSA published Emergency Regulations implementing AB 40, effective 6/23/25
  - Cal. Admin. Code Title 22, Division 9, Chapter 1.2, Delivering Equitable and Person-Centered Care, Ambulance Patient Offload Time

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Proposed Definition

- EMSA's initial Emergency Regulation (Article 2 § 100002.18) included this definition:

"Transfer of care" means when an ambulance patient, who has arrived at the receiving area of a general acute care hospital, is transferred to the hospital gurney, bed, chair, or other acceptable location and the hospital staff receives report and provides electronic signature on the ePCR ***at which point the EMS crew is free to leave***

162

This language raised immediate red flags…

163

From Data Element to Choke Point

- EMSA's emergency rule turned AB 40's data collection mandate into an *explicit* condition precedent to EMS leaving the hospital
- California Ambulance Association (CAA) submitted formal comments, drafted by PWW, objecting to this proposed language

164

Final Definition = *Still Problematic*

- The final Emergency Regulations ultimately removed the phrase "***at which point the EMS crew is free to leave***"
  - ***However*** → the definition still requires an electronic hospital staff signature to document transfer of care which is also problematic

165

Creates an Implicit Mandate

- Gives hospitals control when and whether signatures are provided
- EMS crews cannot complete required APOT documentation **without hospital action**
- In practice, this compels EMS to remain on hospital property until signatures are obtained

166

Hospitals Have Previously Used Signatures to Delay Release

- There have been documented instances where hospitals refuse to sign ePCRs until they unilaterally decide to "accept" care
  - ***Therefore*** → AB 40 signature requirement gives hospitals additional leverage
  - The result can actually ***prolong*** APOT, the very thing the law was meant to ***reduce***

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When the Hospital's Duty of Care Arises

- Under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), a hospital's duty of care arises upon the arrival of a patient on hospital property
- The statute does ***not*** condition this duty on documentation or signatures

42 U.S.C. § 1395dd

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EMTALA

- 42 USC § 1395dd(a) broadly states:

"If any individual… comes to the emergency department and a request is made… the hospital must provide for an appropriate medical screening examination."

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Arrival on Hospital Property Triggers EMTALA Obligations

- An individual is considered to have come to the emergency department if the individual arrives by ambulance on hospital property (42 CFR § 489.24(b))
  - Regulations are explicit that EMTALA obligations arise when the patient arrives on hospital property
  - Imposition of the duty is not delayed by patient handoff documentation formalities

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What is "Hospital Property"

- EMTALA defines hospital property broadly
- Includes areas well beyond the ED doors
  - Parking lot, sidewalk, and driveway (42 CFR 489.24(b))
  - Areas within 250 yards of the main buildings (42 CFR § 413.65(a)(2))

171

Hospitals May Ask EMS to Stay But CANNOT Require It

- Centers for Medicare & Medicaid Services (CMS) which oversees/enforces EMTALA provides clear guidance that continued EMS presence is optional
- Hospitals may request assistance, but EMS is ***not*** obligated to remain

CMS EMTALA Interpretive Guidelines, § 489.24(a)(1)(i))

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California Signature Requirement Conflicts with Federal Law

- Electronic signature requirement risks a *de facto* delay in assumption of the hospital's duty, which federal law fixes ***at arrival*** on hospital property
  - State regulations cannot alter or delay federally imposed obligations and may not stand as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress

173

Forced In-Hospital Care and EMS Resource Drain

- Extended EMS presence in the ED results in uncompensated in-hospital staffing
- Communities lose 911 coverage while units are detained "on the wall"
- EMS is substantially more resource-constrained than hospitals

174

Additional State Law Conflict

- California law limits paramedic scope of practice to *prehospital* settings:
  - "The statute does not extend the scope of practice of a [paramedic] beyond prehospital settings"
  - ***Therefore*** → regulations requiring extended in-hospital practice are inconsistent with this statute

Cal. Health & Safety Code § 1797.194

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Bottom Line

- We should support APOT data collection and accountability (good intentions) but not at the overall expense of EMS systems
- Even well-intentioned and seemingly innocuous data collection requirements can impair EMS system sustainability

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BARRIER #4: Structural/Political Barriers to Efficient System Design

177

Restricting EMS System Design

- Some EMS statutes go beyond regulating care
- Some expressly prescribe or limit which personnel or agencies can furnish certain services
- These often reflect political preferences for constituencies that are better financed and more politically powerful
  - These can include labor unions, hospitals, nursing interests, etc.

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EXAMPLE: CALIFORNIA

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California's CP/TAD Statute

- Community Paramedicine / Triage to Alternate Destination (CP/TAD) law is codified at Cal. Health & Safety Code §§ 1800–1850
- ***Appears, on its face, to support innovation***

180

What is CP/TAD?

- Allows EMS to transport selected patients to appropriate non-ED destinations after clinical screening by a community paramedic
- Includes transport of patients with behavioral health crises (but no emergent medical needs) to mental health crisis centers
- Includes transport of acutely intoxicated patients without acute medical or psychiatric needs to sobering centers, instead of emergency departments

181

Intended to Expand Options

- Reduce unnecessary ED utilization
- Improve patient-centered, low-acuity care
- Increase EMS system sustainability

182

Innovation with Conditions

- CP/TAD is not treated as a core EMS service
- Statute tightly controls how programs may be implemented
- Local EMS agencies' flexibility is drastically constrained

183

First Key Limitation: § 1841(e)

(e) The local EMS agency shall not include, in a request for proposal or otherwise, the provision of community paramedic program specialties or triage to alternate destination program specialties as part of an existing or proposed contract for the delivery of emergency medical transport services awarded pursuant to Section 1797.224. The local EMS agency shall not offer additional points or preferences to a bidder for emergency medical transport services on the basis that the bidder will provide, or has negotiated or agreed to provide, community paramedicine or triage to alternate destinations.

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Cal. Health and Safety Code § 1841(e)

- Effectively restricts how CP/TAD may be incorporated into EMS system design
- California law permits local EMS agencies to establish "Exclusive Operating Areas" (EOAs)
- The CP/TAD law prohibits local EMS agencies from requiring CP/TAD in EOA procurement processes

185

What § 1841(e) Actually Does

- CP/TAD may NOT be included as a required element of an EOA contract
- THEREFORE → CP/TAD becomes optional and peripheral
- Integrated, system-wide deployment is effectively blocked

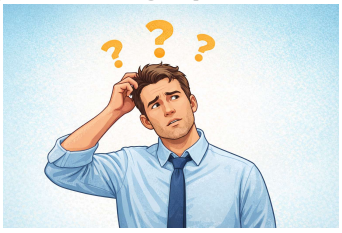
186

Why These Restrictions Matter

- EOAs are the backbone of California's EMS system design
- RFPs for EOAs determine *what services are provided* and *how the system functions*
- ***Therefore*** → excluding CP/TAD from RFPs prevents ***full integration*** of patient-centered EMS modalities

187

Although California law allows for CP/TAD, it only does so in ways that prevent it from ever truly becoming a part of the system itself…



188

Second Key Limitation: § 1842(a)(1)

- A Local EMS Agency that elects to develop a community paramedicine program shall:

(1) Provide a first right of refusal to the public agency or agencies within the jurisdiction of the proposed program area to provide the proposed program specialties for community paramedicine. If the public agency or agencies agree to provide the proposed program specialties for community paramedicine, the local EMS agency shall review and approve any written agreements necessary to implement the program with those public agencies.

189

Right of First Refusal

- Before any EMS organization may provide CP/TAD services, the LEMSA must first offer public agencies within the jurisdiction the opportunity to provide these modalities
  - If a public agency agrees to provide the CP/TAD specialty, the LEMSA must approve agreements with that agency
  - Only if the public agency declines may the LEMSA consider other providers

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Definition of "Public Agency" – § 1817

- "Public agency" means a city, county, city and county, special district, or other political subdivision of the state that provides first response services, including emergency medical care

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Because fire departments & fire protection districts are predominantly the *public* entities providing "first response services, including emergency medical care" in California, the statute effectively gives them *de facto* priority access to provide CP/TAD Services statewide

192

What This Really Means

- Fire departments must be offered CP/TAD roles first, ***even if another provider is better positioned and even if system integration would be improved otherwise***

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What This Really Means

- This has nothing to do with the old debate about whether EMS is best positioned in the public or private sectors
- EMS systems – whether fire-based, third-service, hospital-based, private or nonprofit – can deliver high quality, patient-centered care regardless of ownership
- This is about protectionist laws that artificially preserve political advantages at the expense of coordinated EMS system transformation

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Political Preference Written in Law

- CA EMS law reflects long-standing political compromises between fire service interests, local government, and private EMS providers
- Rather than setting outcome-based standards, the statute allocates priority based on provider type and due to legislative advocacy by public unions often favors public agencies (i.e. fire-based EMS)

195

Political Preference Written in Law

- This embeds political accommodation directly into law, limiting local EMS agencies' ability to design systems based on performance or need

196

Combined Effect of the CP/TAD Statute

- LEMSAs are barred from integrating CP/TAD into core system contracts through EOA RFP restrictions
- Participation is pre-allocated by statute, requiring public agencies (i.e. fire depts.) to be offered CP/TAD first
  - ***Therefore*** → provisions strip LEMSAs of meaningful authority to design integrated, patient-centered low-acuity care systems

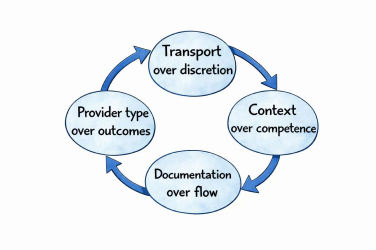
197

A Potential Bright Spot

- Key CP/TAD provisions in Cal. Health & Safety Code contain a sunset date in 2031
  - This at least creates a built-in opportunity to revisit and modernize (albeit not for another 5 years)
  - And, the same interest groups that procured passage of this law will be equally powerful (if not more so) in 5 years

198

A Repeating Legal Pattern



199

What These Laws Have In Common

- These rules were generally shaped by longstanding tradition and a parochial view of what "EMS" can be
- Some EMS laws also spring from political accommodation, economic protectionism and special interest legislation

200

Why This Matters NOW

- Legal reform CANNOT wait:
  - Workforce shortages
  - ED boarding & APOT crises
  - Proven alternative care models already
  - Financial unsustainability

- Non-reform risks ***stagnation***

201

Laws Should Be Enabling & NOT Create Obstacles

- Modern EMS law should:
  - Enable discretion
  - Follow evidence
  - Support integration
  - Be outcome driven

202

What Reform Should Look Like

- Recognize that EMS is *mobile healthcare*
- The unit of value must be the **clinicians** – ***not the ride to the hospital***
- Legal default favoring transport must be eliminated

203

What Reform Should Look Like

- Statutes and regulations must incorporate competency-based scope of practice frameworks
- Clear limits on operational control by hospitals
- Outcome-driven system design authority
- Performance measured by clinical excellence and not speed, provider type, employment status, location or other non-clinical criteria

204

What Reform Should Look Like

- 50-state adoption of the EMS interstate compact
  - "Recognition of EMS Personnel Licensure Compact"
  - "REPLICA"
  - Permits EMS clinicians holding a license or certification in a Compact state to practice in other Compact states without needing separate certification or license

205

What Reform Should Look Like

- Physician delegation pathways outside of the traditional EMS system can also facilitate innovative practice modalities
  - Some state medical practice acts allow physicians to delegate medical tasks directly to individuals the physician deems competent, regardless of EMS licensure or certification
  - These laws have allowed companies offering in-home acute care, telehealth and other patient-centered modalities to deploy EMS clinicians in alternative care models without implicating the EMS Act

206

This Requires Collaboration

- EMS leaders
- Regulators
- Hospitals
- Physicians
- Nurses
- Legislators

207

Identifying Legal Barriers to EMS System Transformation

Doug Wolfberg, Esq.

Widener University Commonwealth Law School

208

The "People" Side of Change:

Leading the EMS Workforce to a Transformative EMS System

Steve Wirth, Esq.

Widener University Commonwealth Law School

209

Overview

- Putting Today's EMS Workforce into Context
- What Paramedics *Really* Want
- The "Expectations" Problem We've Created
- The "Foundational Four Cs" for Workplace Success During the EMS Transformation
- EMS Leadership Action Steps

210

Putting Today's EMS Workforce Issues Into Context – Practical and Legal Landscape

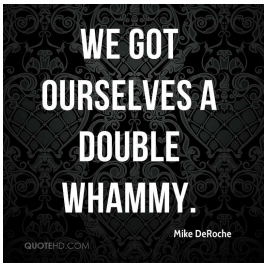
211

It's Tough Out There – Especially for Our People!

The "Double Whammy" for EMS – Social Unrest and COVID-19

Increased call volumes with non-acute patients and system *misusers*

Inadequate reimbursement and system design issues



212

Americans Agree Nation Is Divided on Key Values

Percentage perceiving natio... new high

Americans under 30 are miserable compared to Boomers: 'The future is looking pretty bleak'

Nine in ten Americans say overcoming divisiveness is now more important than ever before

New report card on American well-being finds U.S. is 'so wealthy but so unhappy'

213

The Price of Incivility

by Christine Porath and Christine Pearson

From the Magazine (January–February 2013)

Coping With The Rise Of Incivility

Follow Author

By Joyce E. A. Russell, Contributor. Joyce EA Russell is an expert on leadershi...

Future Healthc J. 2023 Mar; 10(1): 69–77. PMCID: PMC10538688
doi: 10.7861/fhj.2022-0092 PMID: 37786504

The impact of interprofessional incivility on medical performance, service and patient care: a systematic review

Clive Lewis, doctorate student[A]

214

METRO

'Lazy Medic' drops patient day after fake phone call

By Georgett Roberts, Jennifer Bain and Laura Italiano

L.A. firefighter who struck handcuffed patient accepts suspension as video is released

Fairfax County (VA) Firefighter on Leave for Allegedly Assaulting Patient

215

Iowa EMT placed on probation for improperly administering ketamine

The Iowa Department ... Public Health said the EMT also falsified records

State says paramedic misled doctor, sent 'dead' woman to funeral home who was still alive

Family files lawsuit blaming Fla. paramedics for woman's death

A complaint filed last week says Crystle Galloway died "because of the negligence ... of four paramedics who failed to properly treat her"

216

Cincinnati 911 dispatcher suspended for reportedly refusing to send ambulance to stroke victim

Officials say the dispatcher didn't initiated an EMS response during or after the eight-minute 911 call despite having the patient's address

Paramedic suspended after punching accident victim in ambulance

2 EMTs suspended for allegedly assaulting handcuffed patient

The EMTs are accused of verbally provoking the injured man and physically striking him multiple times

217

Root Cause of the Problem?

"Two thirds of our youth feel that their parents do not value caring for others as much as they value achievements and accolades."

- *"The Children We Mean to Raise: The Real Messages Adults are Sending about Values"*, Cambridge, Harvard Graduate School of Education (2014)

218

Root Cause of the Problem?

"Fully One Third of All Americans Do Not Even Consider Compassion for Others as One of Their Core Values."

- *"A Divided and Pessimistic Electorate,"* Pew Research Center (2016)

219

Why Your People are the Key - Research Shows It!

Most lawsuits are NOT based on negligence, but on COMMUNICATIONS ISSUES, LACK OF COMPASSION and instances of disrespect and inattention

220

Lack of Communications/Compassion

- Deserting the patient
- Devaluing the patient's views
- Delivering information poorly
- Failing to understand the patient's perspectives
  - ***These problems were present in 70% of all malpractice depositions !***

Beckman, The Doctor-Patient Relationship and Malpractice, Arch Intern Med. (1994)

221

Effects of Poor Communication in Healthcare

Posted By Steve Alder on Dec 23, 2023

THE HIPAA JOURNAL

Medical safety experts at CRICO Strategies investigated 23,000 medical malpractice lawsuits and found more than 7,000 of those lawsuits could be attributed to communication failures. Those communication failures resulted in $1.7 billion in malpractice costs and almost 2,000 preventable deaths. A study conducted by the Joint Commission found 80% of serious medical errors were the result of miscommunication between caregivers during patient handovers.

222

What EMS Clinicians *Really* Want

223

The impact of leadership

When it comes to retention, poor leadership was cited by 7 in 10 respondents this year (72%) as having an impact on retaining quality people. This is up from 64% last year.

- "The lack of leadership contributes to the lack of retention, recruitment and further short staffing ambulances to a busy 911 system."
- "Leadership is out of touch with personnel wants. They do not realize they are no longer innovative and believe there is no need for change in current department culture."
- "Our leadership feels threatened by anyone with more experience that offer solid ideas to assist them with their duties. Most of our leadership do not have the qualifications to hold their positions and lack the personality to be positive influences on the system."

What Paramedics Want, 2022
Fitch & Associates, EMS1 and Pulsara

224

Leading causes of stress

Given the environment most EMS professionals work in, this is probably not surprising to most. What should be of concern is those stress-causing factors topping the list. While a variety of elements were identified, respondents ranked the most stressful aspects of their job as:

1. Poor agency leadership
2. Their direct supervisor
3. Personnel management/staffing
4. Salary

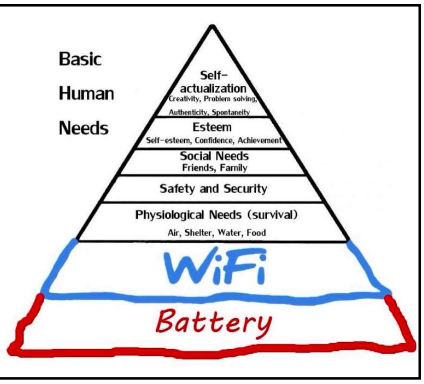
225

	2025	2024	2023
1	**Burnout**	**Retention of quality personnel**	**Retention of quality personnel**
2	**Retention of quality personnel**	**Funding and reimbursement**	Career development/advancement
3	**Funding and reimbursement**	Career development/advancement	Recruitment of qualified applicants
4	Career development/advancement	Leadership	Provider mental health
5	Recruitment of qualified applicants	Recruitment of qualified applicants	Leadership
6	Leadership	Provider mental health	Education of the workforce
7	Provider mental health	Provider safety	Provider safety
8	Education of the workforce	Education of the workforce	Wait Times/hospital delays
9	Provider safety	Criminalization of medical errors	Quality of care
10	Wait time/hospital delays	Wait time/hospital delays	n/a

What Paramedics Want, 2025
Fitch & Associates, EMS1 and Pulsara

226

Challenges of Today's Workforce



227

How Covid Changed The Workplace: It's A Whole New World Out There

Gen Z Is Toxic for Companies, Employers Believe

The New Challenge of Engaging Younger Workers

228

The Generations

- Baby Boomers (1946-1964)
- Generation X (1965-1980)
- Millennial Generation or Gen Y (1981 – 1996)
- Generation Z or iGen (1997-2010)
- Generation Alpha (2010 – 2024)
- Generation Beta (2025 – 2039)

229

Big Part of the Problem

230

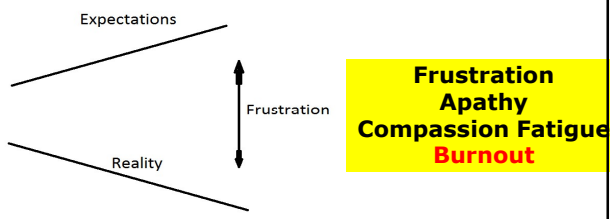
The "Expectations Problem" We Must Address as We Move to Transform EMS…

231

"We're Going to Train You to Save Lives With Sophisticated Medical Skills and Equipment"
(a/k/a lifesaving interventions)

232

The Big Disconnect



Frustration
Apathy
Compassion Fatigue
Burnout

233

"Misalignment" of Expectations – Often Our Fault!

234

Andy's Expectations

"Patients and incident responses are not an interruption of our day - *they are the reason we exist!*"

Andy Lovell, Chief)(*alovell@co.gloucester.nj.us*)

235

The Legal Landscape

236

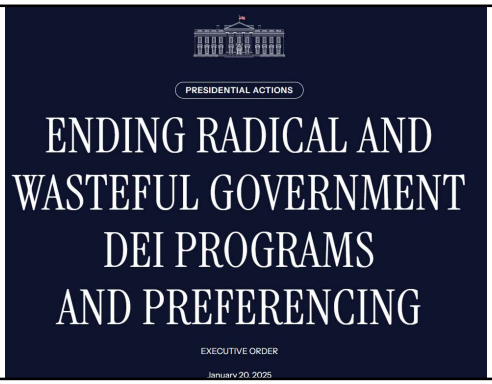
EEOC Retires Guidance Protecting LGBTQ Workers and Others From Discrimination, Continuing Rapid Remake of Federal Policy Through Presidential Action

Trump's Mass Firings of Federal Workers Spread Chaos Nationwide

Trump DEI Order: How Could the Administration's Plans to Target Private Sector Impact Employers? (US)

President Trump Eliminates Affirmative Action and Anti-Discrimination Requirements on Federal Contractors (US)

237



238

Remember: Federal and State Anti-Discrimination Laws Have Not Changed!

- Employers must ensure a non-discriminatory workplace
- Discrimination on the basis of sex, gender – including "sexual orientation" and "gender identity" - STILL PROHIBITED!

239

Best Advice

- Treat everyone in the workplace with fairness, respect, and dignity
- Employment decisions should NOT be based on the person's age, race, sex, religion, national origin, sexual orientation, gender identity or any other protected class

240

The "Foundational Four Cs" Necessary for Workplace Success During the EMS Transformation

241

The "Foundational Four Cs"

- *Competent* Care
- *Communicative* Care
- *Collaborative* Care
- *Compassionate* Care

242

Competent Care

243

Competent Care

- Are we adequately checking our people out?
- Do we provide proper onboarding?
- Do we effectively evaluate clinical competency?
- How do we handle medical errors and untoward events? Just Culture?
- Do we keep up with the ***new modalities of care***?

244

New Modalities of Care

- ***Treatment in Place*** - added requirements for patient communication and documentation
- ***Telehealth*** – interface with scene care and documentation

245

New Modalities of Care

- ***Increased interfacility transports*** – more acutely ill patients transported longer distances – do we have adequate protocols, equipment, clinical training, staffing and transfer of care procedures?

246

Other Critical Patient Issues In This Transformation…

- Mental health and "difficult" patients – we are caught in the midst of a mental health crisis
- Elderly patients – increasing population of elderly and fear of hospitals and costs
- Pediatric patients – increase in number of sicker infant and pediatric patients

247

Communicative Care

248

Verbal Communication

- Confident initial approach to the patient
- Warm, friendly introduction
- Sincere concern and empathy
- Verbal and non-verbal techniques to enhance communication

249

Verbal Communication

- Communicate with family
- Comforting verbal tone and volume
- Avoid extraneous chatter with co-workers
- Smile!
- Say Goodbye!

250

Written Communication

- Complete and thorough patient care report (PCR)
- Explanation of forms and obtaining proper signatures
- Completing supporting and other patient documentation
  - It's about ***creating an accurate and complete medical record***

251

Collaborative Care

252

It's a Team Effort!

- We work with diverse professionals
- Need to be cooperative in all aspects of our work
- There should be no barriers when it comes to communicating about patient care!

253

We Need to be Adaptive!

- Telehealth is here – brings in other professionals and unique challenges
- Now working more often with "Advanced Practice" providers and clinicians
- Need to consider outpatient treatment plans, unique needs of home visits with community paramedicine and "hospital at home" programs

254

"EMS Is No Longer Just *Emergency* Medical Services"

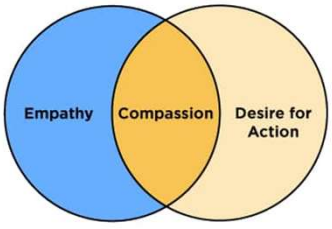
But…
We Are Still High *Touch* and High *Tech* - We Must Lead in Both Categories Working *Collaboratively*

255

Compassionate Care

256

"Empathy is *Feeling* – Compassion is *Action*"



257

Compassion: The Ability to…

- Understand the patient's situation, perspective and feelings
- Communicate that understanding and check its accuracy
- ***Act on that understanding in a helpful and beneficial way***

258

Compassion: Results In . . .

- Patient reporting more about his/her symptoms and concerns
- Increased diagnostic accuracy by the provider
- Patient gets more illness-specific information
- Patient's increased participation and education

259

Compassion: Results In . . .

- Patient's increased compliance and satisfaction
- Patient's greater enablement
- Patient's reduced emotional distress and improved quality of life

260

Compassion Cascades

Kindness Is Contagious – Let's Start an Epidemic!

- Michelle Getchell

261

The "Foundational Four Cs"

- *Competent* Care
- *Communicative* Care
- *Collaborative* Care
- *Compassionate* Care

262

8 Leadership Action Steps To Prepare the Workforce for the Transformative EMS System

263

1. Establish a Positive and Supportive Culture for Change

264

"We may only be a BLS service...and our scope of practice may be limited, *but our ability to make our patients feel good is unlimited!*"

Steve Grau, Royal Ambulance

265

"Our business has very little to do with our ambulances, equipment, or gurneys. *It has everything to do with the people providing care and interacting with patients and their families.*"

- Paul Scarborough, Premier Ambulance

266

"We don't treat patients, we CARE for PEOPLE"

267

2. Train *Everyone* on Positive Communications and Compassion Skills

268

"Thankfully, all of us have the power to get better at compassion for others if we keep a growth mindset and are very intentional about it. We are all works in progress, *but if we believe we can get better at empathy and compassion, we will.*"

https://hbr.org/2023/02/leading-with-compassion-has-research-backed-benefits

269

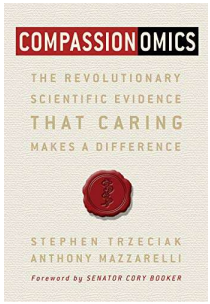
"Compassion Training"

- Integrate "compassion skill checklists" into supervisor, FTO, QA, and cont. ed. materials
- Consider sim-based scenarios with – virtual reality and augmented reality applications
- Consider use of Body Worn Cameras (BWCs)

270

Compassion Makes a Difference

- Mitigates Pain – Physically and Psychologically
- Increases Fulfillment in Careers
- Reduces Likelihood of Medical Errors
- Increases Patient Cooperation
- Improves Patient Outcomes
- Reduces Complaints and Lawsuits



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HARVARD BUSINESS REVIEW

"The good news is that becoming more compassionate is not only possible; it's actionable"

Leading with Compassion Has Research-Backed Benefits

by Stephen Trzeciak, Anthony Mazzarelli and Emma Seppälä

February 27, 2023

Juan Moyano/Stocksy

272

3. Develop Innovative Training Programs

- Virtual Reality, Augmented Reality, AI, Holistic Simulation Environments – allows for training in routine, dangerous, or uncommon situations in a realistic and safe environment, enhancing skills
- Smartphone based applications and tools

273

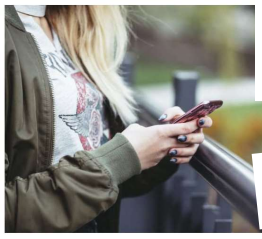
JULY 17, 2025 The GIST

International study shows impact of social media on young people

by Nanyang Technological University

edited by Lisa Lock; reviewed by Andrew Zinin

The use of social media is contributing to declining attention spans, emotional volatility, and compulsive behaviors among young people, according to a new report by Nanyang Technological University, Singapore (NTU Singapore) and Singapore-based research agency Research Network, in collaboration with U.S.-based AI platform ListenLabs.ai.



"TikTok has made my attention span so low that I can't even watch a one-minute video."

Credit: Unsplash/CC0 Public Domain

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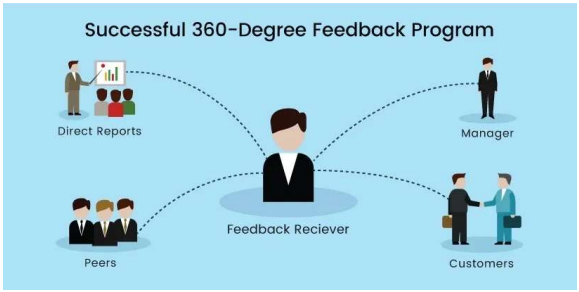
4. Implement 360 Feedback



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5. Provide Effective Mental and Physical Health Resources

276

6. Develop a "Peer Support" Program

Peer support: The key to combatting occupational stress

Understaffed, overworked first responders need robust wellness programs to combat stress

February 28, 2024 10:43 AM • Kerri Hatt

EMS1

277

7. Practice Empathetic Leadership

- Train supervisors on "Emotional Intelligence" and Positive Employee Relations
- Management by "Being There"
- Daily Check-Ins With Your People
- Get to Know Your Team as "People" and Not Just "Employees"

278

8. Develop Mentorship Programs and Alternate Career Pathways

- Formal Mentorship Programs
- Informal Mentorship Programs
- Tuition and Educational Support – It's OK if people leave you after a few years!

279

280

ROYAL AMBULANCE

VISION MISSION & VALUES

OUR VISION

To modernize healthcare transportation by inspiring and empowering a community of thousands of healthcare professionals who will impact 10s of millions of lives.

OUR MISSION

To positively impact the patient's journey, make our customer's jobs easier, and develop healthcare leaders.

281

The Accelerate Scholarship Awards

$10,000 Every Year

to four deserving team members.

ROYAL AMBULANCE

/ALUES

To modernize healthcare tran
community of thousands of hea

OU
To positively impact the patient
and devel

Empowering Tomorrow's Healthcare Leaders

We're on a mission to develop the next generation of healthcare leaders.

By creating financial support programs we've helped our EMT's enter paramedic programs, pursue nursing degrees, become PA's, doctors and more.

If you're an EMT looking to take the next step in your healthcare career, we're here to help.

282

Some Closing Thoughts…

283

Remind Everyone of the Inherent *Value* of Our Work!

284

It's All About

ATTITUDE! . . .

285

Positive Attitude/Compassion =

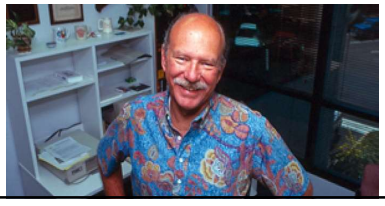
Excellent **Patient Care**
Excellent **Patient Satisfaction**
Excellent **Documentation**
NO Lawsuits!

286

"Saving Our Society"

"There is a great power in small acts of human kindness amidst *social upheaval* and *barbarism* – and YOU have the opportunity to exercise that kind of power every day!"

- Chief James O. Page



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Thank You For Being Here and For All You Do for Your Communities!

288

The "People Side" of Change:
Leading the EMS Workforce to a Transformative EMS System

Steve Wirth, Esq., MS, EMT-P

Widener University Commonwealth Law School

289

BREAK

Widener University Commonwealth Law School

290

State and Federal EMS Legislation

Donald Dereamus
Doug Wolfberg
Steve Wirth
Matt Zavadsky

Widener University Commonwealth Law School

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EMS Advocacy and Legislation in the Commonwealth

Agenda and Current Legislation
2025-2026 Legislative Session

292

Legislative Tracking

- Not just about the "ambulance"
  - 67 different categories
  - 210 tracked bills

293

Legislative Tracking

- Budget
- Business
- Clinical
- Education
- False Claims
- LODD
- Marijuana
- Minimum Wage
- Municipal Funding
- POLST
- PTSI
- Recognition
- Recruitment
- Reimbursement
- TIP
- Worker's Comp

294

EMS Advocacy

- Legislative agenda
  - Workforce
  - Sustainable Funding
  - Reimbursement

295

Workforce

- HB 73 (PN61) – Referred House VA&EPC
  - **EMS Recertification:** Simplifies recertification for EMRs and EMTs with expired certifications (6 years or <) through testing, continuing education, and CPR certification.
  - **EMS Vehicle Training:** Allows digital vehicle operator training and removes CEU requirements for vehicle operator registration.
  - **Ambulance Staffing Flexibility:** Adjusts ALS staffing for flexibility during emergencies, for ALS calls. It also permits early-arriving crew members to begin care at their skill level.
  - https://www.palegis.us/legislation/bills/2025/hb73

296

Workforce

- HB 996 (PN 1085) – Referred House VA&EPC
  - The bill primarily focuses on the EMS system, specifically regarding minimum staffing levels for BLS ambulances, and making a previous temporary act (Act 72 of 2022) permanent
  - Removes the current sunset date (April 29, 2027)
  - https://www.palegis.us/legislation/bills/2025/hb996

297

Sustainable Funding

- HB 393 (PN 358) – Referred Senate Local Government
  - Fire Services Tax: Increases the maximum millage a township can levy for fire services from 3 mills to 10 mills
  - **EMS and Rescue Tax:** Increases the allowable tax for ambulance and emergency services from **0.5 mills to 5 mills**
  - **Voter Approval:** If a township proposes a tax rate higher than these new 10 or 5-mill limits, the question must be submitted for **voter approval**
  - https://www.palegis.us/legislation/bills/2025/hb393

** Act 54 of 2025 – Raised millage to same rates in areas of southeastern PA
To date no municipality has raised their millage since passage

298

Sustainable Funding

- SB 737 (PN 1278) – Senate – First consideration
  - **Public Safety Authorities:** Counties are authorized to create these authorities to manage and support EMS and other "public safety projects"
  - **Optional Participation:** Municipalities have the option to join a county authority or contract with one to satisfy their emergency service obligations
  - **Funding and Rates:** Authorities are empowered to fix and collect reasonable, uniform rates for their services, with public notice open meeting requirements.
  - **Supporting Existing Services:** Designed to support, rather than replace, existing EMS agencies by providing centralized administrative and coordination tools.
  - https://www.palegis.us/legislation/bills/2025/sb737

299

Reimbursement

- HB 1152 (PN 1272) – Referred to VA&EPC
  - **Direct Reimbursement:** Requires health insurers to pay EMS agencies directly for 911 emergency services, even if the agency is "out-of-network"
  - **Increased Rates:** Mandates that insurers reimburse EMS providers at **350% of the current Medicare rate** for ambulance services
  - **Prohibition of "Balance Billing":** Prohibits "surprise billing," where patients are charged the difference between what insurance pays and total cost of the service
  - **Mandatory Payment Timeline:** Insurers must issue these direct reimbursements within 45 days
  - https://www.palegis.us/legislation/bills/2025/sb737

300

Reimbursement

- HB 857 (PN 895) – Referred to House Human Services
  - **Reimbursement for Non-Transports:** Beginning July 1, 2025, licensed EMS agencies would receive reimbursement for emergency services even if the enrollee refused transport or did not require it
  - **Rate Adjustment:** Reimbursements would be set at the greater of either the highest 2025 Medicare rates published in the Ambulance Fee Schedule or current Medicaid Ambulance Fees
  - **Human Services Code Amendment:** Amends the Human Services Code of 1967 specifically regarding public assistance and emergency transportation
  - https://www.palegis.us/legislation/bills/2025/hb857

301

Reimbursement

- SB 622 (PN 633) – Referred Senate Banking & Insurance
  - **Direct Reimbursement:** The bill repeals previous requirements from Act 84 of 2015 leaving just the "direct pay" provision
  - https://www.palegis.us/legislation/bills/2025/sb622

302

Transformation

- Alternative destinations
- Community paramedicine
- Telehealth
- County 911 PSAP dispatch protocol
- IALS dispatch
- EMS Commissioner and/or EMS Act revisions

303

Legislative Success 23-25

- Act 15 of 2023 – Medical Assistance increase
- Act 42 of 2024 – Insurance coverage for telehealth
- Act 121 of 2024 – Worker's comp coverage for PTSI
- Acts 139, 140, 141 of 2024 – Local EMS Tax flexibility
- Act 18 of 2025 – EMS to ODIN reporting network
- Act 1A of 2025 – Budget - $6 million increase to EMSOF

304

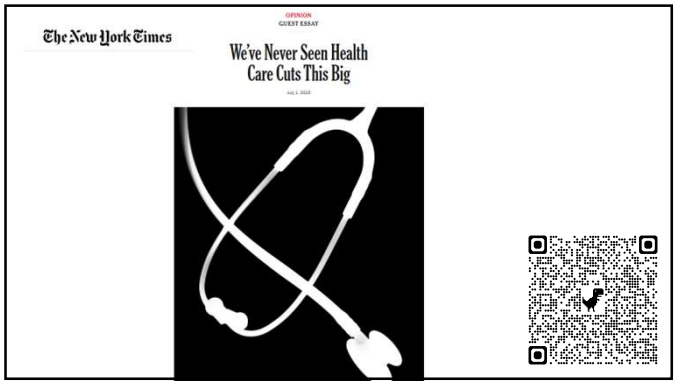
New Federal Laws and Pending Legislation

305

Major OBBBA Impacts

- OBBBA will have significant impacts on EMS agencies
- These will be across the board in all parts of your payer mix
  - Medicare
  - Medicaid
  - Commercial Insurance
  - Self-Pay

306



307

Major OBBBA Impacts

- OBBBA also brings changes to workforce issues that will impact EMS

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Major OBBBA Impacts

- Provisions of the OBBA take effect at various times over the next several years
- Most of the tax cuts and taxpayer benefits take effect sooner

309

Major OBBBA Impacts

- Many of the healthcare cuts take effect later
- Also, remember that Congress could take action to delay or reverse some of these provisions before they take effect

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Medicare Impacts

311

S-PAYGO Trigger

- "Super Pay As You Go" law
- Requires automatic spending cuts when certain deficit levels are reached
  - OBBBA scored at over $3 trillion impact to deficit
- This could have triggered Medicare cuts of almost $500 billion
- However, Congress ***blocked these cuts***, preventing a potential 4% hit to Medicare payment rates

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Medicaid Impacts

313

Fewer Medicaid Enrollees

- Work requirements (2026)
- More frequent eligibility determinations (2026)
- Reductions in eligibility (2027)
- Reduced retroactive eligibility from 90 days to 30 days (2027)

314

Note About Work Requirements

- There is an exception to the Medicaid work requirement in OBBBA in counties where unemployment is at least 8% or 1.5x the national unemployment rate
  - ***If*** the state applies for an exemption

Source: KFF Health News, September 29, 2025

315

Fewer Medicaid Enrollees

- Some ACA "expansion states" also have "trigger" laws that would automatically end Medicaid expansion when Federal Medicaid participation funds are reduced
- *EMS impact: significant payer mix shift from Medicaid to uninsured*

316

Medicaid Cost Sharing Changes

- OBBBA requires states to impose cost sharing on Medicaid expansion adults (i.e., those with incomes over 100% of FPL)
  - Effective 2028
  - Limited to $35 per service or 5% of individual's income
- *EMS impact: reduction in Medicaid reimbursement*

317

Supplemental Medicaid Funding

- OBBBA prohibits states from establishing new provider taxes or increasing existing provider tax rates (effective immediately)
- *Potential EMS impact: no increases to GEMT funding amounts*

318

Cap on State Directed Payments

- OBBBA caps state directed payments (SDPs) at 100% of Medicare rates for Medicaid expansions states
  - This provision is effective upon enactment, but has grandfathering provisions until 2028
- *Potential EMS impact: reduction of Medicaid supplemental payments to Medicare amounts*

319

Despite the "phased in" timeline under OBBBA, some states are already moving to reduce Medicaid spending

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KFF Health News

States Are Cutting Medicaid Provider Payments Long Before Trump Cuts Hit

Nationwide, states are scrambling to close budget shortfalls and are eyeing Medicaid, generally one of a state's biggest costs — even before President Donald Trump's hulking tax-and-spending law decreases federal spending on Medicaid by about $1 trillion over the next decade.

North Carolina and Idaho have already announced plans to cut Medicaid payments to health care providers, including hospitals, doctors, and caregivers.

In Michigan and Pennsylvania — where lawmakers have yet to pass budgets this year — spending on Medicaid is part of those debates. In Washington state, lawmakers approved cuts to the program that will not affect who is eligible, said Hayden Mackley, a spokesperson for the state's Office of Financial Management.

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Commercial Insurance Impacts

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Daily Briefing

Health policy roundup: ACA premiums skyrocket after enhanced subsidies expire

This was one of the key issues behind the 2025 Federal government shutdown

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Not Dead Yet?

The New York Times

House Votes to Restore Health Subsidies, Raising Hopes of a Deal

The passage of the bill was a triumph for Democrats, who drew substantial Republican backing. But it has no path forward, and an election-year compromise is a long shot.

By Michael Gold and Carl Hulse
Reporting from the Capitol

Jan. 9, 2026

324

Limits on ACA Exchange Enrollment

- Shortens enrollment window
  - No automatic re-enrollment
- Limits eligibility, removes premium tax subsidies
- Effective upon enactment
- *EMS impacts: payer mix shift from commercial insured to self-pay/uninsured or Medicaid (if eligible)*

325

Self-Pay/ Uninsured Impacts

326

OBBBA Self-Pay Impacts

- Net result of OBBBA changes to Medicaid and commercial insurance will be to increase the self-pay/uninsured portion of the ambulance service payer mix
- *EMS impacts: less net revenue as self-pay recovery rates are historically extremely low*

327

Workforce Impacts

328

"No Tax on Overtime"

- This is a bit of a misnomer
  - Federal income taxes still withheld
  - But, employees may *deduct* up to $12,500 of OT
- This is *retroactive* to January 1, 2025
- Ends December 31, 2028

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"No Tax on Overtime"

- *EMS impacts: employers must include the amount of qualified OT as separate line item on employees' W-2*
  - *EMS employers must already keep distinct records of overtime compensation as per the FLSA*
  - *Since this OT tax provision is retroactive, for 2025 employers may "approximate" the amount of qualified OT using a "reasonable method"*

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Employer Temporary Relief

- Though OBBBA requires employers to report exemption-eligible overtime, retroactively for 2025, the IRS recently announced "transition penalty relief" for the 2025 tax year
  - IRS Notice 2025-62

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IRS

Treasury, IRS provide penalty relief for tax year 2025 for information reporting on tips and overtime under the One, Big, Beautiful Bill

Transition penalty relief for tax year 2025

Notice 2025-62 PDF provides penalty relief from the new information reporting requirements for cash tips and qualified overtime compensation under the OBBB to employers and other payors for not filing correct information returns and not providing correct payee statements to employees and other payees.

332

I-9 Compliance

- OBBBA substantially increases funds for immigration enforcement
- 10x increase in employer penalties for I-9 compliance errors
- *Potential EMS impacts: increase in workforce immigration compliance activity*

333

Rural Health Transformation (RHT) Program

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RHT Grants

- The Rural Health Transformation program is awarding $50 billion to states for a range of initiatives
- Many state grant applications included EMS as a key component of their efforts

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RHT Grants

- First round of grant awards announced December 29th
- Average state award = $200M

CMS.gov Centers for Medicare & Medicaid Services

Newsroom

Press Releases Dec 29, 2025

CMS Announces $50 Billion in Awards to Strengthen Rural Health in All 50 States

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RURAL HEALTH TRANSFORMATION

RHT PROGRAM STATE PROJECT ABSTRACTS

https://edit.cms.gov/files/document/rht-program-state-provided-abstracts.pdf

337

PWW's Summary of EMS Initiatives under the RHT Program

PWW|AG

EMS Initiatives Under the Rural Health Transformation Program

A National Summary

December 2025

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A Few of the State RHT Initiatives Involving EMS

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Florida

Plan Highlights: Deploys community paramedics and, where appropriate, other licensed practitioners to provide on-site support for minor illnesses within their scope of practice and deliver post-discharge care for high-risk patients to reduce preventable readmissions.

Planned Investment: $18M over the five-year grant period

Partners Identified: Not specified.

Pennsylvania

Plan Highlights: EMS/Transportation initiative modernizes fleets and equipment, stabilizes the EMS workforce, expands paramedicine and mobile integrated health, and strengthens MATP/NEMT for preventive and routine care in rural communities.

Planned Investment: ≈$86.5M

Partners Identified: EMS agencies and regional councils; FQHCs, rural health clinics, and primary care clinics; Pennsylvania Emergency Health Services Council, PSAPs, rural hospitals and health systems; training institutions, high schools, shared-ride providers, transit authorities, and county MATP administrators.

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Virginia

Plan Highlights: Community Paramedicine funds EMS-led treat-in-place care, preventive visits, and telehealth consultations; mobile and hybrid care expands primary and preventive services via mobile units and telehealth in rural communities.

Planned Investment: Included within the $412M Connected Care, Closer to Home initiative; specific EMS allocation is not broken out.

Partners Identified: EMS organizations are not named individually; community paramedicine and EMS-led services are implemented through rural providers and local health systems.

Hawaii

Plan Highlights: A statewide, real-time, coordination hub will unify EMS, hospitals, telehealth, and air-medical systems across all islands into one interoperable network. EMS fleet modernization will replace aging vehicles including ambulances, paramedicine units, mobile medical units and rapid response vehicles to improve reliability, reduce downtime, and expand access to care in rural and underserved areas.

- Integrate community paramedicine and home-based care models to reduce preventable 911 calls, ED utilization, and hospital readmissions. Deploy secure, video enabled application to support paramedic visits.

Planned Investment: $55M over the five-year grant period.

Partners Identified: Not specified

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EMS OBBBA Action Items

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Determine Revenue Impacts

- Perform economic modeling of payer mix shifts
  - Determine the potential impacts to your agency
  - This is critical to knowing how much revenue you may need to replace after OBBBA cuts take effect

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Improve Payer Discovery

- With shifts in payer mix, and eligibility changes, robust payer discovery will be critical
- This includes both:
  - As part of the billing process, *and*
  - At time of service
    - Crew members should ask about – and document - insurance whenever circumstances and pt condition allow

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Improve NET Intake

- For non-emergency transports:
  - Improve information gathering at time of requests
  - Make pre-transport medical necessity determinations
  - Capture pre-transport payment for non-covered services

345

Implement Alternative Modalities

- One key to success in the post-OBBBA environment will be to "right size" your response and transport services

346

Implement Alternative Modalities

- Reduction of unnecessary response and transport volume
  - Pre-dispatch disposition
  - Non-transport modalities, telehealth, etc.
  - Transport to alternative destinations
- CP/MIH programs

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Readmission Penalties

- The number of hospitals faced with readmission penalties is forecast to rise to its highest level since 2022
  - Over 8% of all hospitals
- EMS can make a strong case for readmission avoidance through MIH/CP programs

https://www.modernhealthcare.com/providers/mh-cms-hospital-readmission-penalties-2026/

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Other Impacts

- Rural hospital closures → *Expect longer transport times/distances*
- Increased primary care in EDs → *Longer ambulance patient offload times*
- Reduced hospital capacity → *Potential for more interfacility transports*

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Other Federal Legislation

350

Continuing Appropriations Act

- Extended the Medicare Ambulance Fee Schedule bonus payments through January 30th
- These bonuses pay additional amounts for ambulance service bae rates + mileage depending on the point of pickup of the patient:
  - 2% urban
  - 3% rural
  - 22.6% super rural

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Continuing Appropriations Act

- Also extended through 1/30/26:
  - Medicare "Hospital at Home" initiative
  - Medicare telehealth flexibilities
  - Some EMS agencies across the country deliver care modalities under these programs

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Ambulance "Extenders"

- The Medicare bonuses are scheduled to expire January 31st
- Legislation to extend the bonuses:
  - HR 2232 - Protecting Access to Ground Ambulance Medical Services Act of 2025
    - Would ***extend*** the current bonuses
  - S. 1643 – Senate version
    - Would extend ***and increase*** the bonus amounts

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EMS Workforce Legislation

- HR 2220 – Preserve Access to Rapid Ambulance Emergency Medical Treatment Act
  - "PARA-EMT Act"
  - Would establish a pilot program to award grants to EMS agencies for the recruitment and training of EMTs and paramedics

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Payment for Treatment Without Transport

- HR 2538 – Comprehensive Alternative Response for Emergencies Act
  - "CARE Act"
  - Would establish Medicare payment for "dispatch of a ground ambulance vehicle [without] a corresponding transport payable under [Medicare]…"

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Keeping Our Eyes on These Interesting Judicial Signals…

Possible unconstitutionality of the *qui tam* provisions of the Federal False Claims Act?

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Qui Tam Refresher

- The Federal False Claims Act (31 U.S.C. § 3729 *et seq.*) contains "whistleblower" provisions which permit private parties ("relators") to bring lawsuits in the name of the Federal government for the filing of false claims (§3730(b))
- Most FCA cases against ambulance services are brought by FCA relators

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Qui Tam Unconstitutionality?

- Two U.S. Supreme Court justices have made passing comments in opinions in other cases raising constitutionality concerns with the *qui tam* provisions as potential Article II violations
  - i.e., improper delegation of Executive branch powers

358

The Act's qui tam provisions raise substantial constitutional questions under Article II.

- Justice Kavanaugh, *Wisconsin Bell, Inc. v. United States ex rel. Heath*, 604 U.S. 140 (2025)

"There are substantial arguments that the qui tam device is inconsistent with Article II and that private relators may not represent the interests of the United States in litigation. In my view, the Court should consider the competing arguments on the Article II issue in an appropriate case."

- Justice Thomas, *United States ex rel. Polansky v. Exec. Health Res., Inc.*, 599 U.S. 419 (2023)

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Closing Thoughts/Q&A

Matt Zavadsky
Steve Wirth
Doug Wolfberg

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Thanks for Attending!

Attorneys: remember to turn in your CLE forms
EMS Clinicians: make sure you signed the CE sign-in

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